



House of Commons
Health Committee

Dental Services

Fifth Report of Session 2007–08

Volume III

Oral and written evidence

*Ordered by The House of Commons
to be printed 23 June 2008*

HC 289-III
Published on 2 July 2008
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Taken before the Health Committee on Thursday 7 February 2008

Members present

Mr Kevin Barron, in the Chair

Charlotte Atkins
Mr Peter Bone
Jim Dowd
Sandra Gidley
Stephen Hesford

Dr Doug Naysmith
Mr Lee Scott
Dr Howard Stoate
Dr Richard Taylor

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

Q1 Chairman: Good morning, gentlemen. Could I welcome you to the Health Committee. This is our first evidence session on our inquiry into dental services. I wonder if I could ask you for the record if you could give us your name and the position you hold?

Mr Crouch: My name is Eddie Crouch. I am Secretary of Birmingham Local Dental Committee and I am Chair this year of the annual conference of LDCs, local dental committees.

Mr Renshaw: I am John Renshaw. I am a general practitioner in Scarborough and I am one of the founder members of CHALLENGE.

Mr Taylor: I am John Taylor. I was until two years ago the Chief Executive of the Dental Practice Board for England and Wales.

Q2 Chairman: John, could you give us a brief description of what CHALLENGE is exactly?

Mr Renshaw: CHALLENGE is a political pressure group that we created, Eddie and I and a friend of ours up in Teesside, Ian Gordon. We did not like what we were hearing from the profession in rebuttal and refutation of what was going on in dentistry and we challenged that and created a new organisation to try to argue the case in what we felt was a more robust manner.

Q3 Chairman: Thanks for that. Could I ask a general question to open this session to all of you? Do you accept that NHS dentistry required reform?

Mr Renshaw: Yes indeed. I do not think anybody would ever claim that the old system was perfect. There are very few systems in this world that are perfect, but the old system had some major advantages and one or two very serious disadvantages. I think the fact that the system had been around for 58 years or so and had been worked on constantly during that time meant that everybody who worked in the industry was familiar with the contract and how it operated. Familiarity does not always breed contempt; sometimes it breeds reassurance. What also was clear from the old system was that flexibility for developing and shrinking practices as and when it suited the practice

and the patients who were wanting to use the service was a huge advantage which is missing from the current system. I think the biggest problem we all perceived was that the fee per item payment system was always seen as being potentially open to abuse. The trouble is, of course, that other systems may be just as open to abuse and we do see some evidence of that with the new system, the way it is being introduced. Yes, we would absolutely accept that the old system was flawed but I do not think that anybody, apart from the Department of Health, would say that the new system that has been introduced is an improvement.

Q4 Chairman: Would you both concur with that, Eddie and John?

Mr Crouch: From my own point of view the difficulty that I have had with the contract is that it has not allowed me to carry on providing NHS treatment for the amount of patients that I want to provide it for. The flexibility has not been there with the introduction of the contract and for me it has been a real hardship, turning patients away who were seeking my help. I find that most frustrating.

Mr Taylor: There are two parts to my answer. To administer payments to dentists was not difficult at all. To prevent and detect fraud and other forms of abuse the reform that I would have pursued would have been to increase the surveillance of the system, and I think with an increase in surveillance it would have been a very good system.

Q5 Chairman: So you think the changes should have been more of an auditing than a new contract?

Mr Renshaw: The tragedy from our point of view was that the new system was never tested at all. It was just introduced across the board without any consultation and nobody knew how it was going to fly. There had been some work on some new pilots on PDS and new ways of working, and the BDA at the time, when I was Chairman of the board, was very supportive of that work and we were hoping that that would produce some real evidence of new ways of working that would be better than the current system, but that was all swept aside and a

new system was introduced without reference to anybody other than the department's internal systems, and the trouble is that nobody bought into it apart from the Department of Health.

Q6 Dr Stoate: The impression from the submissions we have received and what you have just said yourself, John, is that you seem to think that the new system was not sufficiently thought through. Which particular aspects were not thought through? Is there any way you can tell us what they did wrong?

Mr Renshaw: We have thought about this because we knew that this was likely to be the kind of question you would throw at us, and we ended up with a list so long that we thought we could not really give you the whole lot in one go, so I will just read you out some of the bullet points on the lack of forethought. The first thing was that the early work on PDS was simply discarded; that was thrown out as being of no value. There was no formal consultation with the profession. We believe that the duress that was placed on practitioners to sign this deal was grossly unfair. Basically, people were told, "Sign it and you are in. Do not sign it and you are out and you need not think you are coming back". That was basically the message that we were told.

Q7 Dr Stoate: From the department?

Mr Renshaw: From the department, yes. The PCTs at the time of this happening were undergoing internal reorganisation so they had their eye on a very different ball. PCTs were already overspent; they were in serious financial difficulties and did not have any play money to solve any local problems. They did not have anything left to do that. There were no roadshows for dentists to explain to them what was going to happen. The UDAs (Units of Dental Activity) have never been tested. There was no time to argue about the UDAs as a concept. There was no chance to properly argue about individual UDA targets and contract figures. Funding was based on a snapshot view of practice finance at a particular year in time with no room for manoeuvre. I got caught with that. The number of charging bands and patients' charges were certainly worked on but had not been consulted on with the profession. Patient information arrived late. There was not any information for patients ahead of the change. The number of disputed contracts was in excess of 2,000 out of a sum of something like 9,200, which meant that they were really going to dispute the figures and the conclusions in them. The disputed contracts cost a fortune. It just goes on and on. The out-of-hours arrangements, which had been working perfectly, simply went into abeyance. There are virtually no out-of-hours arrangements in many places.

Q8 Dr Stoate: But apart from that it went fairly smoothly?

Mr Renshaw: Apart from that it was pretty good! The thing that concerns us more than anything else is the gulf between what the Department says and everything that everybody else says. I am perfectly willing to concede that I might have a prejudiced

view because I might as an individual have been badly done to in the changeover, but I do not think we have 3,000 members joined up to our campaign because I personally have been badly done to. Three thousand people to me says 3,000 people feel badly enough to go and join an organisation.

Q9 Dr Stoate: Can I just ask John Taylor, do you think the Dental Practice Board should have been more involved in the setting up of the new contracts?

Mr Taylor: No. I think we were well enough involved. The new work was going on roughly and it is our job to administer whatever politicians want; it is not our job to question. We can advise, of course, on our experience but we got the job done so we must have had enough involvement.

Q10 Dr Stoate: So as far as you are concerned you were sufficiently involved?

Mr Taylor: We were sufficiently involved to get the job done and the job was to be able to administer a system after 1 April 2006. We got that job done, so we must have been involved enough. It is not our part to question policy. It is our part to get the administration done.

Q11 Dr Stoate: That is very clear.

Mr Crouch: I would say quite the reverse, I am afraid. John obviously would be very loyal to his position but I personally as a dentist was unable to transmit any information to the Dental Practice Board until the summer of the new contract, three months late. There was no piloting or testing of the software that we were supposed to use. There were no discussions about how these forms should be filled in. Everything was thrust through. We had information given to us at the last minute. Patients were unsure of what system was working. We were not sure of what bands we were supposed to be ticking people into. The information that we could have sent we could not send through the software, so in the end we had to revert to a paper form to at least to keep things ticking along. There was a mad rush to introduce a system that clearly had not been thought through properly.

Mr Taylor: In the light of that could I just add one comment? All my nerve ends tell me that if you are going to introduce a new system you must test and test and test. We did not have the time to test our computer systems but, again, we have got to do the best we can. I would have preferred more time but that was not quite the question I thought you were asking me.

Q12 Dr Naysmith: Mr Renshaw, there is an alternative view to what you have just promulgated, which is that the BDA and dentists refused to engage in proper discussions with the department and eventually the department got fed up and said, "We are going to have a contract anyway". What do you think of that?

Mr Renshaw: It is a view but, of course, you would have to be listening to the Department of Health to take on that view.

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Q13 Dr Naysmith: So you think there is no truth in that at all?

Mr Renshaw: None at all because that is a spun version of the truth.

Q14 Chairman: Why did everybody join Challenge then when they had got professional representation in the country?

Mr Renshaw: If you are claiming that the BDA were not doing their job properly—

Q15 Chairman: No. Normally professional associations negotiate on behalf of the profession.

Mr Renshaw: Yes, they do.

Q16 Chairman: We have it with the rest of the medical profession, quite successfully, we are led to believe, but why in this case did it not happen and organisations like yours appear?

Mr Renshaw: I cannot help but feel that the association was left with some internal conflicts of interest with a number of members that it had working on both sides of this system and it was difficult for them to be as critical as we could be simply because we were representing just one particular group of practitioners who were the contract holders for the new system.

Q17 Dr Naysmith: So there was some alternative view within the representatives of the profession that they wanted to carry on talking perhaps, for whatever reason?

Mr Renshaw: I do not think there was, no.

Q18 Dr Naysmith: You have just said there was because of a conflict of interest. You just said there was.

Mr Renshaw: Yes, but the problem was that the willingness to challenge strongly was tempered by some internal conflicts of interest within the BDA. From our point of view those conflicts of interest did not affect the membership that we had. We did not feel that need to be more circumspect about our criticism. We thought we were entitled to make—

Q19 Dr Naysmith: But what you have said is that there was no-one who was interested in talking about the new contract, basically, and that is not true.

Mr Renshaw: Are you talking about on the profession side or the—

Q20 Dr Naysmith: That some members of the BDA were talking to the BDA and talking about getting this conflict of interest that you are talking about. There is a conflict of opinion as well. There were people on both sides—

Mr Renshaw: You will never find 20,000 people—

Q21 Dr Naysmith: I know that.

Mr Renshaw: You put five people in a room and if they are dentists you will get 27 opinions about what is the best way forward. The problem is that we will

always find factions within professions. We represent a faction that was very unhappy about what was going on.

Q22 Dr Naysmith: That is not true of the whole profession.

Mr Renshaw: Not necessarily in our case, no.

Mr Crouch: I would like to comment on that. If you are having a dialogue with someone who is introducing something you would expect some dialogue to take place. There were many promises made about what the introduction of the new contract would do for the profession and for patients. None of those we thought was a real aspiration for what was being forced upon us, and therefore, if you are having a dialogue with someone, you would expect some give and take, and when there was no give and take it is not surprising that the BDA decided to walk away, because what is the point of them being there and giving advice if it is not listened to?

Mr Renshaw: The worst aspect of that was that the department were clearly going to use the fact that the BDA had been there as a justification that the profession had been involved and that therefore it was okay, guys, and the BDA clearly at that time was not agreeing with that and they felt that the only way they could get away from that was to walk away. You can ask them yourselves. They will be coming along later.

Dr Naysmith: We will do.

Q23 Charlotte Atkins: Is not the reason the department took this all-or-nothing approach, you are either in or out, that it was partly to stop the totally unacceptable practice of dentists bribing parents to take private dental treatment so that their children would be treated on the NHS?

Mr Renshaw: The number of child patients who are being subjected to that kind of pressure I would imagine is very small. I have never seen any evidence of that going on. I know individually you can find practices where they were doing that.

Q24 Charlotte Atkins: Say you had evidence in my constituency?

Mr Renshaw: I am not saying it did not happen but I do not think it was ever a major problem, and if you look at the figures there are something like seven million patients still being treated as children on the NHS.

Q25 Charlotte Atkins: The body language, going round this committee, indicates very strongly that it is not a tiny problem; it actually is an extensive problem in some areas, certainly in my area. I only speak for my own constituency, but, judging by the nodding of heads around this committee, it is very clear that it was a widespread practice and people were forced into things like Denplan simply because otherwise their children would be left without NHS treatments.

Mr Renshaw: I beg to differ with you because I think that the big problem is not about what is going on with the children. Why are adults being taken out of

the system? The answer has to be because the practice cannot make a living, it is not viable on the kind of money that the dentists were going to be getting for looking after the adult patients. If you then have the children, most dentists wanted to be able to keep on their child patients. If you look across the board—

Q26 Charlotte Atkins: No, I am talking about the situation prior to the new contract, the situation which led the Department of Health to say, “You are either in the NHS or outside it”. I am not talking about the new contract. I am talking about the situation before the new contract came in and why the department took the position they did, which was that you were either in, totally with the NHS, or you were outside. You could not have a situation where parents were being bribed to take out private dental treatment for themselves so that their children would have the benefit of NHS treatment.

Mr Crouch: My comment on that would be that initially, when the contract was placed out, within the terms of the contract it allowed practitioners not to discriminate against anyone that they took on as patients. The Department of Health had to change their position on that. Because of the fact that it had not been negotiated they had to allow practitioners to have child-only and selective contracts simply to get the thing in place, so if that was an issue that could have been sorted out with debate ahead of the introduction, but in effect they rushed through with the introduction with that problem still there and it is a lingering problem because these people are still having these lists and they will still have them up until 2009.

Q27 Charlotte Atkins: So do you think it is an unacceptable practice?

Mr Crouch: It does not happen in my particular area. I work in Birmingham.

Q28 Charlotte Atkins: Do you think it is an unacceptable practice?

Mr Crouch: I would be very horrified to think that people were bribing people to sign up to private plans simply by accepting their children. I think that is an unacceptable practice, yes.

Q29 Mr Bone: Does not Government, in a state-run health service, have the right to try and increase access to the NHS for dentistry, which is what was the driving force for this new contract? I suppose the question is, have they succeeded?

Mr Crouch: No, quite clearly, because even from their own figures a quarter of a million fewer people saw an NHS dentist in the first year of the contract.

Q30 Mr Bone: Okay. That is pretty clear. I am not allowed to agree but I do agree, but the issue was that also behind the Government’s idea was, “You horrible dentists are not treating NHS patients in deprived areas”, and they were trying to get more NHS access into areas where there was great poverty or real social problems. Have they succeeded in doing that?

Mr Crouch: No, quite clearly not. The problem with the introduction of the contract was that because it was untested and because it was not piloted every single PCT in the land was a million pounds short in their budget because of the patient charge problem. In my city six practices left the NHS in April 2006 and in January 2008 they replaced the service. They only replaced it then because for the first year of the contract they balanced the books with the million pounds’ worth of dentistry they should have bought with the million pounds that they were short on the patient charge revenue. The idea that a dentist leaves the NHS and another dentist is purchased is admirable but in practice it does not work. Every single dentist who has under-performed in their contract has in some areas had money taken back off them. The PCT are not spending that on additional dentistry. They are not liaising with the local population on what services they want and this money is disappearing into the ether. It is no good having ring-fenced money if it is not accountable, and when we ask our PCT for accounts of how they have spent the budget for the first year we do not get any answers. It is all fudged and hidden.

Q31 Mr Bone: I think, Chairman, this is a very important point because in my area you have described exactly what has happened. All the dentists, dentists who have been in the NHS for years and years, decided they had to go private. There are no NHS dentists available in my constituency. You have to go out of the county to get an NHS dentist. I was forced to go on Denplan, as were thousands of other people, but what struck me as bizarre was, where on earth has all the money the PCT would have been paying to those NHS dentists gone? Have you any idea?

Mr Crouch: First of all, the whole way that the contract was introduced was based on historic funding so, if your area was always an area where it was difficult to access dentistry, unless there were huge amounts of extra money poured in where was that extra dentistry ever going to come from? That is the first point. The second point is that the introduction of the contract came when the finance people within the PCTs were trying to balance the books and that driver from the people within the finance department meant that the ethos of a new contract just did not happen from day one.

Q32 Mr Bone: So, given where we are now, what can be done to encourage NHS dentists into local PCTs? We are where we are so what can be done to improve the situation?

Mr Crouch: Obviously, the department will say that the extra 9% funding they have announced in the new spending review is a step forward in that direction and I probably would agree that some extra funding is definitely necessary and that will help. The problem is that there is a real difference in meaning between access, ie, getting in and sitting on the dental chair, and getting the quality of care that you really deserve when you get in there. There is a real difference with that. If it means that loads of people are not writing to MPs because they can get

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in and sit on the chair, but that once they get in the quality of care they get, because of the system that we are operating under, is not up to the standard, then extra money is not the solution. Extra money only works if the system changes to mean that patients get the quality of care they really deserve.

Q33 Mr Bone: Chairman, I understand we are under pressure of time but again that exactly mirrors what has happened with my constituency. Experienced dentists left the NHS. Inexperienced dentists came in and established new practices, but now the problem is not the access; it is the quality of service they are getting when they go to those new ones. Would salaried dentists be a viable option?

Mr Renshaw: If you go across the border into Scotland they have certainly looked very long and hard at introducing salaried practices and they have brought a lot of salaried people in, particularly into areas where populations are relatively scattered and where the normal model of practice will not work because it is not financially viable. The problem with it is that the output from a salaried practitioner is approximately 40% of the output from a contracted practitioner and therefore value for money is relatively poor, but on the other hand it is a very good answer if you have a particular situation where, for example, you might have high needs but there is a very low economic base which would not make a normal dental practice viable. You can take in there the salaried practitioner. Nobody has ever said, certainly I have never said, that salaried practitioners are of no value. They may not be the answer to the whole thing but in certain places they are a very good answer.

Q34 Mr Bone: My final point, and I do really know how you answer this in a few words, is that my dentist has spent many hours when he has been working on my teeth telling me why he has had to go outside the NHS, but what are the main factors why people who have been in the NHS for years and years, dedicated to the service, feel that they now have to go outside?

Mr Crouch: First of all, we have a cash limited service which puts different emphasis on the way that you prescribe for your patients. If you have a limited budget and also a target to hit, it is not the way that I was taught to do dentistry. I was taught to provide quality of care for my patients irrespective of any target, irrespective of how much budget I had. I wanted to provide the best for my patients. I understand that you must have cash restraints on any service but the amount of money that was being spent on dentistry before the new contract and now, the budget for dentistry never really exceeded what was already in the pot.

Mr Renshaw: Can I just explain my situation? I worked in the NHS for 37 years and I left when the new contract was introduced because I simply could not countenance it, and they made me an offer that was very easy to refuse, frankly, mainly because I got caught in the test period, having been engaged as

Chairman of the BDA and taking a lot of my time away doing that so my practice had shrunk away, but then I had finished and I needed to go back to working and they were not prepared to accommodate me, so 37 years of my efforts on behalf of the NHS were simply—well, two fingers was even less than I got. It was just very destabilising to have that happen after 37 years. What I was looking at in terms of what I wanted to do was maintaining standards. I wanted to be able to keep offering a sensible service to the people I was looking after. I had 1,000 patients registered at that time on the NHS. I refused to dumb down the quality of what I was offering and, frankly, if I had taken that contract, that is exactly what I would have had to do. I was not going to be able to do any preventive work, which I was managing to get a little bit of with the NHS as it stood, and all of a sudden every bit of the financial risk on the contract had shifted to me. I was the one that was taking all the financial risk and the PCT was simply prepared to walk away and say, “And if you do not meet the contract we will take the money back. We will not argue about it. We will just take it because we have got your money”. I thought, “Does that really feel like a good deal for me after 37 years? No. I’m out”, and I walked.

Q35 Stephen Hesford: Eddie, you said that no PCT steps in where dentists choose to go private; that is what you said. My experience in my constituency is quite the opposite.

Mr Crouch: I am not sure I said that.

Q36 Stephen Hesford: No, you did say that. It is quite the opposite and that is the way the scheme, as I understand it, is supposed to work. I will just give you a quick example: dentists about your age, about three or four years before retirement, yes?

Mr Renshaw: You have just insulted one of us!

Mr Crouch: I have got a hard time at the moment. I am really sorry!

Mr Renshaw: He has done a lot of mileage!

Stephen Hesford: Bear with me. Two examples, same situation: one coming up to retirement in unsuitable premises, upstairs, and the PCT said, “Look; you are single-handed. We want to replace your practice with somebody else”. That dentist would not play ball, sent out letters to his patient group saying, “They are forcing me out. I want you to join up to Denplan”. That is what he did. The PCT said, “You should not have done that. You are abusing your position. You either come and negotiate new premises or we will take the contract away”, and he was not performing on his original contract, so he went private, but the PCT have persuaded another dentist to set up in his stead in different premises, better premises, ground floor access, all this sort of stuff, so they came and provisioned where he was. On your explanation that poor man was forced out and there would have been a gap, and the blame would be on the system, but the PCT stepped in.

Chairman: Hurry up, Stephen.

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Q37 Stephen Hesford: But this is important, Chairman. The other example, and this comes to the age thing, both age examples, is that very few dentists in my area walked away from the contract, very few indeed.

Mr Renshaw: Could you tell us where that is?

Q38 Stephen Hesford: Wirral.

Mr Renshaw: Very heavy NHS commitment area.

Q39 Stephen Hesford: Yes. Very few walked away. The one that did walk away in my constituency disputed the new contract and appealed. The appeal failed, but he came to see me in my constituency, a senior man like you, and basically what he said to me was, "Do you know, at my age, Steve, I want to do less work for the same money", and that was what his dispute about the contract was. He wanted the system to pay him at a higher rate so he did not have to work harder at his age, "at my time of life", that is what he said to me. What do you say to that?

Mr Renshaw: There are 22,000 dentists out there who are offering a service of one description or another and we can go through the individual cases and give you evidence of individuals who are just as badly done to as you feel they were not badly done to. I am not going to argue that that did not happen because clearly it did. I am not going to call you a liar; it is not the case, but there are plenty of other cases, which we would say would be a preponderance, where the opposite has happened, where PCTs have taken the money that was saved by people leaving and have not, until much later, re-provided, and they have taken the money and they hope to set it against their overspends. They will deny it till their dying breath, of course, but that is what they do.

Q40 Chairman: I was going to ask you about that, because you said that there are PCTs in your area that are effectively not sticking to the ring-fencing of this money.

Mr Crouch: What I am not sure is whether they are because there is no transparency. It is public money that is being spent but at the end of the year maybe the PCTs could produce a budget for the population that they provide the service for to show exactly how much money they have spent, how much money has come in from the Department of Health and how much money has been delivered for the service.

Q41 Chairman: I thought you had said earlier that they were not using the money ring-fenced for dentistry.

Mr Crouch: Absolutely clear.

Q42 Chairman: I am going to ask you to give us a name and/or the evidence that that is taking place because we understand that that is not what should be happening, and I would like to see the evidence of that. Do you have it?

Mr Crouch: I have the evidence. I have the evidence from Birmingham East and North Primary Care Trust, that a million pounds' worth of NHS dentistry was forsaken on the introduction of the

contract and it was only replaced in January 2008. If you claim that money spent on dentistry is the money that you balance the books with for the patient charge shortfall, then technically it is being spent on dentistry, I suppose, but it is not being spent on the delivery of service to the patients that it was supposed to provide the service for.

Q43 Chairman: If you have any further evidence on that and, John, if you have as well I would be more than happy to receive that to see whether or not that is taking place.

Mr Renshaw: One of the biggest problems we have is with the lack of transparency at PCT level and what they are spending. The fear has to be that the reason they will not tell us what they are doing is that they do not want us to know.

Chairman: Again, if you have any suspicions perhaps you could put that on paper and give it to us and we will investigate that.

Q44 Jim Dowd: That just cannot be true; otherwise Mr Crouch would not have said what he just said. Where did you get the evidence for that, if you are saying they are not telling you?

Mr Renshaw: No, because we know what has gone on in a particular PCT.

Q45 Jim Dowd: You cannot say, "We do not know what is going on" and then say, "We do know what is going on".

Mr Crouch: I can categorically say that I have the evidence because I know the practices that left the NHS and I know that the service that they have now trumpeted, which is a commission to one of the body corporate, opened in 2008 to provide that service. I have that evidence.

Q46 Chairman: There may be a problem. There is one in Rotherham and it has decided to go private and they are having to get the patients into other practices and you do not do that overnight and that has to be negotiated. These are small private businesses and they need to make it fit to the business plan. It does not mean to say that there is any intent to spend the money elsewhere. It might be the practicalities of transferring the money from one practice to another.

Mr Renshaw: Indeed.

Chairman: I have that but I also have expanding NHS dentistry because of that, I suppose, in a sense.

Mr Bone: I do think, Chairman, that it is varied around the country because in my case there were so many dentists that went private, the level of money the PCT must have saved was enormous and we have not seen that number of dentists open.

Chairman: Chase it up for us, Peter, because I have chased mine.

Mr Bone: Right; will do.

Chairman: We will have to move on now.

Q47 Dr Taylor: It is not actually moving on because it is still on PCT commissioning. Most of us have had our ears bent when we have been in the dental chair. My own dentist works for two different PCTs

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and one of them is good and one of them is bad. What we are looking for is evidence of the failing of the commissioning services. You have told us about lack of transparency and you are going to give us some evidence on that. In what other ways are they failing?

Mr Renshaw: The problem that we have had with PCTs is the variability of the quality of the managers who are dealing with these issues. Some of them are very good and I do not want anybody saying that we are saying all PCTs are bad because they are not; 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. It just happened recently in East Yorkshire where a new head came in, started throwing his weight around, being difficult and threatening practices with all and sundry in legal terms if they did not behave themselves and do this, that and the other, and you think, "I am sorry, but you do not have a legal basis to start doing that. You have to start working within the rules", and the fact is this guy simply does not understand the rules but he is not the only one.

Q48 Dr Taylor: So, lack of transparency, variability of the quality of managers.

Mr Renshaw: Yes indeed; not enough of them.

Mr Crouch: Manpower. When people come into post they often stay there for a very short period of time. They build a rapport with the dentists of that particular area and then they get moved on to other things. Dentistry in most PCTs' budget is between 3% and 4% of their spend and therefore they feel that dentistry requires 3% or 4% of the manpower. Dentistry is a quite complex thing. There are 60 practices in one of the PCTs in my area and it is just too much for the people to go out and do their jobs properly. They have not got the manpower to do it. They do not go out and do mid-year reviews, they do not go out and do end of year reviews. They do not do anything that this contract is setup to do. They do not go out and consult with the profession about how the service can be developed. They do not go out and talk to the patients. None of the building blocks of this contract is possible with the structures that we have at the moment.

Q49 Dr Taylor: Thank you. We have already talked about gulfs between everybody's opinion of what is going on and the Department of Health. One is about the number of patients being seen because the department's figures suggest that there has been very little change. Are those wrong?

Mr Renshaw: The thing I would question about those figures is that what they have started to do is use two-year figures. We have never seen these appear before. Over the last 24 months a certain number of patients have been seen. Can I just remind you that the contract has not been in place for 24 months yet? The figures that we are being shown include the period when everybody was working like crazy to try and get people straightened out before the new contract started, so we have still got the

overrun of that, and the data in my opinion are inflated, not because they have been inflated on purpose; do not get me wrong, I am not saying they are being deliberately inflated, but they are inflated by a period when the old contract was still in place where people were trying really hard to get everybody tidied up before the end of the old contract and the beginning of the new because we were told the best thing to do was get everything signed off so that we could have a nice clean break and start the new contract on the new system. Those figures in my opinion are highly dubious and certainly not worthy of consideration properly until the contract has been in place for two years and then it will start to make some sense.

Q50 Dr Taylor: Can we go to the numbers of dentists because the Government tell us the number of contracted dentists has risen, but you say that because of the lack of accurate and sophisticated data about whole-time equivalents the NHS has no idea how many dentists actually work in the service?

Mr Renshaw: They cannot tell you what the whole-time equivalent dental workforce is. I have never ever been able to find a figure and, believe you me, I have tried for the last ten years to find one. There is not one. I find that extremely frustrating, because from a planning point of view it is extremely difficult to try and work out what on earth we are going to try and do if we do not even have a clue how many dentists we have got.

Q51 Dr Taylor: Such a huge gap. In principle do you object to PCT commissioning or if they got it right would that be okay?

Mr Renshaw: PCT commissioning is in theory an excellent idea. I think the idea of local commissioning is relatively sound providing you have a decent national framework within which they can operate. What worries me is the variability of performance at PCT level which makes local commissioning look very bad where it is done very badly. Actually, it is done very well in some places and, of course, it does not tend to get noticed so much then.

Q52 Mr Scott: Can I just record my thanks, Chairman, for you allowing me to bring this forward as I have to attend the Chamber? I am particularly concerned about orthodontic services. Do you think there is a shortfall in orthodontic practitioners in England and, if you do, do you think the new contracts are by any chance going to address this shortfall?

Mr Crouch: My own particular circumstances are that I do provide an orthodontic service. I want to provide more orthodontic service. My own particular circumstances are that during this snapshot year, which affected orthodontics far worse than anywhere because orthodontic payments are over a much longer period of time and therefore, to take an arbitrary snapshot of funding without looking at any trends, without looking at the needs of the local population, has effectively frozen my orthodontic budget. I have gone from having no-one

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on my waiting list to nearly 700 patients in the first 18 months of the contract. I want to provide care for them. I do not want to be sitting there twiddling my thumbs, but I have been caught out by this inflexibility of the way the contract has been introduced. We have a real manpower shortage in orthodontics. We have a problem with the secondary service where this new 18-week rule will be unattainable completely within the orthodontic service. There is capacity to take some of that service out of secondary care into primary care and it has not been utilised because the PCTs did not have the flexibility to spend some of that money on enhancing the service. Orthodontics is my pet subject because it affected me so badly.

Q53 Mr Scott: Both Johns, are you in agreement?

Mr Renshaw: I am right with Eddie on this one. He is the orthodontist, not me.

Q54 Mr Scott: The British Orthodontic Society has made this clear but there are many orthodontists who are not working to capacity anyway because they simply cannot do so. I visited one servicing my own constituency where they told me that the main practitioner was not working full time, people working for him were only working part-time and their waiting lists are getting longer and longer. This is obviously a ridiculous state of affairs, particularly in children's cases. It is becoming too late for that treatment to work or even take place.

Mr Renshaw: There is a practice in my town where we managed to acquire a Finnish consultant in orthodontics who is excellent, really excellent, and he was providing a fantastic service. Up comes the contract. He had already arranged with the PCT to bring in a second orthodontic specialist, a specialist practitioner, not a GDP but a qualified orthodontist, the idea being to double up the capacity because they were beginning to mop up all of the excess treatment that was required in the area and they were doing a really good job, very popular. A Czechoslovakian guy comes in. All of a sudden, because of the contract, it is frozen in time; there is no more money, so we only have enough money for one of the orthodontists to work. The Finnish guy has kept the practice on, the Czechoslovakian guy is working there and doing a great job but within the constraints of what he is allowed to do, and the Finnish guy has gone back to Finland. What is that about? Somebody went to a lot of trouble to do that recruitment work and it cost a lot of money, and now all of a sudden it is just thrown out of the window and he is now talking about selling up the whole thing. I just despair.

Mr Crouch: My comment on that would be that there are certainly some areas of the country where orthodontists are working that are quite happy with the new contract because it gives them a lever now to suggest to the patients that they have that treatment privately. I work in a very deprived inner city area of Birmingham and even I have been approached by patients who say, "Please do not put me on the waiting list. How much will it cost me to get my child's teeth straightened?". I feel very bad about

having to charge someone who is on income support for private orthodontics. That is not what I want to do. I want to provide that service.

Q55 Mr Scott: So basically the new contracts are letting down orthodontic services?

Mr Crouch: Completely.

Q56 Charlotte Atkins: Are you concerned that the new dental contract will lead to a deterioration in oral health in this country?

Mr Renshaw: I am.

Mr Crouch: Certainly I think the pressures within the contract to hit target are a driver. The Government and the Department of Health will say that the courses of treatment have become simpler but the patients that are coming through are exactly the same patients as we have always had. If they are trying to suggest that over-treatment was a problem in the first place then there may have been an element of truth in that in the profession but this driver that we have now is to provide simpler courses of treatment, and when you get the same reward for a simple bit of treatment and a more complex bit of treatment and at the end of the year you must hit a target and if you have not hit that target then funding will be taken away from you, there is inevitable pressure on the type of care that is provided. The Dental Laboratories Association will say that the amount of complex work has dropped dramatically and it is inevitable when you have a fixed budget to work with that you are cautious in how you spend that budget.

Mr Renshaw: We did some survey work amongst our membership at the end of March 2007 after 12 months of the new contract, and they were saying at that point that 67% of them were doing fewer root treatments than they had done previously, 75% were saying they were depressing the amount of cobalt chrome denture work they were doing, 85% were doing less multiple crown work than they were doing before, 85% were doing less bridge work. You can always argue about individuals but when you get mass information like this it is extremely difficult to argue that reducing the amount of bridge work by 85% across the board is somehow a good thing.

Q57 Charlotte Atkins: What was this survey?

Mr Renshaw: This was a survey of our members. We asked them to tell us a little bit about what they were doing so that we could get a glimpse, if you like, of what their performance was and what they were doing. We did not lead them. We gave them choices about were they doing a bit more, doing a bit less, whatever, and the figures were really alarming. We were astonished.

Q58 Charlotte Atkins: So your main concern from that survey is about the more complex work not being done. Is your concern also about having very little priority for preventative treatment in the contract, or are you more concerned about the fact that the more complex work is being crowded out of the system?

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Mr Renshaw: The key issue with prevention is that you have to talk to the patient. It is not about doing things to them. If you cannot count it you cannot have it and the Department will not pay for it. If I want to talk to a patient about looking at how they have got themselves into difficulties with their oral health and I am going to go through that with them it is going to take me 15, 20 minutes. I know that is not a lot but you do that 2,000 times a year and you have got a lot of money standing around doing nothing. If you want to try and do some preventive work with patients you really do need to have some time and it does have to be figured into the cost base of the practice.

Q59 Charlotte Atkins: So you are saying the previous contract—?

Mr Renshaw: It was not there in the previous contract. I am not pretending that it was. One of the key things about the new one, however, was that it was supposed to be a key driver to increase the amount of preventive work. My view is, listening to the people that we represent, that it has not happened.

Q60 Charlotte Atkins: So there was no golden age in terms of preventative work?

Mr Renshaw: There never has been in the UK.

Q61 Charlotte Atkins: Except, of course, we hear that English children have the best oral health in Europe.

Mr Renshaw: If you really want an argument about that nonsense, that absolute piece of arrant nonsense, I would suggest you get some statistical advice on it because those figures are not comparable. Some of the figures that have been quoted are 15 years old and the 12-year olds are a snapshot view. I have to tell you: it is a very selective view which has been picked deliberately because it is the only one that shows that oral health in this country is any good.

Q62 Charlotte Atkins: So was it true 15 years ago?

Mr Renshaw: No.

Q63 Charlotte Atkins: And it is not true now?

Mr Renshaw: No.

Q64 Charlotte Atkins: So can you provide us with the statistical evidence to demonstrate that?

Mr Renshaw: Yes.

Q65 Charlotte Atkins: I do not know if that was in your submission.

Mr Crouch: No, it was not.

Q66 Charlotte Atkins: But you will supply that evidence to us?¹

Mr Renshaw: Yes.

Mr Crouch: Yes.

Q67 Charlotte Atkins: What is your view about the Secretary of State's announcement on Tuesday about the money for fluoridating the tap water supply?

Mr Renshaw: This is going to sound like heresy but I think that political boat sailed a long time ago.

Q68 Charlotte Atkins: Sailed a long time ago?

Mr Renshaw: It has gone. Fluoridation will never be accepted in this country in my view because it is a political dead duck. It has got nothing to do with the rights and wrongs of fluoridation. I just think politically it will never sail.

Q69 Charlotte Atkins: But Eddie is in Birmingham.

Mr Crouch: Yes.

Q70 Charlotte Atkins: And Birmingham's evidence is pretty uncontroversial, I would have thought, in terms of comparison with Manchester?

Mr Crouch: Absolutely. I appeared on Sky News on Tuesday pontificating on the benefits of the fluoridated water that we have had in Birmingham and I would say that the problems are that there is a huge lobby out there that is anti-mass medication. There are other ways in which fluoride can be applied and that could be introduced in various ways. There is some debate on whether it is the effect of fluoride toothpaste rather than fluoride in the water supply that has made the biggest difference and I think there is more evidence that needs to be found out for that, but certainly from what I see in Birmingham we come top of the league in dental health in the West Midlands every time there is a child dental health survey, so to me the evidence is clear.

Q71 Charlotte Atkins: If it was down to toothpaste how would you say there is a difference between Birmingham and Manchester?

Mr Crouch: That is right.

Q72 Charlotte Atkins: Should they just have more toothpaste in Manchester?

Mr Crouch: As I say, I think there is more evidence that needs to be sought on that.

Q73 Dr Naysmith: That evidence has been looked at over and over again.

Mr Renshaw: Yes, indeed.

Dr Naysmith: It is very clear that there is a difference between Manchester and other places that do not have fluoride in the water.

Q74 Charlotte Atkins: But I should just declare an interest as the Vice President of the British Fluoridation Society.

Mr Renshaw: The York review was not at all convincing. I have known Trevor Sheldon for a long time and they were not at all convinced that the evidence was there to back up either side. Do not get me wrong. I am absolutely pro-fluoridation.

¹ Ev149

Q75 Charlotte Atkins: You do not welcome the announcement then?

Mr Renshaw: The announcement is fine but it will not get you anywhere.

Q76 Charlotte Atkins: And you agree with that view of John Renshaw's?

Mr Crouch: I do not. Myself and John do not agree on everything.

Charlotte Atkins: I am glad to hear it.

Q77 Dr Naysmith: Does Challenge have a policy on it?

Mr Crouch: No! We can find one.

Q78 Charlotte Atkins: From your practical experience in Birmingham rather than the York study you recognise that there are benefits?

Mr Crouch: There are huge benefits but there are still huge pockets of inequality within Birmingham. In some of the areas that I work in I still see rampant problems with decay because of the fact that they are from the ethnic minorities, often shopkeepers who have a huge abundance of sweets. Fluoride may be one of the answers but obviously prevention and dietary advice and sugar control and various other things are so much more important as well.

Q79 Charlotte Atkins: What would you say the single most important issue is in terms of reducing inequalities in oral health?

Mr Crouch: Obviously, adding fluoride to the water supply allows people of low social background to have some element of fluoride if their parents cannot afford the drops and the mouth rinses and various other things. I am totally for fluoride.

Mr Renshaw: Can we just make the point though that the best oral health in Europe is in Scandinavia where they are not fluoridated? They have a very intensive campaign that runs with children from day one. They are really regimented into—

Q80 Dr Stoate: But that is about deprivation and social inequality, which Scandinavia is extremely good at. We know that.

Mr Renshaw: But they have conquered the problem without using fluoride.

Q81 Dr Stoate: They have got a completely different social structure.

Mr Renshaw: Yes, they have.

Dr Stoate: This is slightly off the subject, Chairman. Look at America and the evidence is far more clear-cut, but we are straying somewhat, Chairman.

Chairman: Can we move on?

Q82 Dr Naysmith: Sometimes people compare the provision of dental services with the provision of primary care services, doctors and so on, and the difference is obvious in one sense in that you go to the doctor when you feel unwell but you go to the dentist, or you used to do under the old contract, every six months, some sooner. Do you think that was necessary, that six months?

Mr Renshaw: It is interesting because, although people always claim they went every six months, if you look at the data they actually went about every nine months. If you are going to ask somebody, "How often do you go to the dentist?", they will say, "Oh, yes, I go every six months", but in fact the data from the DPB says no, they do not.

Q83 Dr Naysmith: In 2002 the Audit Commission said that they thought this was unnecessary.

Mr Renshaw: Yes, they did, and, of course, the NICE guidelines have been brought in to see whether a longer period between check-ups is appropriate for some people. Of course it is. It stands to reason. You cannot have a rule of thumb that says everybody goes every six months regardless. It is nonsense. People are not that regimented and they should not be.

Q84 Dr Naysmith: That aspect of the old system was unnecessary really, if people come along for an unnecessary scale and polish every six months.

Mr Renshaw: I think there is a big argument about the necessity for scale and polish. If you look at the level of periodontal disease in this country it is very hard to argue that more scale and polishes are not required. We are getting into the technicalities of disease patterns here, which is fine, but they are not terribly wrapped up in the recall interval. The recall interval is really a preventive measure to try to reinforce the messages to the patients. If you look at the patients who come regularly on a six-monthly basis, they are generally speaking the better quality mouths that you see around. That is not every single one of them but on the whole they are very healthy individuals. The ones who come less often tend to be the ones who have the trouble, but there is a happy medium. I would suggest that we have been moving away from the six-monthly recall period for some time. NICE guidance has pushed it a little bit further and pushed the pace along a bit, and I certainly have a lot of patients who come in on an annual basis and they are perfectly happy with that and I am happy with it because I am not finding problems with them.

Q85 Dr Naysmith: But the NICE guidance also said there were some people, and possibly they were the people who most need dental treatment, who should come more frequently.

Mr Renshaw: Indeed.

Q86 Dr Naysmith: Do you think that is happening?

Mr Renshaw: Absolutely.

Q87 Dr Naysmith: It is the other way round, and I am looking at your statistics, that the ones who have the good mouths are probably those who come from the better-off parts of whichever society we are talking about.

Mr Renshaw: Indeed. It does not always follow.

Q88 Dr Naysmith: The ones who need to be encouraged to come are those from the more deprived areas. Do you think that is happening?

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Mr Renshaw: That is right. It is not acceptable. It is a fact, is it not? We know that is where the problems are, but trying to get into those areas and get them to come to the dentist, and I do not want to be any part of dragooning people into going to see a dentist if they do not want to, is an uphill struggle. Even where access centres have been placed right in those areas their uptake is relatively low and it tends to be episodic visits. They come in when they have got toothache. Changing that culture is not going to happen overnight and what needs to be there is a strategy, if you like, a project, to try to get the population in those areas to value dental services and use them when they are available, and it is not going to happen simply because you go and plonk somebody in the middle of it.

Q89 Dr Naysmith: Okay, but what I am trying to get you to answer is, is there any element of the new contract which encourages what NICE was recommending rather than what happens with the system that you now operate, being almost outside of the NHS system?

Mr Renshaw: No. My view would be that the system as it stands now encourages regular visits, just like the old contract did.

Q90 Dr Naysmith: So it does not make any difference?

Mr Renshaw: I do not think so.

Q91 Jim Dowd: I used to go regularly to the dentist every six months or so and I now calculate that I have not been for nine years and I do not seem to be any the worse for it. I met my dentist as a matter of fact just a fortnight ago at a dental committee.

Mr Renshaw: He says he is your dentist?

Q92 Jim Dowd: No, no, because he asked me to go and address the annual dinner of the local dental committee.

Mr Renshaw: So for a while he was your dentist?

Q93 Jim Dowd: It was the first time I had been in a room with him for such a long period without him inflicting great pain upon me, but could I just ask Mr Taylor, who has been very patient down the end there—

Mr Taylor: I do not want to interrupt you but could I say something about the recalls because I mentioned the DPB data?

Q94 Chairman: I should have asked you.

Mr Taylor: At the time we are talking about the fee that the dentist got for an examination was time-barred at six months, so the dentist could only get a fee every six months. He could see the patient as often as he liked but he would only get a fee every six months, so the recall was fixed by the payment system. If you are talking about access you should look at the characteristic: how many people come back? Middle-class people do as they are told. If the dentist tells them to come back every six months they come back every six months. Other people may not. When you are looking at what actually happens you

should look at the characteristic: how many people at six months, how many people at a year, how many people at two years? We did that all the time, but when the access comes up what do we know about access? We know a hell of a lot about access. Almost everybody in the population attends over a ten or 15-year period, almost everybody is in the NHS, but if you make it a ten-day period hardly anybody is in the NHS. To understand it you have probably got to define the terms and look at the figures.

Q95 Dr Naysmith: There used to be the system, of course, where people registered with their dentist.

Mr Taylor: That was an intermediate thing, and I agree with this. One of the solutions to the problem is to put prevention into a capitation-type scheme and put the other things into a payment-by-results scheme, and that would have been an intermediate step, which is something we said at the DPB.

Dr Naysmith: That is a very interesting point. Thank you.

Q96 Jim Dowd: On that point, this committee interviewed Rosie Winterton before the contract was brought in and what we managed to establish then was that the only way of calculating who had a dentist and who did not was presentations within the last two years because you do not keep them on the books, so to speak, in the way that a GP does, and all they could really calculate was the number of people who had attended a dentist in the last two years.

Mr Taylor: But we know for ever. The thing about dentistry is that because we have the payment claims we know absolutely everything for ever, or for a very long period.

Mr Renshaw: And the tragedy of the new contract is that most of that has now been lost.

Q97 Jim Dowd: Okay, so that is the volume of activity, but could you just tell us what measurements there were to calculate the quality of dental care under the old system and can you say how it has changed things?

Mr Taylor: I do not know whether you know about the Dental Reference Service but the Dental Reference Service was set up about 1935 to keep an eye on the quality of dental services and it was run out of the Ministry of Health and into the Department of Health and the DPB took over the management of it but not the principles and duties of it in about 1990; I cannot remember exactly when. The Dental Reference Service examined on behalf of the Secretary of State, managed through the DPB, patients before a course of treatment and after a course of treatment, and so we knew within limits how many people we saw and what the standard of treatment was, so it was known.

Q98 Jim Dowd: You say it was. That system is no longer there?

Mr Taylor: As far as I know, and I have lost touch with this over the last couple of years, obviously, the role of the DRS has become pastoral, I think the word is. They visit dentists and they talk about things, but there was this hammering away at

examining patients before and after treatment so that the necessity for it could be assessed and the standard could be assessed, and whether in fact it took place at all, of course, which is a matter of the proper use of public funds. We knew that and my argument was, and your committee many years ago at times would argue, that we should have more; the Dental Reference Service should have been strengthened. As I understand it, and I might be wrong here so I do not want to mislead you, it has effectively been withdrawn.

Q99 Dr Naysmith: I can confirm this, Chairman, because I used to be a member of the Family Practitioner Committee a few years back and there used to be evidence presented sometimes between the people you are talking about and practitioners who were in dispute about payments that had come before the FPC and all the things you are talking about were available, all the evidence of everything that had been done and independent people had examined them to see whether it had been properly done or not and all that information was available, which it is not any more, I dare say.

Mr Taylor: I do not know, but when I left the intention was that the DRS would take on a pastoral role.

Q100 Jim Dowd: You did say in your submission that the new contract had weakened the ability to provide quality assurance and to detect fraud.

Mr Taylor: Yes.

Q101 Jim Dowd: Could you expand on that?

Mr Taylor: I hope I did not make a submission. I put in some observations which I thought might be of help. The Dental Practice Board's job was to examine whether public funds had been used as Parliament wanted them to be. Parliament would not know in detail what they wanted so we interpreted what we thought it was. That was our job. We had for that purpose two major things. One was all of the treatment data because the dentists could not get paid unless they told us what they were claiming for. They might not have done it, of course, but it might have been all sorts of things, so it was not only deliberate theft by deception, which is fraud, because that is a matter for the courts to decide, but it was also about use of public funds other than as Parliament would have wanted, and we could get from the data and from the Dental Reference Service because where we had a suspicion we could send a dentist to examine the patient to see whether it had happened and to what standard it had been done. Did I make that clear? I have talked a lot but I do not know whether I was saying very much.

Q102 Chairman: Can I just confirm, John, that your submission is not published with the first tranche of written submissions because it was not for publication but it has advised us and thank you very much for that.

Mr Taylor: I am quite happy about that. I was not trying to interfere. I was trying to help.

Q103 Chairman: Thanks for putting that question into the context of what you have done as well. Can I move on very briefly to dentists' workloads? John, your submission states that 47% of dentists fail to reach their units of dental activity as set by their PCT in 2006-07. Can you explain why?

Mr Renshaw: Yes, because the targets were too high in the first place. Our argument has been ever since the start of this that the way that the UDAs were calculated has never been explained. How the targets were arrived at has never been explained in my knowledge or anybody else's that I am aware of. I wrote a paper which I am perfectly happy to hand over for you, which explains a view of how the figures were wrong but I do not know how they were arrived at in the first place. Therefore, it is very difficult to be certain that the calculations that were used originally were wrong, but the fact is that if 47% of people fall below the target rate you have to assume either 47% of them are not trying or 47% of them had figures that were completely wrong.

Q104 Chairman: Were they not based on a two-year average of the activity that had taken place?

Mr Renshaw: In theory, yes, but in fact the system that was working at the time the figures were collected was one system and then you installed a new system and applied some kind of retrospective calculations of the new system back on to the old data and came up with a number. The number is very important because that is the target, and if you do not get to it they come back raiding the money. Our argument has been, "Please tell us how you arrived at those data because those targets are really important", and I have never in the last 18 months seen an explanation and nobody will admit how those figures were arrived at.

Q105 Chairman: They are just not realistic in your perspective?

Mr Renshaw: No.

Q106 Chairman: Do you agree with that, Eddie?

Mr Crouch: I would, yes. This comes on the back of the fact that the promise was that we would have 5% less work. That was the promise, that we would have 5% less work to do the prevention and yet the targets, as I perceive them, have been inflated. There are so many grey areas when treatment was submitted to the Dental Practice Board, and perhaps John might comment on this, such as, was that a piece of emergency treatment, which was 1.2 UDAs, or was that a piece of restoration work that required three UDAs? A significant amount of that within a practice make-up would inflate a target quite significantly and the statistics seem to show that people are finding it very hard to hit the target. Every dentist that I speak to says they are working harder under this new system than they were under the previous system, so the offer of 5% less work is not there and I think the contract was inflated, maybe—and this is cynical on my behalf—deliberately to improve the access problem.

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Q107 Sandra Gidley: This is to John Renshaw and Eddie. Before 2006 dentists were paid according to the number of procedures they completed. It was a sort of piece-rate system. One of the reasons for change was supposedly that the old system encouraged unnecessary interventions. Would you agree with that?

Mr Renshaw: That was a perception, yes.

Q108 Sandra Gidley: You say that was a perception.

Mr Renshaw: Yes, because there is no evidence that it was true.

Mr Taylor: Do you mind if I—

Mr Renshaw: Here is the man with the numbers.

Mr Taylor: There is no doubt that if you pay people by the item you get more items. Some of those items will be unnecessary and some of them will be shady. If you are going to intervene you might intervene earlier because you have a gap in your practice or you might intervene later because you are very busy, but there is an enormous amount of evidence that over-prescription was significant but small and by “small” I mean 2%, 3%, 4%, 5% of the total amount of money going to GDP. We have got tremendous evidence of that and in money that was £20-£80 million a year.

Mr Renshaw: But there is no doubt at all that in principle, as John says, quite rightly, that if you pay piecework rates you will get more pieces. That is the purpose of pieces. That is why the piecework rate was introduced in the first place, because they wanted loads and loads of work out of people, so the best way to do it is to pay them on a piece rate. The trouble is we have moved on from that now and we are now into a new era and we were, up till 18 months ago, carrying an old-fashioned payments system and we needed a new payments system. Nobody but 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 or not. The testing that had been done had been done on an entirely different model. It was not on the model that was finally introduced and so we were left with the whole profession sailing 100% into a new system which was completely untried, and, of course, we have now found out that if 47% of them cannot make their targets there is something wrong with the system. It cannot possibly be right.

Mr Crouch: I would comment also that there is still no disincentive to sometimes potentially over-treat a patient because if you are falling behind on your target and a patient comes in and that is something that you might sit and look at and not intervene at that particular point, if you are behind on your target there must surely be an incentive to say, “I must do it now because at the end of the year if I do not do it I will not hit my target”. If you introduce a system that is supposed to deal with that I do not think this is the system to deal with it.

Q109 Sandra Gidley: Is there not another direction this could go in as well because there has been some evidence submitted to show that work is not done to the same standard as before because the bandings are too broad, so it does not pay a dentist for doing what he or she would have done before and they will do something that will do but is probably not quite as acceptable to their patient?

Mr Renshaw: The purpose of a publicly-funded service in my view ought to be that patients should feel confident when they go to the service that they will be treated with respect and with due care. A payment system should not drive the provider of that care in any particular direction. It always ought to be absolutely neutral. Trying to find an absolutely neutral system is probably impossible but I cannot help feeling that what we have done is stagger from one very imperfect system to another very imperfect system and what is going to have to happen is that there is going to have to be another correction because what should have happened was that a test period should have been gone through to assess whether or not the new system was going to work and then have it modified to make it more suitable.

Q110 Sandra Gidley: Just to change tack slightly, we have heard how dentists are not meeting targets but how has their income been affected by these changes?

Mr Renshaw: It is a very serious effect. I have been doing some consultation work with some practitioners who have run into financial problems as a result of the contract and the sums of money being clawed back are enormous; they are very significant.

Q111 Sandra Gidley: Can you explain “clawed back”?

Mr Renshaw: “Clawed back” is getting the money back after the year has ended because you have not hit your target. I have to say that the first year was bad enough but I have a horrible feeling the way things are going that the second year is going to be significantly worse. The amounts being required to be repaid—and this is quite interesting if you think about the UDAs and the way they are structured—are that they are simply wanting back all the money for all the UDAs that were not performed. The trouble is that the UDA, if you like, the currency, in the way a practice operates is made up of two elements: the fixed cost element of providing the service and the treatment element of providing the treatment itself for the patient, and if you claw back all the money it comes straight off the dentist’s bottom line, every penny of it. Nothing is then allowed for the expenses that were incurred in that year for running the practice despite the fact that those UDAs were not delivered. The expenses of the practice ran on regardless. The rent still had to be paid, the rates still had to be paid and a service was provided. It may not have been to the quality and quantity that was required but nevertheless the service was provided, so I think the effect is horrendous, absolutely horrendous.

Q112 Sandra Gidley: We have received relatively little evidence on that. It is probably the most unanswered question, so if you do have anything concrete we would be grateful.

Mr Renshaw: The trouble is that a lot of it is very personal stuff. It is not the kind of thing that people want being bandied around in public, to be asked to repay £230,000 out of a contract.

Q113 Sandra Gidley: I am sure it could be anonymised in some way.

Mr Crouch: The year 2006/2007 was an anomaly, because from my point of view as an orthodontist my income actually went up, and the reason it went up during that year was that I was paid for work in progress for moving from the old system to the new system, so I have had a balloon in my income which I am paying the tax for. My tax bill has gone up substantially this year because of my income going up, but that is not a true picture of the way things will develop.

Mr Renshaw: That is why the second year will be worse, because the claw back will have more of an impact because the first year was protected to some extent by the run-off from the original contract.

Mr Crouch: One other important thing: plus the fact that a lot of PCTs dealt with the end of year of the first year by not clawing back the money but allowing the dentists to forward the target to the second year. It was difficult to achieve in the first year, it is equally going to be as difficult in the second year for quite a few people and, therefore, they will not be able to deliver the newer, higher target that they had previously.

Q114 Sandra Gidley: Why is it so patchy? Why have dentists not been able to achieve this in some areas, whereas in Dorset they ran out of UDAs and could not treat anybody? Are they more efficient in Dorset?

Mr Renshaw: This is the problem we have. Because we do not know how the figures are arrived at, it is very difficult to look at an individual area and say, "Obviously the reason for this is X." I am not aware that Dorset has any better oral health than anywhere else—I am sure it probably has excellent oral health, but I am not aware of any particular differences there—but if you go to parts of the West Riding of Yorkshire that I am more familiar with, there are plenty of areas there where everybody is hitting their target because, frankly, they have no alternative because they cannot afford not to, and they are being driven in a way that I am sure you and I would not be happy about. I am afraid, if you make the target, there is a danger that you may have been less than sensible about the way you have done it.

Mr Crouch: It could be, of course, that the funding that was given to Dorset, because of the way it was worked out because of the test year, was inadequate. That would be an argument that the Citizens Advice Bureau would make, that the introduction of the contract was based on the historic spend and not looking at the proper needs of the local population.

Q115 Sandra Gidley: We have talked about the impact on dentists' incomes, but actually, as politicians we are quite interested in what is better value for the taxpayer as well. John Taylor, would you like to comment on whether the new system represents better value?

Mr Taylor: As Mao Tse Tung said about the French Revolution, it is a bit early to tell. When I came into dentistry out of heavy engineering, everybody told me that the system in the United Kingdom delivered the highest productivity, adequate dentistry. Not brilliant—nobody is claiming there was not some range—but, overall, adequate dentistry at low unit cost, and I am a sceptic—I have seen a lot of dentistry—and I became convinced of that. I have been in all sorts of previous systems, a bit like our Chairman who I read about earlier, I was an electrical fitter many, many years ago. I am a lot older than he is. I have been under all sorts of paper systems and all sides and I was entranced by this. That system, if you mean adequate dentistry at low unit cost and the interests of the dentist in getting the patient and treating them, was a super system. Whether that is what you want is another matter. It may be you want something else. Nobody has ever told me what the GDS (General Dental Services) is supposed to be for. So, we had a system which delivered high productivity, adequate dentistry, large quantities, low unit cost. Some dentists got very rich on it and, I think, that upset a lot of people, but the system was, in that sense, value for money. The new system might give you value for money. I do not know what the objectives of it are, so I do not know how we can tell, but this transition period is a false period and I do not think anybody should base their opinion on this three-year transition period. Dentists are watching, waiting and looking and adjusting themselves, and you will not find out until some time after that, maybe a year, two years, three years. That is when you should have your next inquiry to see has happened then. This is a false period to draw conclusions about.

Chairman: Thank you for that.

Q116 Dr Naysmith: You will be glad to hear, we are almost on the last lap. I have got a couple of questions for Mr Crouch and Mr Renshaw, but, first of all, I would like to ask Mr Taylor. When the question was asked earlier about a salaried service and salaried dentists, Mr Renshaw was rather dismissive and talked about 40% lower productivity. What do you think of a salaried service, Mr Taylor?

Mr Taylor: I am an old man and I have been around a long time. You get higher effort from self-employed people working on piece work than you do from salaried people.

Q117 Dr Naysmith: Do you get better quality work?

Mr Taylor: I think John said something about some jobs you cannot—a fitter on contract work. On some jobs you cannot make money and those jobs you give to some people who are meticulous and pay them a salary, but the bulk of work you get adequate quality. The thing about dentistry which is different

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from all the other medical people is the Dental Reference Service. We can check the quality, so we know we are getting adequate dentistry.

Q118 Dr Naysmith: Could there just be a possibility that someone who has been paid a salary was treating areas of the country where there was a lot more deprivation and a lot more difficult work and to compare them with the average dentist might not be a very fair comparison?

Mr Taylor: It might not be, but (and I think John's figures were flattering) we have got the community dental service, so we have known for a long time that there is a salaried service running alongside the contracted service.

Q119 Dr Naysmith: That tends to be for children's work though, does it not?

Mr Taylor: There are those factors, but my recollection, and I might be wrong and John might be right, is about one sixth of the output from the salaried service.

Q120 Dr Naysmith: You are both agreed on that.

Mr Renshaw: The study I am referring to was done in Scotland and it was done on a straight comparison between salaried practitioners and general practitioners working in similar sorts of areas, and the work was done properly and the figure came out at 40%.

Q121 Dr Naysmith: I can see that you are not very keen on salaried service, are you?

Mr Renshaw: I think salaried service is fine. I do not have a problem. It is a good answer in the right circumstances. I am not sure it is the right answer for everything.

Mr Taylor: I do not think you can show that somebody working on a salary would be a better dentist, providing better quality work than somebody working for themselves. I really do not see how that could be. Let us say with people with a phobia, terrified of the dentist. If somebody does not want to do that, goes to the community service, and it possibly takes longer, but I do not see that you would get better dentistry.²

Q122 Dr Naysmith: We can check that. What I really want to get on to is the fact, Mr Renshaw, that in fact you have been here before.

Mr Renshaw: Yes; indeed.

Q123 Dr Naysmith: In 2001 you told this Committee that the relationships between dentists and the department were a running scar. That is how you described it at the time. This time you describe the relationship in your submission for this inquiry as "irretrievably damaged". What, in your opinion, do you think now?

Mr Renshaw: I think I was quoting somebody else as saying there were commentators who said the relationship was irretrievably damaged. I do not believe that that can be allowed to be maintained. We have to get back a working relationship between the department and the dentists, because if we do not get that back we are not going to have a service, we are not going to be able to make any progress, and at the moment—

Q124 Dr Naysmith: You think under the new arrangements, if we do not do something about it, then we are in for a real problem with the National Health Service dentists?

Mr Renshaw: I think maybe in April 2009, when the three-year so-called guaranteed income period comes to an end, there may well be a further water shed. If you look at the way private practice has developed in this country, there has been a series of water sheds, frankly, every single one of them precipitated by government action. If government takes another step like that, the move into the private sector will become, I think, irretrievable.

Q125 Dr Naysmith: What can we do about it? What particularly do you think can be done to encourage dentists to work for the National Health Service? Two or three important points and then I will ask Eddie for the last word?

Mr Renshaw: I think there are a few things that could be done. If anything, I think we are going to have to concentrate on the younger practitioners, because a lot of the people who are leaving are going to be the older men, like me, who are experienced and can hack it in the private sector probably. The younger ones are the ones who will be the life blood of the service for the foreseeable future and, although they may not have any alternative but to work in the NHS, I do not think what we should be looking for is a system where a bunch of disgruntled youngsters are coerced into working for the NHS. I think that is a very bad state of affairs to get into. That would be atrocious for patients—you really could not have a worse situation—but I think what we have got to do, and I think this has to start at the top of the department, we have to rebuild some faith in the fact that the Department of Health actually wants a dental service to survive and start behaving as though they want a dental service to survive, not just saying they want a dental service to survive. I think we have to look at the young graduates and start encouraging them to work in the NHS in circumstances that they want to espouse. They want to have the time to be able to do their work properly; they do not want to be placed under constraint of output straightaway. They want to be able to develop their skills so that you can get some of the work out of the secondary care sector and into the primary care sector so that the costs of that can be reduced. Patients get a better service that way. There are a lot of ways that you could look at that younger group and say, "We will help you to develop your life and your working practice over a lifetime within the NHS and we will encourage you to do that", but that has to be a lifetime commitment.

² Note by witness: I think my point was that a dentist on piece work would not be able to work quickly on a terrified patient and that dentist and patient might both prefer that the patient use the Community Dental Service.

Q126 Dr Naysmith: Thank you. Mr Crouch?

Mr Crouch: I think, first of all, the Department of Health has to listen to the serious criticism of the system that we have got and work with the profession to cure some of the faults that are there. If that happens, then at least we are moving towards better service for patients. It is really my concern that we get a better service for patients. I think, if you are to rely on the primary care trusts to do some of the work in commissioning the service and getting the best service for the local population, then we need quality people working with the profession locally in that area. I am sure the Chief Dental Officer will come along and say that there are areas of the country where that has happened and it has worked really quite well. He will quote all the areas of the country where it is working, and they tend to be the areas where the PCTs have good managers, have a good understanding of the local area and they also work well with the profession. If that works, then that is at least a step in the right direction. Unfortunately, it not happening in many places.

Dr Naysmith: Thank you very much. That is very helpful.

Q127 Chairman: John, can I ask a final question to you. Quite a lot of what we read, in a sense, shows that some parts of the country do quite well out of NHS dentistry, and probably mine in South Yorkshire is one of them, maybe because of need and everything else, where some of us have a lot more private dentists. Is that related to income more than anything else?

Mr Renshaw: No, if you look at the data from Her Majesty's Revenue and Customs, who are the final arbiter on who is earning what, the difference between an NHS dentist and a private dentist, from the last figures I saw, was £600 a year, and I do not think anybody is going to claim that private dentists are making a fortune.

Q128 Chairman: I am not saying that. If we were to say to you: what do you think NHS dentists will be like in ten years time? In our area, Yorkshire and the Humber, income is rising. It has been quite low over the region in comparison with the South East, but income is rising. Is that likely to mean that we will see more private practice if income does rise in areas like ours?

Mr Renshaw: Yes, because the one thing that makes a private practice possible is an economic base locally where people have enough disposable income to be able to spend on that kind of treatment. It has to be a lifestyle choice in a lot of ways, private treatment.

Q129 Chairman: First of all, except for a very small group of people, we do not have free treatment on the NHS in this respect.

Mr Renshaw: No, you do not.

Q130 Chairman: It is not free at the point of need in as much as you need a filling; depending what your income is, you may have to pay for it.

Mr Renshaw: Quite a lot, yes.

Q131 Chairman: Where is the break? Maybe an NHS patient has cosmetic treatment in an NHS surgery and pays for it. Where is the break in all this?

Mr Renshaw: It is an interesting situation. We are in a fluid situation at the moment, are we not? It is influx. As far as I can see we have always had the top end private stuff, the fancy Harley Street prices that are telephone numbers. I do not know how on earth they get away with that kind of price, but, nevertheless, that is what people fixate on. They think £5,000 a tooth. That is nonsense; gibberish. What is emerging is a much more price conscious, private service which is saying, "We are a bit more expensive than the NHS, but we are not that much more expensive and we are trying to offer you a sensible product, not necessarily the high end stuff, and if you want some fancy stuff you can buy that from us as well, but we can offer you routine care at a sensible price." In an area where there is enough money for that to float (and we already have the evidence from Denplan: there are plenty of people around who are prepared, I would not say willing but prepared to pay a sensible price for their treatment), then I think that will gain ground and people will find that middle way. There is always going to be room for a middle way, and I think that is where it will be.

Q132 Chairman: And income will drive that, you think, all the time?

Mr Renshaw: I think so, yes.

Q133 Jim Dowd: I was looking on the Net the other day and I came across a dentist based, I think, in Budapest. They were advertising for patients. If you cannot find an NHS dentist or you think that private dentistry is too expensive, they will actually fly you out to Budapest, do the principal work there and arrange for any follow-up work in the UK, if need be. In your experience, are many people susceptible to that?

Mr Renshaw: It has certainly grown, because it is built on a complete lie and it is built on a lie of how much those things cost in this country. They always quote Harley Street prices, and actually, if you shop around a bit in his country, you usually get it cheaper. Frankly, if you are going to Budapest, get off the plane in Budapest, get on another plane and go to San Paulo in Brazil, because Brazil is the cheapest place in the world for dentistry, and the other one is Beijing.

Q134 Chairman: Can I thank all three of you very much indeed. A very lively session we have had, the first one on this inquiry. I am afraid we have run over substantially on the time we were going to have.

Mr Renshaw: Our apologies, Chairman.

Chairman: I think there were good reasons for that. Thank you very much.

Witnesses: **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, gave evidence.

Q135 Chairman: Good morning gentlemen. It is nearly good afternoon. I am sorry that we have run over time a little bit. We will try to have some sharper questions next and possibly sharper answers as well! If you do not disagree with what has been said in answer to a question, you do not have to repeat it, please. Could I first of all ask you to give us your names and the position that you currently hold, for the record, please?

Mr Dyson: I am Ben Dyson; I am Director of Primary Care for the Department of Health.

Dr Cockcroft: I am Barry Cockcroft; I am the Chief Dental Officer for England.

Mr Lye: I am David Lye; I am Head of the Dental and Eye Care branch of the Department of Health.

Q136 Chairman: Once again, thank you and sorry for the delay. Your submission states that the first 18 months of the new contract has demonstrated beyond doubt that the system is workable and working. I have to say, the overwhelming number of submissions that we have received at this stage suggest quite the opposite of that. Indeed, when we received the written submissions which we have published—I showed this earlier—the temptation would have been to write to everybody else and say, “Are you sure you have got this right? Because you are completely out of line with what the Department of Health say.” I wonder if you could account for or just explain why you think there is this disparity in terms of people’s response to the new contract?

Dr Cockcroft: I think there are two things to say, first of all. One is that there is a misconception that, just by moving from the old contract to the new contract, everything is automatically sorted, and that is clearly never going to happen. The issue is about having to recommit to give the PCTs a sound basis for reforming dental services. The old system, which was the cause of the issue and, of course, the famous pictures in Scarborough and all that sort of stuff, was under the old system. What we are saying is there needs to be a sound system that enables PCTs to grip the agenda and improve access to dental services. What we are saying now is that in areas where that has happened we have got clear evidence that PCTs are able to grow services in some of most challenged areas (and Eddie referred to them—the Isle of Wight, Devon, Lincoln, Milton Keynes) where PCTs had real problems and, where they were more engaged, have been able, using this new system, to transform the nature of local services. I think I would also agree that the engagement with primary care trusts has been varied, and that is one of the reasons why we included *Improving Access to Dental Services* and the *Operating Framework* before Christmas to try and guide and help or support PCTs where they really want to focus on these issues. Some of them have done incredibly well, some of them have done okay and some of them have let it slip a little bit. I think we need to get them all performing at the top level. The evidence I heard more or less implied that, if we do that, this system actually works, and we are taking a slightly longer view. The other thing I would pick up from what was

said just previously, and I cannot remember the quote exactly but John said the thing that dentists really hate is the absolute flexibility to grow services or reduce services, and that is the exact thing, in the old context, that caused the problems. Dentists could often increase or reduce the amount of NHS dental services they did, and the NHS had no means of countering that. What the new system does is it gives the PCTs a duty to commission services. It also gives them a budget to do it. The thing that John said the dentists did not like, which from my point of view I do not think is that true now, talking on behalf of patients, is the very thing that means this contract is in the best interests of patients. I think it also has to work for dentists and I think it has to work for all sides. What we are saying is we are moving in the right direction; we are moving in the right direction quicker in some areas than others. On the whole, through a difficult transition period where PCTs have been in a reconfiguration situation, I think they have done remarkably well. We think access is relatively stable. John doubted the validity of the access figures. They are information centre data; we think they are accurate. They look back two years, and in that two-year period was the transition period where we have already said we lost 3.6% of service. If you transfer that into patient numbers, although it was not measured exactly the same, that is actually about 960,000 patients. So to actually keep relatively stable through a period that includes that period, when we know we have lost that amount of service, I think is actually quite an achievement.

Q137 Chairman: Is access the main criteria that we should use to judge the contract?

Dr Cockcroft: I think it is measurable criteria. For me personally as Chief Dental Officer, that is absolutely not the only criteria. It is about numbers of people that can access services. From my point of view as Chief Dental Officer, I want to improve the oral health of the country. As you said, we have the lowest rates of dental decay in Europe—that is World Health Organisation figures, by the way, it is not flaky data—comparable with the best in the world, but there are big inequalities which we need to tackle and I think the fluoridation stuff on Monday tackles that inequality.

Q138 Chairman: We may come on to that in a few minutes. Quite clearly, the picture prior to 2006 has not been good, and from some of the written evidence it has not been good for decades now, in terms of the relationship between the department and the profession. Do you think that these new reforms have made what was probably a bad situation worse?

Dr Cockcroft: In terms of relations with the profession?

Q139 Chairman: Yes.

Dr Cockcroft: One of my aims and objectives for the next couple of years, I have described it as “peace for the profession”. I was described by Susie Sanderson, who is John’s replacement at the BDA, as the most

accessible Chief Dental Officer there has ever been, and one of the things I do in my job is go out on a regular basis and meet as many ordinary dentists as I possibly can, and I am opening two new practices in Oxfordshire tomorrow. I think the transition was a very difficult period for everybody in very difficult circumstances, with money being tight and PCTs being reconfigured. If we end up with a situation that works for patients and does not work for dentists, that is not going to be a successful, long-term, sustainable system. The BDA, who I know are not giving evidence today, have recently had a meeting with the Minister about how we work looking forward. I think that meeting is very constructive. I met Eddie and a whole number of representatives at the Annual Conference of Local Dental Committees a couple of weeks ago, and I think Eddie in his notes said it was a very constructive meeting and, clearly, living in a period of constant tension and aggravation between us and the dentists is certainly not what I intend to do. When I go out I sometimes get a much more grassroots view of the contract, and it is often much less aggravated than you get from political leaders. The other thing, of course, is that every time you go out to tender for a new contract there are lots of people who are due to provide services, so it is not putting people off, people are actually wanting to provide more services under these new arrangements. I think we have got rid of the old system with some of the things that damaged patients' interests. We have to develop what we have got now as a sound basis, but the omens, I think are good, because where it is working, it is working well.

Q140 Dr Taylor: I want to pick up on that. What you are really saying is the new system is the right one and is successful because it is working in some places. Where it is not working you are blaming PCTs and you are blaming management. We need some evidence to say exactly where it is working, because we have got the Citizens Advice Bureau survey, we have got the Commission for Patients Public Involvement in Health overview and the Dentistry Watch campaign, which point very much the other way. We have got your report, which actually is pretty anodyne and does not really give much detail at all of what is happening. What we really need is to know exactly where it is working in detail—which PCTs. Is that possible?

Dr Cockcroft: I think it is working two ways in terms of access.

Q141 Dr Taylor: I do not want it now. I want a geographical list across the country of where everybody is happy with it.

Dr Cockcroft: I am not sure that is—

Dr Taylor: That is what you are implying.

Q142 Dr Stoaite: I think it is going to be a short list!

Dr Cockcroft: I did not say everybody was happy. I am not sure how you would do that survey.

Mr Dyson: What we are saying is that we still believe very strongly that this provides a much better basis than the previous system to enable PCTs to grow services and to develop services so that they meet the

needs of local populations. We can provide evidence—in fact evidence is already publicly available—to show, by PCT movement, the number of people accessing dental services. You can track from that areas where access has improved or access has gone down since the introduction of the new arrangements, but it is important not to look at that information in isolation. What you also need to look at is the developing plans that PCTs have for commissioning new services. Many PCTs will acknowledge there were problems in that first, very difficult transitional year of the new arrangements, and they would also acknowledge that they were somewhat slow at putting in place new services, but they are doing that. The number of services commissioned by PCTs is growing pretty much by the month.

Q143 Dr Taylor: You probably heard the first lot of witnesses. One them said we had staggered from one imperfect system to another. What we really want to know is why there were not any pilot trials of this: because these were suggested by the National Audit Office, Challenge, the people we have just had referred to the personal dental pilot sites and they felt that these should be revisited and perceived failures ironed out. So, why did you rush into it, because really, sitting on this Committee for some time, it has been the fault with most of the Government reforms that they have been rushed into without piloting. Why have you not learned the lesson and tried to pilot something?

Dr Cockcroft: I do not think that is accurate. I came into this, and I was in general practice for 27 years, and I was a PDS pilot from 1998. There was an original wave, then there was a second wave, then there was a third wave, then the Modernisation Agency field sites and there we rolled out PDS. You do not pilot what works, you pilot a range of issues, a range of models, and look at what works and what did not, and there were some things that we learnt from PDS that clearly did work, were appropriate. The reduction in complex course of treatment was clearly learnt from PDS piloting and it has been reproduced within the new contracts. We also learnt very clearly that you cannot have a system that does not have some form of monitoring. John, quite rightly, said if you have a currency, you will get that currency delivered. “Item of service” was an inappropriate currency in an ever improving oral health system, and if you go to the non-monitored capitation based scheme, the risk always is that people get registered but do not always get the appropriate treatment, and courses of treatment, which is what this is, is an attempt to find a middle line between an output-based item of service, which is clearly inappropriate in the oral health situation, to a capitation based scheme, which is very difficult to do nationally, but also you need some monitoring to see what activity goes on within that.

Q144 Dr Taylor: One of our previous witnesses in his written submission was very complimentary about the amount of information that was available under

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the old contract, and he went on to say, "As a result, in the GDS, more than anywhere else in the NHS, it was possible to know. It would have been possible to conduct experiments and pilot studies and pursue a practical phased introduction of the new arrangements. This would have made it easier, quicker and cheaper to recover if things looked like going wrong." I find it very hard to be convinced why—

Dr Cockcroft: I think the concept of a phased introduction would have been an absolutely logistical nightmare, certainly in terms of patients' charges, because it was illegal to have different patients' charges in different parts of the country at any one time, so you had to change patients' charges in one go.

Q145 Dr Taylor: By law you could not have phased it in; you had to do the big bang?

Dr Cockcroft: You could not have people in different parts of the country paying different charges for the same thing in different areas. It was a legal thing. When I set up my PDS in 1998 I spent a whole week developing a new system of patients' charges and then I was told by the Department of Health I could not do it legally.

Q146 Dr Taylor: In the period before it started, did you talk to any people about piloting it? Did you take advice on that?

Dr Cockcroft: We had been having discussions with the British Dental Association. They made it very clear that they could not negotiate because dentists are independent contractors and they would have to make their own decisions, but we were talking about this for quite a long period of time. There was a little mini group set up which tried to look at what a currency might be, and that group arrived at the concept of weighted courses of treatment, and we actually got as far as having a draft agreement, which included weighted courses of treatment, but then the relationship deteriorated and it did not go forward in that case. So they have been very involved in developing the concept of weighted courses of treatment over quite a long period of time.

Q147 Dr Naysmith: Before we leave that, you say they were involved, but they say they were involved for a bit but you did not listen to anything they said. That is the message which comes from that. Did you take any notice of what they were saying?

Dr Cockcroft: We certainly did. We spent several years talking to them trying to go forward, and they fed in. At times it got very difficult and at times we did not accept some of the things that they said, but we certainly spent a long time listening to them. In terms of patients' charges, they were on the working group which came up with a new patient charging system which produced unanimous recommendations. So, they were involved, but we did not always agree with what they said.

Q148 Dr Naysmith: Did you sometimes agree?

Dr Cockcroft: Sometimes we did.

Q149 Sandra Gidley: I am increasingly uncomfortable. We are talking about access and I have to challenge your statement that the queues were all under the old system. The only reason you do not have queues under the new system is that you cannot now register with a dentist, so there is no point in queuing. I think we need to get that straight. According to the department's 2002 *Options for Change* paper, one of the stated aims of the contract was to improve patient access to NHS dentists. Most of our submissions seem to say that this has not happened.

Dr Cockcroft: What I said right at the beginning, 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. It takes time to do that, to commission new services. I know in your own constituency the PCT got four tenders out, or they have got tenders now for four services, including Romsey, West Leigh—

Q150 Sandra Gidley: Yes, but only because I suggested that. They were going to do it over a whole geographical area, which would have left no dentist in Romsey.

Dr Cockcroft: We asked all PCTs to do a needs assessment in their area. People talked about the delay between loss of service and recommissioning. The PCTs should not just recommission what was there before blandly, because there may have been a surfeit of people in one area and not in another; so before you go ahead and tender we asked PCTs to do a needs assessment. So you can either do it very quickly and make it more comfortable for me sitting in this sort of area, or you can take a bit of time, do it properly and base it on needs. Like I say, in areas where the need was quite glaringly obvious, then people moved very quickly. In other areas, some PCTs have not moved as quickly as others. We clearly accept that. We are doing everything we can to support them to get a primary care contract.

Q151 Sandra Gidley: There is something here I am not quite understanding. We heard in the previous session that the money allocated to a particular PCT was based on historical provision; so in areas where it was good there was a lot of money; in areas where it was less good, some deprived areas, I would contend my part of Hampshire, the money stayed the same. Given that, where is this magic pot of money coming from to commission new services? All that has been done in Hampshire is to recommission the unused UDAs, so I cannot see how that is improving access.

Dr Cockcroft: We put some money into the early PDS pilots where they were targeted at areas with high access and we invited PCTs and dentists to bid for that. What we have now done, with the inclusion of the *Operating Framework*, we have also increased

dental budgets by 11% from next April, so now there is a lot more free capacity or free finance for people to do that.

Q152 Sandra Gidley: Is that across the board or has that been targeted at areas of need?

Dr Cockcroft: 9% goes to PCTs and 2% goes to strategic health authorities to focus on specific access issues or issues of service that might be better dealt with at a strategic health authority level, like commissioning orthodontic services across three or four PCTs rather than just putting it into one PCT. That money, as you say, goes out. It is in the *Operating Framework* and it goes out from 1 April. I am much happier putting that money in now than I might have been before we did this: because if we put a lot of extra money in over the transition period, within experienced PCTs I think we might have spent that money and not quite got so much benefit for the public and patient out of it; people might well have bought off difficult issues. I am very happy with that money going out now, and it is a real chance to expand the services.

Q153 Sandra Gidley: So, it is up to strategic health authorities whether more of that money is targeted on—

Dr Cockcroft: 9% PCTs, 2% SHAs.

Q154 Sandra Gidley: Why does access seem to be a particular problem in some socially deprived areas in particular?

Dr Cockcroft: Historically the areas where access has been most difficult has usually not been in socially deprived areas, it has been in the more affluent areas where dentists were more easily able to move into Denplan and things like that, where patients could actually afford it. I do not know the local circumstances in terms of deprived areas in your area.

Mr Lye: There is an issue about people not actually accessing services in deprived communities even where services are available. The Greater London Authority report which was published in November gave a very favourable picture of the availability of NHS dentistry in London, and it is probably better in London than anywhere else, but there was still a problem that people were not accessing the services. So there is another issue, which is what we can do and what primary care trusts can do to actually try and improve awareness of access and to look at innovative ways of taking services out to deprived communities. Barry was talking about what we are trying to do to try and improve relations with the BDA, and one of the things that we are talking about is joint work that we can do with them to look at ways of doing innovative outreach services to get precisely to those deprived communities, especially to children in deprived communities.

Dr Cockcroft: I think one of the bad things over the last couple of years is in quite a few areas there is access but people make the assumption that there is not access and do not take it up, and that is certainly an issue in London, I think.

Q155 Sandra Gidley: Recently published figures in Scotland show that they seem to have both increased the number of NHS dentists and the patients registered. There seem to be a success story there. Could we be learning from them?

Dr Cockcroft: I would not want to comment on what Scotland are doing, but certainly in certain areas of Scotland we have got huge waiting lists and people not able to access care. What Scotland do is not my issue. The great benefit of our system is that it is locally commissioned so that the NHS controls where NHS services go for patients. If you lead a system where dentists decide where the service is located, how much there is, how little there is, you are still at risk of the same sort of problem that happened in our old contract here where you created the dental deserts that the Citizens Advice Bureau spoke about.

Q156 Sandra Gidley: A final question about data. The evidence submitted by CHALLENGE suggests that the Department lacks accurate and sophisticated data. We heard evidence earlier that previously there was a lot of information available and we are in danger of losing some of that which is quite valuable. We also heard that it is impossible to have a clear picture of the number of whole-time equivalent dentists working in the NHS. We seem to have those figures from everybody else.

Dr Cockcroft: The issue about whole-time equivalent dentists is that some dentists work largely in the NHS and part private, some dentists work largely private and a small bit of the NHS, although a lot of those people left. A good example would be around the change from the two contracts. In 2006 about 1,000 dentists rejected contracts. It was 3.6% of service. It was certainly significant, indicating that those people had not got a very large NHS commitment, in general—some obviously had. What we do know, and the most important thing for patients, is the amount of service commissioned, and that is looking-forward data rather than the access data which always looks back. We have announced today, the commissioned activity is enough to provide extra care for about 180,000 patients just in the last three months. Obviously there is an issue about commissioning and delivery, and that is what we have to support PCTs in. John talked about the data on “item of service”, and I think it is quite right that dental practise years ago on “item of service” had very accurate data about how many fillings were provided and what they did, but I do not think that data was in any way related to oral health. Especially now, as we have got far, far less decay, the one thing we would not want to do is encourage more intervention. We are also introducing from April an enhanced clinical data set. We have recognised (and the NHS has asked us) that we need a bit more detail to know what is going on within these bands and these courses of treatment; so we are introducing a very simple enhanced clinical data set from April which will include what is in band one, what is in band two and what is in band three, and that is for

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the benefit of both dentists, so they can demonstrate what they are doing, and PCTs to know what they are commissioning.

Q157 Sandra Gidley: Will it be possible to compare what is going with the old system, because that is what people are really interested in?

Dr Cockcroft: Broadly, but not individually by every single type of filling, but you will know how many fillings, how many extractions, how many root fillings, how many crowns. The reduction in intervention, broadly, is a good thing. One of the learnings from PDS pilots from a long time ago is that if you reduce the item of service incentive you get a reduced level of activity; and there was some research done by the National Audit Office on my own practice compared to another one in a similar area. We had a reduction of about 15–18%, I think, and there was no difference in the level of oral health between our practice, where there had been a reduction in activity, and a comparable practice—I think they did it in the evening—where they continued on the item of service basis. It was a very small survey, but there was no discernable indication that because you had done less activity oral health was in any way damaged.

Q158 Charlotte Atkins: Ministers have already admitted that commissioning by PCTs has to become stronger, so why do you think, therefore, that they are going to be good at commissioning dental services when dental services represent such a small part of their budget?

Mr Dyson: The kind of competences, skills and disciplines involved in commissioning good dental services are actually quite similar to those involved in commissioning other health services. The commissioning framework that the Department has now developed takes PCTs through a commissioning cycle which begins by assessing the needs of local patients and then works through how you engage with clinicians locally, how you engage with patients and the public locally, how you review service provision and how you develop new services, both by working with existing providers and, where necessary, by procuring new services. Although there are some distinct challenges, inevitably, in dealing with an area like dentistry, those competences, those skills, those disciplines are actually broadly the same as any other area of NHS provision; so we believe very firmly that by skilling up PCTs to become better commissioners of health services generally, they should also be in a much stronger position to develop dental services.

Mr Lye: Can I add to that, because there are, obviously, some specific issues in dentistry as well, and one of the things that we do as a branch is we have a contract with Primary Care Contracting, which is a consultancy run within the NHS and it is NHS people who run it, specifically to work on developing commissioning of dentistry. In the last year, for example, they have produced all sorts of guidance on practice visits, on how to deal with contract breaches and frauds, just on the management of commissioning, on how to carry out

needs assessment, on clinical governance, specific guidance on the 18-weeks target and the specialties where the 18-weeks target applies, and we will be rolling forward that contract next year as well. So we are trying to provide specific advice and development for PCTs to help them develop their commissioning.

Q159 Charlotte Atkins: But surely you need some sort of needs assessment before you can decide what dental services should be commissioned.

Mr Dyson: Yes.

Q160 Charlotte Atkins: It seems to me that does not really happen?

Dr Cockcroft: Many of the SHAs, in working with their PCTs to discuss how they are going to develop services, have asked all their PCTs to come up with a needs assessment and a commissioning plan to take things forward, so that is happening at the moment.

Q161 Charlotte Atkins: Many of them have not. Most SHAs are more interested in PCTs getting into the black than they were into—. I do not think it is funny, because actually a lot of people in my constituency cannot access a NHS dentist and, what is more, because you are basing everything on historical dental activity, it means that where you have a rubbish service in the past you have a rubbish service in the future. That is the problem, is it not?

Dr Cockcroft: Yes, but your PCT particularly is commissioning services within that area to meet the need.

Q162 Charlotte Atkins: Do you know why?

Dr Cockcroft: Like Miss Gidley, you have asked them.

Q163 Charlotte Atkins: Because I have spent two years pressurising them and telling them of the fact that Biddulph has not had an NHS dentist for many years, and if you looked into it you would know that. Elderly people are being forced into Denplan or into non-treatment simply because they cannot afford Denplan, and there has not been access for a very long time. You would have heard the earlier exchange when I raised the issue of parents being forced into Denplan, bribed to take up private dental treatment because they wanted NHS treatment for their children, and I applaud the Department of Health for stopping that appalling practice, but it still leaves the problem of not having sufficient NHS dentists. The reality is that PCTs have not seen dental activity as being a priority. How are you going to make it a priority?

Mr Dyson: That is specifically the reason why for 2008/2009, for the coming financial year, we have made this one of the key national priorities in the *NHS Operating Framework*, which is the document that really defines what we want PCTs to focus on as priorities, and dentistry is up there as one of the leading priorities alongside other areas of primary care access. It is also the reason why we have increased budgets by 11% so that there is more money going in, and it is also the reason why, as

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David describes, we are providing ever more support to dentists. If I could also add, contrary to the impression from one of the previous witnesses, both the Dental Reference Service of the dental services division and dental services division more generally are continuing to provide a high level of service to PCTs to help them understand what is happening in their area, to understand the data and to provide targeted support to those PCTs in developing services and managing contracts.

Q164 Charlotte Atkins: How often will they carry out a needs assessment in terms of dental activity?

Mr Dyson: The primary care trust.

Q165 Charlotte Atkins: Yes, so that they can, therefore, commission on the basis of evidence?

Mr Dyson: It is difficult to say they must do it every six months or every 12 months. It will depend to an extent—

Q166 Charlotte Atkins: How often do you think would be good practice?

Mr Dyson: I think it is good practice to have a strategic commissioning plan which is reviewed at least on an annual basis but is also adjusted where new evidence comes to light. One of the key features of good local commissioning, which we accept is not happening everywhere but is certainly happening in an increasing number of PCTs now, is that you have systems in place to capture the views of members of the public, the views of clinicians locally and the views of other stakeholders, and where it is evident from that that there are problems which are not being addressed by the commissioning plan you have put in place, then you clearly need to make adjustments.

Q167 Charlotte Atkins: The Government seems very clear that GPs are not delivering what patients want in terms of extended hours, but the Government does not seem to be so aware that dentists, in the past and now, are not delivering what patients want; and so when I talk about a needs assessment, I mean that it should not just be a general needs assessment, it should be specifically focused on the need for dentists. Is that going to happen?

Mr Dyson: Yes. First of all, the operating framework which we have referred to, interestingly, has dentistry alongside the key priority for access to GP services, so it sets out what we want PCTs to do to improve access to GPs, and then, directly alongside that, it says to PCTs that they must develop, if they have not already done so, strategic commissioning plans based on the aim of ensuring year on year improvements in access to NHS dental services in their area.

Q168 Charlotte Atkins: Surely, going back to historical point, it really does hinder the PCT's ability to commission services realistically if it is going to be based on historical dental activity. How do they break out of that straightjacket?

Mr Dyson: Through an 11% increase in the budget given to them for commissioning dental services on top of the additional funding that was put in place in the years leading up to the introduction of the reforms.

Q169 Charlotte Atkins: That is for next year. What about subsequent years?

Mr Dyson: That will then be built into the recurrent PCT dental—

Mr Lye: It is not a one-off 11%, it is a rolling, it is a recurring 11%.

Q170 Sandra Gidley: Can I come in on that. I can hardly believe what I am hearing. We are nearly two years into the new contract and you are just starting to give PCTs experience in commissioning. Maybe this explains why when I had a conversation with my PCT they said, "We are commissioning so many thousand units of dental activity." I said, "How many dentists is that?", and they could not work it out. That would be a fairly simple question and would be something that would have been thought through. How can anybody have any confidence in a system where the commissioners at PCT level do not have a clue what they are doing?

Dr Cockcroft: One of the most frustrating things through this process was when we started out we went and did workshops for dentists, and I have been going round the country all the time talking to dentists.

Q171 Sandra Gidley: These are not dentists.

Dr Cockcroft: We also spoke to commissioners, and one of the most frustrating things was doing this at a time when reconfiguration of PCTs was happening. It was very frustrating for us because you would go out, you would speak to a room full of commissioners and, six months or a year later, different people would be asking the same question again. There is absolutely no doubt that reconfiguring PCTs in the middle of this was really difficult. Some of them, like you say, are getting there now, but they are starting from a base that we had previously got other people to, but the reconfiguration of PCTs was not my policy.

Mr Dyson: Quickly adding two points. The first is, I am sorry if I have given the impression that the support we are giving to PCTs is only starting now. We have been giving dedicated support to PCTs from the very start of the dental reform programme. What we are doing is trying to build that up. Initially, PCTs had to concentrate on the basics: they had to concentrate on establishing the new dental contracts, making sure that there were clear arrangements in place for commissioning any services that were lost where a minority of dentists left the service and on getting those basics in place. What we are doing is taking them through a process which enables them to build on that base and become more sophisticated in the way that they commission services, and I will not dwell on that. Secondly, I recognise the frustration about whole-time equivalent dentists. The contracts that PCTs hold are not with individual dentists, they are with,

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typically, dental practices or providers of dental services. Within those practices dentists can still do a mix of work, and so, although it might be technically feasible to try and estimate the number of whole-time equivalent dentists, it would be a meaningful figure because it would not be a reliable guide as to the amount of dentistry that is being commissioned from that practice or the amount of dentistry that patients can expect, and that is why we focus on looking at the levels of service that have been commissioned and the numbers of patients accessing services.

Mr Lye: The list of products that I referred to that Primary Care Contracting have delivered are all products which have already been delivered. They have been delivered in the past year. They are not things which are being delivered at the moment. So it is just amplifying the point that Ben made that this is something that we have already been doing.

Q172 Jim Dowd: Charlotte covered a lot of the ground that I was going to look at, but can I say that the ring fencing ends next year, does it not, at 1.9 billion?

Dr Cockcroft: At the moment we have committed to ring fence for the first three years of the new system; we have not said that it will end after three years. That is a decision for ministers. It is guaranteed for the first three years.

Q173 Jim Dowd: You have not “not” said it?

Mr Dyson: We have said that the assumption would be that from the following year—. The resources are still there, they are brought within PCTs’ overall budgets, but that is a decision that will be kept under review.

Q174 Jim Dowd: You are saying no decision has yet been made about assured levels of funding for dental activity after 2009?

Dr Cockcroft: The funding that is going in now is recurrent funding, so that money is always going to be in the budget.

Q175 Jim Dowd: I do not know, Dr Cockcroft, if you were here, but your colleagues were here for most the last session, and there were allegations that there is a certain sleight of hand being practised by PCTs already. Once the ring fencing comes off, surely that position will only become more difficult?

Dr Cockcroft: I think that is certainly one of the issues we would have to consider when we decide what we discuss with ministers about beyond 2009. One of the issues was that there was no evidence to support this, about people siphoning it off, and also there is always going to be a gap, if services stop, between recommissioning. You have to keep back a full year funding for a new contract and you may not have spent that in the first year, but in the second year you certainly will if that is up and going.

Q176 Jim Dowd: I believe Mr Crouch—I hope I am not misremembering it—did say he did have evidence of siphoning off and he is going to provide us with it.

Dr Cockcroft: Yes.

Mr Dyson: At national level we know that in the first year of the reforms (and I do not have the precise figures to hand, David may have the precise figure to hand) about 99% of the intended budget was spent on dentistry. There was a small shortfall, which was not surprising given that a number of PCTs had to commission new services and, as the Chairman has indicated, it can take time to establish those new services.

Mr Lye: It was 98.6%.

Mr Dyson: On ring fencing, there is no suggestion that the additional money we are investing in dentistry is going to disappear from PCTs’ budget. That is a recurrent allocation. That will remain in PCTs’ budget. The issue is this. There is virtually no other area of NHS spending where we say: “This is the amount we are allocating you and you must not spend a penny less.” In all other areas of NHS spending we say: “Here is an overall budget. It includes resources for a number of areas, for dental services, for secondary care services and mental health services”, and so forth. The precise balance of investment decisions between those different areas is made locally, based on talking to local patients, talking to local clinicians, assessing local needs. It is becoming increasingly out of step with the way that we handle the rest of the budget.

Q177 Jim Dowd: Mr Dyson, that is perfectly true. The problem with global commissioning is you will get variations. Of course, the other side of the coin is the postcode lottery, which is, if you like, the expression of local priorities being established differently in one area to another, but the fact that you ring fenced it all indicates that there must have been fears as to what would happen to the spend.

Mr Dyson: There were certainly fears, and the reason that ministers made the decision to ring fence was to provide additional confidence during those first three years of reform while things were bedding down. I would say the better way to hold PCTs to account is not by specifying the financial inputs, it is by saying: “These are the outputs that we want to see”, and that is why we come back to the fact that the *Operating Framework* has set this priority objective of guaranteeing year on year increases and levels of access. If PCTs are delivering that, it is very much a secondary issue what level of financial—

Q178 Jim Dowd: I understand that entirely. The problem is, once you do delegate it to the PCTs, you can have all the frameworks you like but they will not necessarily agree with them. They will not prioritise them in the Department. It sounds to me as if you are trying to run a national service thorough local delivery. Is that the right model for dentistry?

Mr Dyson: With respect, the *Operating Framework* sets out a limited number of priorities which the Department is insisting PCTs make, it is not to the exclusion of other local priorities, and it covers things like the 18-weeks target for some time spent from GP to hospital treatment, it covers reductions in healthcare and associated infections. I believe the

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Department has a good track record. Where it chooses to focus on certain national priorities like those, PCTs do very much treat those as priorities and do deliver.

Mr Lye: Dentistry is one of them.

Q179 Jim Dowd: What measurement will you put in place to decide which PCTs are performing well and which are not performing well?

Mr Dyson: The number of people accessing dental services within each PCT, within each two-year period, which is measured on a quarterly basis, and we can track each quarter whether there is movement or not.

Q180 Jim Dowd: So it is not quality; it is just volume?

Dr Cockcroft: No. That was always the danger of having something measured as the indicator, that people would say all you are interested in is numbers of people, not the quality. We produced guidance to PCTs in January taking forward NHS commissioning. There is a clear line in there that says, if a service is not a quality service, it is not value for money no matter how cheap it is. John Taylor talked about the reference service. We are enhancing the role of the reference service to get them to focus more on quality, and there is a large amount on the clinical governance framework in the contractual—

Mr Lye: I do not know if the committee has seen that guidance, but we can provide copies, if that would be helpful.

Q181 Jim Dowd: Finally, just to test whether you have got the right model here. The patient revenue, patient contributions, in the first year was 150 million plus, less than anticipated: (a) does that reinforce or undermine your faith in the system you have employed? and (b) will PCTs be reimbursed if there is a continuing shortfall?

Dr Cockcroft: If there is continuing shortfall, then I think there is an issue, but what we know, as everybody has said today, is that the first year was an anomalous year, it was the first year of a new system. The reason for the PCR was very multi-factorial but there were very significant numbers of them. It was a transitional period, and dentists, as John said, actually worked quite hard to finish treatment under the old system, so the first month was almost a patient-free zone.

Q182 Jim Dowd: There has only been one. That was two years ago. There has not been a second year, so how can you say the first one was anomalous?

Dr Cockcroft: Because the figures in the second year are looking much more in line with—

Q183 Jim Dowd: So the indications are there?

Dr Cockcroft: Yes, the indications are that it will be much better this year.

Q184 Jim Dowd: Where did the missing quarter of a million patients go? The figures were there from the year before by a quarter of a million.

Dr Cockcroft: The quarter of a million was related to the transitional period when service was lost, and we had to recommission that and bring that back. I do not know where the individual quarter of a million patients went, but certainly PCTs worked very hard to recommission services as quickly as they could.

Jim Dowd: Perhaps they went to San Paulo! You never know.

Q185 Chairman: Just before we move on to the issue of charging and remuneration, could I ask you, you said it is a decision for politicians about ring fencing of the current budgets until 2009 when, I assume, Mr Dyson, you think that the operating framework will take over. Given the description you give us of the commissioning of dental services currently, do you not think it would be wise if budgets were ring fenced for a bit longer than next year?

Mr Dyson: We think there are certainly arguments on both sides. It is to some extent a question about confidence. The argument for ring fencing was never one based on, as I have indicated earlier, the overall approach to NHS funding. In fact, it went against that. It was primarily to generate confidence and provide stability during that transitional period. The ministers will be looking at both sides of the argument before making a final decision.

Q186 Chairman: Given the historical nature of the new contract, in as much as where there was NHS dental activity that is where money went, it went on that basis—Charlotte, my colleague, described it very well, and we, obviously, have different experiences in our constituencies—would it not be wiser that ring fencing should be extended? You say there are things for and against this. Could you tell me what is against this? What argument would you put against ring fencing budgets for probably another couple of years until this thing has bedded down and we know what we are looking at in terms of the new contract's outputs, as it were?

Mr Dyson: I certainly would not want to rule out the possibility (and this is a ministerial decision) of extending for a year or a couple of years, if that is what they chose to do. The argument, in principle, against ring fencing is that it encourages PCTs to focus on the amount of money spent on dentistry as the indicator of whether they are doing the right thing, when, as I have indicated, what we want PCTs to focus on is the outputs, both the number of people accessing services and the quality of the services that are provided. There is a tendency, if you focus on ring fencing, that that becomes the thing. The other argument, as I say, is that it in some way encourages a view that if you have spent that amount of money it is okay, and it may not be but the advantages of putting it within a much broader budget, which is the way other NHS finance is handled, is if PCTs identify improving access to dental services as a particular priority over and above what we are asking them to do, there is greater flexibility to take that from other parts of the budget.

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Q187 Chairman: I do not think anybody is arguing they could not spend more on it; it is the danger of it spending less. We have poor relations in the National Health Service. Sometimes people say it is mental health, it might be the training of doctors under certain circumstances, and that is the real issue. You describe a situation where commissioning is patchy; it might be that the individual professionals down there do not look on dentistry as being something that is that important in their particular area. Indeed, some people might argue there is 59 years of history of that in the National Health Service, and it seems to me, under those circumstances, that arguments against doing this while this new contract comes in are very weak. You think not.

Mr Dyson: No, I am saying there are arguments on both sides.

Q188 Chairman: Notwithstanding at the time of moving budgets if somebody does go into the private sector you need to spend that money elsewhere and that takes time to negotiate, if evidence was given that ring fencing was not being kept to at the moment, would that change your mind about the for and against ring fencing?

Mr Dyson: It is certainly evidence that could be taken into account, but I am trying to think what it would show. You could use it to show that ring fencing is not necessarily the most effective mechanism, because, again, it is focusing on the financial inputs rather than the outcomes.

Q189 Chairman: It would also show that the intent from the centre is not being delivered at local level, would it not?

Mr Lye: The question is what is the intent, and the intent is to improve access and quality, not to determine how much money gets spent.

Chairman: We will probably pursue this further in this inquiry.

Q190 Dr Naysmith: As the Chairman said, we are moving on to talk about charging and the way dentists are remunerated. The currency, the way it is done, is through units of dental activity. The BDA described the new system as unfair and arbitrary. Can we ask you what sort of evidence you would use to develop this? What is the evidence base?

Dr Cockcroft: The UDA is a measure of a course of treatment. It is incorrect to say this is the only measure that people include in contracting. You have got certain specific things which are outside that system.

Q191 Dr Naysmith: You said that it was the only method. You said the UDAs were unfair and arbitrary?

Dr Cockcroft: We have to have an activity measure. We learnt that from PDS piloting. What we did was analyse existing patterns of treatment and based it on diagnostics treatment and advanced treatment, which actually is something very similar to what this Committee suggested in 1992. I heard John say that he did not know how this was actually arrived at.

The system how this was actually arrived at was on our website, it might still be on our website, but certainly we provided clear indications and some of the computer suppliers provided software so that dentists could do their own calculations.

Q192 Dr Naysmith: The sort of thing that makes people say this, for instance, is that you can have one filling and that will fall into a band two treatment and that will give three UDAs. Someone can have four fillings, as I understand it, and a root canal treatment and it is still only a band two?

Mr Dyson: There are two separate issues here: the basis on which an individual dentist or an individual practice's new contract was calculated (and Barry has touched on that). The second issue is this question of whether you should remunerate on the basis of individual items of treatment, so you distinguish between doing one filling, two fillings, three fillings, or whether you should have a more flexible system that essentially says, "This is your contract value for the year. We are going to pay you this amount of money over the course of the year in 12 monthly instalments and we are going to tell you in advance that this is the amount of work that we want you to do", but rather than defining that by saying, "We want this number of crowns and this number of bridges and this number of fillings", you say, "We want you to carry out broadly this number of courses of treatment for your patients. We are going to weight it three ways, recognising that some of your courses of treatment are more complex than others, but we are going to ask you, as individual dentists, to use your professional clinical judgment to decide what is best for patients within each course of treatment." I think the very important point here is that, in a way, the prime contractual duty is to provide the care and treatment that is necessary for your patients. They present, you examine them, you decide what is necessary as part of a course of treatment and you provide that. We then designed a contractual system that we believe provides a fair level of remuneration for providing those courses of treatment, but, as one of the previous witnesses indicated, if you have to rely on precise financial incentives to get healthcare professionals to do what is right, to provide the necessary care and treatment, then you are fighting a losing battle. You can try this, you can try that, but it is not going to work.

Q193 Dr Naysmith: On the other hand, you can see why there would be pressure to do shorter courses of treatment. As someone who has undergone a root canal filling, that is a much more stringent and delicate and probably risk-associated procedure than one filling.

Dr Cockcroft: I think there are two issues here. It is often compared to buying baked beans in Sainsbury's: if you buy two tins of baked beans you pay twice as much as if you buy one, but retail is not like healthcare; underlying is what patients need and it is not the same at all. In any system of averaging, people will not point out which things they get a lot

of money for, they will always point out the bit where they lose out. So for every treatment that involves—

Q194 Dr Naysmith: What I am pointing out means that one dentist could carry out a certain amount of work and another dentist could be carrying out a lot more work and they get paid the same.

Dr Cockcroft: No, the historical value, their historical calculated contract value, would have reflected the work they did in the reference period. If you had a dentist who historically did a lot of root fillings, his contract value would be bigger than somebody who did no root fillings if his earnings were greater. The earnings were based on what they did historically. We were saying, “Carry on and work in a less item of service driven way. We will reduce the number of those by 5% and do not just think in items of service culture.” One of the big difficulties here is that dentists have been used to looking at every single bit of work they do and costing it as an item of service, and that culture has been there for 60 years and it is very hard to get away from it.

Q195 Dr Naysmith: We have received lots of submissions from dentists saying they are under huge pressure now to meet the UDA activity, to do what you are saying is the same. If it was calculated historically, you would say it is the same work they were doing before, they are now just being paid for it differently. Yet they feel under terrible pressure.

Dr Cockcroft: But at the same time, just before April last year we were having to do lots of media stuff to defend ourselves because dentists had run out UDAs because they had got through them so quickly. It cut both ways. Basically, it is their previous activity in terms of contract value and just do what is right for your patients with reduced complexity. John said, the reduced complexity is there. There are reduced numbers of root fillings, reduced numbers of crowns. It has got to be appropriate. You cannot just not do things if they are there, but there should be time to do it.

Q196 Dr Naysmith: Do you not accept that the reforms have resulted in an unacceptable increase in some dentists’ workloads?

Dr Cockcroft: No.

Q197 Dr Naysmith: You think they are just telling lies then? These are professional people, you have just described them a minute ago.

Dr Cockcroft: Absolutely. I certainly do not think anyone is telling lies deliberately. I think one of the most difficult areas—

Q198 Dr Naysmith: I do not think you can tell a lie undeliberately.

Dr Cockcroft: It is not a lie then, if people do not understand. People talk about the 47% contract that is undelivered on UDAs, but the amount of contract it actually delivered was 95%, which again was not bad, I did not think, for the first year. Where there was some confusion was with contracts that were

child-only, because under the old system (and, obviously, child-only contracts are usually private adults) those were children with very low needs and quite often you get the capitation payment because children have got no instance of disease: they are very easy to bring back every 15 months and you get a £50 a year capitation fee to do that. What we said was that, if you are getting that £50 capitation fee for that child from a public purse point of view, we would want some activity. So if a child is registered and has not been in at all, we would expect two courses of treatment, which does not seem unreasonable for £50, in the year. I think a lot of people thought we had miscalculated child contracts like that. We had not actually, it was just a different measure compared to adult treatment.

Mr Dyson: There were some cases where, I think, dentists have had to work harder—I want to qualify this slightly—and those are some of the dentists who had been working under the personal dental services pilots which Barry referred to. 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. As Barry has indicated, one of the things we did, therefore, in the new arrangements was to make sure that all contracts are at least underpinned by a consistent monitoring mechanism. We acknowledge that has meant that in some cases dentists who had been working under those PDS pilots had to do more. What we really struggle to accept is that dentists who had been working under the general dentist services contract, which were the majority (about 60-70% of dentists), should not be able to reduce their workload under the new system and yet have the same income as they had under the old system.

Q199 Dr Taylor: I am really most terribly confused, I am afraid. To begin with, we heard that dentists had run out of UDAs and so were being idle, we have certainly heard today that orthodontists have not got enough UDAs, and yet, at the same time, we are being told that people are struggling to meet their UDAs. Can you explain all that to me? I am lost.

Dr Cockcroft: In terms of orthodontics—

Q200 Dr Taylor: Orthodontics, I understand. They have not got enough UDAs and they never have had, so they cannot do the work, so they are sitting idly, but ordinary dental services, at the beginning, we were being told there were not enough UDAs and now we are being told they are having a struggle meeting them.

Dr Cockcroft: What we did, we built flexibility into the contract so that, if a dentist did up to 96% of their activity, they could automatically carry it over to the next year.

Q201 Dr Taylor: Up to what; I am sorry?

Dr Cockcroft: If they did 96% or over but below 100%, they had an automatic right to carry over that under delivery to the next year; but PCTs have actually got the flexibility, if it is outside that, to

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actually discuss with dentists how they are going to handle that, and we do know from information that the BDA supplied us with that a lot of PCTs have done that in the first year. I think a lot of PCTs were very nervous about doing that in the first year, because they did not know where they stood. Now I think there is much more confidence about doing that, and if a practice looks like it is going to under deliver or over deliver, they ought to discuss that at the mid-year review point of discussions with the primary care trust. I think, overall, I said 95% of this activity was actually delivered in the first year, 40% of contracts, I think, were relatively small—some of them were small contracts—but also there are a lot of other things other than that, so it did not mean that 47% of contracts under delivered.

Q202 Dr Taylor: So you do not think there is a risk that they will reduce the complexity of treatment and spend less time on treatment just to meet their targets?

Dr Cockcroft: Dentists are professional people; they should always act in the best interests of their patients. There will always be people in any profession who behave inappropriately, I personally believe that the vast majority of dentists would behave appropriately, but a reduction in complexity, if it is appropriate, is not a bad thing.

Q203 Dr Taylor: But if they have got a rigid target that they have got to meet and they cannot meet it if they do ten fillings instead of one, it is going to be super-human not to cut down, is it not?

Mr Dyson: Can I try and express this in a different way. As I said earlier, this is based on defining in advance the amount of work you have to do over the course of the year. If you then look at the micro-level of what happens when an individual patient comes up, at first blush the system can seem odd.

Q204 Dr Taylor: But each dentist has got to look at the micro-level.

Mr Dyson: But spread over the course of the year, the overall patterns of treatment should be broadly predictable—we know that from looking at the data under the old system—and what the system enables you to do is to plan a year ahead. You can monitor as it goes by, and if there are concerns that they are not going to deliver the amount of work that has been commissioned from you, then the PCT will discuss that with you and you put in place systems to prevent that. During the first year, because the pilot maybe was such a culture shock, such a change from the previous system, it is fair to say that a number of dental practices did struggle, and we do not want to underplay that, but what we found is that through PCTs working with dental practices and understanding the factors in play, it is then possible to start planning services on a more predictable and more stable basis for the following year. Barry is better qualified to talk about this than I am, but I would be very, very confident that this should now be on a much more stable footing.

Dr Cockcroft: These figures were not just plucked out of the air. The actual gross contract value was based on what they had earned in the 12-month reference period and the activity was the activity in that reference period just transmogrified into the banded treatments. As I say, the way we did the logistics of that was openly available to people to actually have a look at and we have never ever come across a case where somebody has said my calculations were wrong and have actually provided the evidence to show that.

Q205 Dr Taylor: We understand a UDA is a course of treatment and you said there were some things that were outside the UDA?

Dr Cockcroft: Yes.

Q206 Dr Taylor: What are those?

Dr Cockcroft: Sedation, domiciliary services, out of hours cover if you have got an agreement to provide some out of hours cover, open access sessions, which have been popular in tackling out of hours services by providing services the next day, and actually anything else that the dentist can agree with the primary care trust. One of the developments we have got now is to develop targeted prevention in areas of deprivation using the public health regulations; so there is absolutely immense flexibility within the contract, it is just that people have not had the confidence. I think it is very difficult to be innovative in a conflict situation. We talked about commissioning earlier on: the commissioning thing goes much, much better where the providers and commissioners work together to get a better service and I think in the last year the conflict situation has really damaged that. One of things I see when I go out is, where providers and commissioners are working together, you actually get a much better product, and we are starting to see that develop now.

Q207 Dr Taylor: But this is extremely difficult for commissioning if there are certain things that they have got flexibility on and they are outside the system.

Dr Cockcroft: It is a locally flexible system to reflect the different health needs in different areas. Knowsley, between Manchester and Liverpool, has some of the worst oral health in the country. They might decide that it is appropriate according to their needs to commission some targeted topical fluoride application, which would improve health. In an area in beautiful south-east England, Surrey, where the oral health on the whole is better, actually better than Birmingham in some of these areas without fluoridation, it may not be an appropriate thing to spend taxpayers' money on.

Q208 Dr Taylor: Do you think the piece-rate payment system did lead to unnecessary treatments being carried out?

Dr Cockcroft: I do not think it was deliberate. I went into a PDS pilot in 1998 which was not based on item of service. Our practice was actually very unusual; we were profit sharing. The three partners and the two associates just worked and we just divided it

equally at the end of the year, so there was no personal interest in how much individual profit you made yourself, and when we went to PDS we found that the numbers of items of service we actually provided, completely without even thinking about it, actually dropped by about 15-18%. It is just that it is a culture that has been there for so long but it is quite hard to get away from it, and a culture change is one of the most difficult things to do. I was asked a question at Westminster Health Forum recently that said, "Intervention in children has fallen since the transition period. Why is that?", and I turned it round and I said, "The incidence of decay in our 12-year old children has fallen tenfold in the last 30 years. Why has the incidence of fillings not fallen tenfold at the same time?" The answer is because there are drivers there which are difficult for people to ignore.

Q209 Dr Taylor: Do you ever think of a capitation and monitoring system rather than fee per item?

Dr Cockcroft: Certainly in the Patients Charges Group led by Harry Cayton, we discussed alternative methods of payment, and that report was unanimous, and was published, and we discussed the different methods of payment there and we came to this one. The difficulty with capitation is it works well within a practice but the logistics of having a nationwide capitation system, especially where there are patients' charges involved, is very difficult as people move around the country. We talk about 55-60% of people being registered or seeing a dentist in a two-year period. Over five years it goes up to about 80% because people come and people go out, and trying to get a workable capitation system around that is very difficult.

Q210 Dr Taylor: To have differing systems would have been—

Dr Cockcroft: Differing system would have been difficult.

Q211 Stephen Hesford: On the back of what Richard has been asking about, Mr Lye mentioned before basically the thrust of the system is access and quality, but we have heard little about quality. Access could be described as bums on seats, people visiting the dentist. Who is responsible for monitoring quality: how is it monitored and how is it assured?

Dr Cockcroft: I nearly used the bums on seats phrase when I was describing the access target. Now you have used it I feel more comfortable about using it. It is not just about bums on seats, it is about equality.

Q212 Stephen Hesford: I said it could be.

Dr Cockcroft: It is not. There is a rigorous clinical governance framework which we have set out. The reference service that John Taylor referred to is not being wound down; we are building up the reference service to do practice visits and to concentrate on quality, and the PCTs have a duty to provide a quality service. One of the other things is starting to get more information from patient feedback: so monitoring things like complaints and acting on

them. I am visiting a practice in Newcastle in a couple of weeks in the evening to go to their patient forum which they have now developed under the new arrangements to actually get feedback from patients. Quality should be writ all through this. As I said before, a low quality service is not value for money no matter how cheap it is, and that is quite clear. We talk a lot about quality in this and we talk about providing access for disadvantaged groups who traditionally have been excluded—some of that is through the salaried service and rural communities and things like that—so developing a quality service that meets the needs of a variety of people.

Q213 Charlotte Atkins: Why are there no UDAs for preventative care?

Dr Cockcroft: Prevention is included in band one. That is clear; so it is there. There was no payment for prevention previously. What we learnt is that when people went into the PDS pilots they all said, "We want to work in a more preventive way", but when you looked at what went on within PDS pilots, none of it was evidence-based. So we have now produced a toolkit, and we have sent it to every single practice in the country, about: "This is evidence-based prevention and this is what you should be doing for your patients", and it is relatively simple. It gives a clear indication to the PCTs what they should be looking for in terms of prevention and some of the new tender documents that are now being given out by PCTs even include the evidence-based prevention toolkit in the specification. Some PCTs are, I know one between Manchester and Liverpool that is, working on an incentive scheme for prevention using fluoride varnishes, which is clearly evidence-based. The other thing is, with this simplification of the course of treatments which everybody has said has gone on, it is not to have a simplified course of treatment and reduce your expenses, it is to replace some of that intervention with some evidence-based prevention, and, again, it has not happened enough yet, but that is where we want to see things developing.

Q214 Charlotte Atkins: How is that going to be monitored by PCTs, because we are hearing from dentists, we are hearing from submissions that they are on a different sort of treadmill than before, a UDA treadmill, and that they are not taking on board preventative treatments. Given that we incentivise GPs to engage in preventative health activities, why are we not doing that more with dentists?

Dr Cockcroft: Certainly PCTs are starting to do that now and are including an evidence-based document in the tender.

Q215 Charlotte Atkins: What is the evidence for that?

Dr Cockcroft: The evidence the PCTs are doing it?

Q216 Charlotte Atkins: Yes.

Dr Cockcroft: I am sorry, I thought you meant the evidence-base for the prevention. We now know that PCTs are starting to include it in their tender documents, and we put it actually in the commissioning framework as well to get them to focus on it. It has been portrayed for quite a long time that this is just about UDAs and nothing else, and dentists who get that information tend to believe it. It is more than that. It is about providing a better and more appropriate service. It needs a culture change, like I said.

Mr Dyson: There are two things you need. You need time for prevention, as I think one of the previous witnesses indicated. We remain very confident, and we think the data bears this out, that the new arrangements enable you to carry out, not just slightly fewer courses of treatments—that is actually not the big issue—it is less complex courses of treatment that genuinely free up time to spend with patients on preventative things. But, as Barry said, the second crucial factor is making sure that that prevention is then evidence-based, and that is where the framework helps.

Dr Cockcroft: The other point to make is that most of this work does not necessarily need to be done by a dentist. The GDC have just included some training programmes for dental nurses so that dental nurses can apply fluoride varnishes, which is the most evidence-based process you can apply to your children through their growing years. So it can be done by a dental nurse, it can be done by a hygienist, it does not necessarily need the dentist to do that at the same time. The growth of skill mix: we have increased the number of therapists in training from 50 to 200—I think there will be more growth in that—so it introduces a better level of skill mix into the way services are provided so that these people can actually do this and the simpler procedures which they would be good at.

Mr Lye: We talked before about the new clinical data set which we have developed and is being launched in April, and that allows some specification of the treatment given, and that does actually incorporate fluoride varnish as one of the treatments in the new data set.

Q217 Charlotte Atkins: Would it not be easier just to put the fluoride in the water?

Mr Lye: Putting fluoride in the water would probably be the single thing that would deliver the biggest benefit, particularly to deprived populations. We know that.

Dr Cockcroft: Even in Birmingham, which is fluoridated, you still get children with decay and, therefore, applying a fluoride varnish in this way improves that on top of that. I agree, certainly fluoride in the water is the best way to address especially children who do not access care.

Q218 Jim Dowd: Why not put fluoride in the fizzy drinks that causes so much of the damage?

Mr Lye: That would be sending a mixed message, I think.

Q219 Charlotte Atkins: I am sure the Secretary of State will take that back and think about that very innovative suggestion! Obviously, I recognise that fluoridation would only happen in a few areas. Is the Department working on areas where that would be most effective, where inequalities are greatest?

Dr Cockcroft: Yes, in our Oral Health Strategy in 2005 we urged PCTs in areas where you have got higher levels of dental decay than was acceptable to look at using fluoridation of the water as one means of reducing inequalities. We know that work is going on in at least four SHA areas now in various stages of the process to introduce fluoridation in those areas to reduce inequalities. We certainly did not change the Water Act in 2003 to then not fluoridate where we wanted to.

Q220 Charlotte Atkins: Someone has worked very hard on that one. Obviously, one of the big issues in terms of prevention is the lack of take-up of dental treatment. What work are you doing on trying to ensure that people do not fall through the net? We do not really have the school dentist.

Dr Cockcroft: We do have a community dental service that still goes into schools.

Q221 Charlotte Atkins: But they are not really looking in detail. They have a very cursory examination of children's teeth, and it is not as effective as I think it was in past decades.

Dr Cockcroft: Some of the best innovative early work has been a couple of PCTs in very difficult areas where they have been taking services directly to these people rather than sitting back and waiting. You cannot drag people kicking and screaming into a caravan in a supermarket car park, but you can make it much more available by doing that. We are certainly at the moment working with one of the major supermarkets to start to take services out to that sort of environment in a deprived area and make it as easy as possible. It is about education as well.

Charlotte Atkins: That supermarket could add fluoride to the fizzy drinks; no problem at all! Could you give us the evidence of this activity by PCTs? It would be helpful, I think, if we could have concrete examples of what is happening at the moment, both on prevention but also on commissioning appropriate extra dental activity.³

Q222 Chairman: Can I just ask you about the School Dental Service. Who measures what it is doing and how comprehensive is it?

Dr Cockcroft: It is directly the PCT providing services, and we have just agreed a new contract for those people to make their terms and conditions more appropriate, and they voted very strongly in favour of that, which was actually good news. They have a service level agreement with the primary care trust, so what they have to do is set it out in that. Certainly the PCT now has some dental public health functions and the PCT provides a services salary. The service has a significant role in doing

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some of that. I think it is very unfair to look at cost per case and say that the salaried service is more expensive than the independent sector, because normally those people go into the service to buy treatment for people who have got really difficult issues, really difficult handling issues—disability, autism—and you cannot say that that is a more expensive service because you have only seen two patients this morning if there were two autistic children and it was an achievement getting them in a chair. It should be focused on providing treatment for people who are not able to access care in the traditional way or choose not to. Over the last few years I think there has been an access element built up in the salaried services because that is the only bit of the service that historically the PCTs have controlled. If the commissioning works well and locally, then the rationale for an access centre in most cases would not be there. So I would like to see the salaried services focus on more deprived, more difficult people, disabled people, the people who have difficulty accessing services in the normal way.

Q223 Chairman: What about education in the classroom about dental health and children? Who covers that?

Dr Cockcroft: We have a series of linked initiatives with the Sure Start programme to actually make toothpaste and toothbrushes available to deprived communities. In Scotland, where I think there is little opportunity for fluoridating water, they have developed an initiative where they are going to go into every single school.

Q224 Chairman: Sure Start is pre-school and is not comprehensive. What about school children? Going to school is pretty comprehensive at the age of four and a half, or whatever it is now. What about education in schools? What is said to school children about dental health?

Dr Cockcroft: Working with the rest of the NHS and initiatives that involve teachers and people and explaining what the benefits are and what people should do is certainly in our policy on *Choosing Better Health*, as it is just consistent with the rest of health. So people should get positive messages, not only when you go and visit the dentist, but actually, when a midwife goes to see somebody when they have just had a child, you can actually use those people to give positive and evidence-based messages to new mums and things like that. Education, education, education in terms of oral health is very important.

Q225 Chairman: Have you ever had discussions with the Department for Education, although it is not called that now, about whether or not dental health education should be on the national curriculum or should be in every classroom in our schools?

Dr Cockcroft: We have certainly not had discussions with the Department for Education.

Q226 Sandra Gidley: Some of the submissions have suggested that the type of care given or delivered by dentists has changed since the implementation of the

new contract, particularly more complex treatments are less likely to be done. How have you monitored what is actually happening on the ground?

Dr Cockcroft: At the moment we monitor according to bands of courses of treatment, and both the Dental Laboratories Association, dentists and primary care trusts have said we need to get more detail about this. Lots of PCTs agree that a reduction in complexity of work is not necessarily a bad thing—

Q227 Sandra Gidley: Patients might disagree.

Dr Cockcroft: It depends if it is needs based or not, I think. I think that is the whole point. What we are doing, we are introducing an enhanced clinical data set, so that from April we will have much more detail about how many crowns are done, how many bridges are done and how many root fillings and things like that are done. We are not going to use it to say, “Look, you did 215 in the reference year and you are now doing 220”, because a reduction is a reasonable thing, but if you did 220 in the reference period and you did none last year, I think that would indicate that there needs to be a conversation between the primary care trust and the provider.

Q228 Sandra Gidley: Why is a reduction a reasonable thing if a patient might be receiving a treatment that is not necessarily to a lesser standard but may not have been what would have been provided before as the optimum? It will be: “This will do to solve an immediate problem”, rather than: “This is best in the long-term”. Those decisions could be made as well.

Dr Cockcroft: I think what the dentists should do is what is clinically necessary for the patient, and that is a clinical judgment and we would expect dentists to make clinical judgments in the best interests of their patients. John Taylor said that there was no doubt under the old system there was a clear incentive to intervene and provide treatment, either simple or even more extensive. I think there was a real contrast between the cost per course of treatment for people who are exempt and the cost per course of treatment for the people who are not exempt, which is actually hard to explain sometimes in some areas on the basis of variation in clinical need. I think that was quite difficult because there was a clear incentive there in the old system to do more, but I think, on the whole, the vast majority of dentists will always behave in the best interests of their patients.

Q229 Sandra Gidley: Even if they find under the new contract there is less profit in it?

Dr Cockcroft: I would hate to think a dentist would profit before patient care.

Q230 Sandra Gidley: Can I come back to something you said earlier. You said that the old contract damaged patients’ interests. What did you mean by that?

Dr Cockcroft: I meant that oral health in this country has improved so much since the inception of the NHS that having a fee for item system in 1948

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was completely appropriate because there was wall to wall disease. Now for 60% our children the care is free. 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. The problem with over provision is that you cannot do anything about it. John Taylor said you could send out a reference officer and look in the mouth. If you had got three fillings, there is nothing to say those fillings were needed in the first place. The thing about under treatment is that you can see it, you can monitor it and you can do something about it. Like John said, I do not think this was a big issue; I think the vast majority of dentists behave in the best interests of their patients, but it was a certain driver in the old system which is counter to improving the state of oral health of our people.

Q231 Sandra Gidley: Could you not have just adapted the old system but introduced some payment for the preventative dental care or health improvements?

Dr Cockcroft: The main reason we introduced this system was to give the NHS a commissioning role so that they controlled the availability of the NHS and did not allow the dentist to control when patients did not have access to care. By having a commissioned system you actually have to have a currency to know how much you are commissioning. I would not like to commission on the basis of an item of service, because you just create exactly the same drivers as everyone else has got.

Q232 Sandra Gidley: So you are saying it is really about keeping the dentists under control.

Dr Cockcroft: No, I meant control in terms of where they set up. The problem with the old system was that you had relatively small market towns where people could just decide to go down the Denplan route and the patients were completely disenfranchised, and there is no money to replace that. Giving control of the contracting so that the PCT has a budget, if two dentists move into the private sector the PCT can then commission the two other dentists to maintain services for patients, and in many ways that is one the reasons why there has been quite a lot of aggravation from some areas: because if your business case is based on there being no opposition, which you could do in the old system, that is significantly challenged now.

Q233 Sandra Gidley: There has been some anecdotal evidence, I think, from the nurses to say that now there are more people with dental problems accessing A & E and trying to find out of hours services because of the contract. Are you aware of that or have you made any assessment of that?

Dr Cockcroft: I was not aware of that as a specific issue. One of the other things is almost all PCTs have a very robust out of hours service and emergency service. Obviously, there is still progress to do on some of those. One of the things is that some people tend to access A & E automatically first point of call, and that is to be discouraged, but I think the media

coverage about difficulty of access might make some people go that way without even trying to get a dentist. One of the other things we are doing, we are working with the PCT so that they all have a point of contact so that a patient can ring up and say, "This is the problem", and they can triage it and deal with it at PCT level.

Mr Dyson: One does pick up anecdotes, and I have heard, I think, one anecdote of that kind. One of the great strengths of the new system is that in the past PCTs, it is fair to say, had no real ownership of dentistry locally, and the reason for that was that there was little they could do to influence it. As Barry said, if a dentist left, then, in some cases, the PCT had to watch, as patients had little choice but to either sign up privately or have no dentistry. Under the new system they can commission other services, but the further advantage is that if PCTs pick up evidence—and I would be shocked to discover that this was on any sort of widespread basis—of patients not receiving optimal treatment or being referred inappropriately to other providers, then the PCT can grip the situation. For the first time in the history of the NHS, it has got the commissioning levers to be able to do that. We accept fully that these have been a difficult two years and that PCT commissioning capability and capacity is building up perhaps more slowly than we might have originally wished, but when we talk about this being a much more stable foundation, that is what we mean.

Dr Cockcroft: The legislation gave PCTs the statutory duty to provide services across the board where clinically necessary. When I first joined the Department there was a complaint to the parliamentary ombudsman about a PCT that had no access, and although the complaint was quite right, the ombudsman could not do anything about it because the PCT had no statutory duty to provide those services. Now they have, and so it is not only me and local MPs who will be watching them, other people will realise they have to meet their statutory obligations.

Q234 Sandra Gidley: Earlier we heard how orthodontic treatment was a particular problem, partly because of the league times and being able to access properly. My understanding is that there were new guidelines as to what should be treated and what was not with the IOTN (Index of Orthodontic Treatment Need) number at the same time. What are you doing to review the orthodontic area, which actually causes a lot of grief to a lot of people?

Dr Cockcroft: PCTs have a duty to provide orthodontic services, just like they have a duty to provide general dental services. The starting point in terms of the distribution of orthodontists across this country was even more skewed than general dental services, because you had a huge availability of access in the south-east of England and in some parts of the north-east virtually none at all. Over time, as PCTs start to commission more services, they can start to commission more orthodontic services, and we are seeing that now but it will take some time.

Q235 Sandra Gidley: Is this included in the 11%?

Dr Cockcroft: Orthodontics is included in the PCT's primary care budget.

Q236 Sandra Gidley: So it will be up to PCTs to decide?

Dr Cockcroft: Yes, but they have a duty to provide it, just like they have a duty to provide everything else and we plan to develop it. We do spend more money directly on orthodontic services than any other country in the world actually.

Q237 Sandra Gidley: A quick question about NICE guidelines. We have recently done an inquiry into NICE and it is quite interesting how many guidelines were very good but did not seem to be taken up. There seems to be quite some enthusiasm about the reduction in dental check-ups. Is that because it is a cost-saving issue as well?

Dr Cockcroft: No, it is an appropriate use of resources. Compliance with all official guidance is a contractual requirement. Compliance with NICE guidance is actually a contractual requirement, so that if you assess somebody, if they have got high needs, if they smoke, they drink and they have lots of active care issues, you recall them very quickly. The vast majority of people do not actually need that, especially with the *Improving Your Health*, do not need six-month check-ups, and in many ways if you have got a budget, then it is a waste of resources. It should be appropriate, and the longest period that NICE recommends is two years, so even if Mr Dowd has not been for nine years, he probably ought to go and have a quick check-up every two years just to make sure.

Q238 Dr Naysmith: Dr Cockcroft, there was talk earlier on about how you really get the new contract working, and so on, in the future is with younger dentists. How confident are you that the new contract and NHS dentistry and orthodontics, as it is now going forward, is attractive to young people and will produce the young students that you want?

Dr Cockcroft: NHS dentistry as opposed to private dentistry?

Q239 Dr Naysmith: Well, the contract.

Dr Cockcroft: Certainly 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 and should not be demand rather than need—the fancy cosmetic stuff and stuff like that—but the NHS providing healthcare, and that is what I think the future will be.

Q240 Dr Naysmith: I am talking about the supply of dentists, NHS and private. Will they be more encouraged to work under the new contract than perhaps those older ones who you see where the change of culture has not quite happened yet?

Dr Cockcroft: I think the culture change has been very difficult, especially for people who have been working in the same system for 35 years. There is a lot of contracting and a lot of tendering going on at

the moment. When I go out I meet lots of young dentists who are very enthused to actually get involved with this and do it. They actually provide a mix in many cases, because that might be appropriate. We do not see any shortage of dentists coming through. Obviously there is an expansion of dental undergraduate training which has not actually fed in yet. The first tranche comes out in 2009. So we have a very significant increase in dental undergraduates coming out of our own dental schools over the next few years. We are working with the deans at the moment to get the evidence-based prevention paper included in their undergraduate training, and we are also developing a lot of outreach teaching so that undergraduates learn their skills in the primary care setting, which is more appropriate to where they want to be in the future, and that has been very well received as well.

Q241 Dr Naysmith: Given that dental surgery now has to be determined by a primary care trust in the locality, and so on, how do you think we are going to plan the workforce for dentists in the future, never mind the fact that dental decay is decreasing in this country anyway?

Dr Cockcroft: We published a Workforce Review in 2004 which showed clearly a growing need for dentists up until a point, I think it was about 2025 or 2030, when actually it peaks and starts to fall, because my children, who are decay free, and lots of children in their early teens, have actually got very, very low levels of disease. That will be an issue for 2020, 2030. At the moment we are pretty confident that we have got enough dentists to actually meet the need. Workforce planning is a nightmare. There are so many variables. Everybody signed up to closing two dental schools in 1988/1989 because everybody was going to be so fit there was going to be no need, and nobody anticipated the massive explosion in cosmetic dentistry that there has been and a relatively smaller increase in private capitation schemes. My job is to advise the Department, HEFCE and all these people about what we should be doing to train. At the moment we have got an expansion coming through. I think we have to let the thing settle down before we make any knee-jerk reactions to changes in workforce. I think there will be a very significant change in skill mix though, because certainly dental therapists, dental nurses have got expanding roles within the regulation and I think developing the skill mix within dental practice will be a significant factor. If you go into an orthodontic suite in America, if it has six chairs, there will be two orthodontists and four therapists; whereas over here it will be six orthodontists. Most of the work, apart from the diagnosis and the treatment planning, can be done by a therapist, and we have now got some orthodontic therapists being trained in this country. So that is going to feed into the workforce planning for orthodontics. It is an unbelievably complex.

Q242 Jim Dowd: Can I say straightaway, I realise I should go to the dentist more often and I would encourage everybody to do so!

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Dr Cockcroft: And there is access there in London.

Q243 Jim Dowd: On the access issue, there is no problem in London, as it says here, although I see the CAB said 19% of respondents in London said they could not find a dentist. I suspect it is one in five people who actually do not like dentists and actually do not look for them. Nonetheless, we will move on. For the future, how would you respond to the suggestion that the way we are moving is towards a basic service provided by NHS dentists and anything more complex or cosmetic is going to be done in the private sector?

Dr Cockcroft: We came under a lot of pressure quite early on to do something like that. There is an element of people who—. It depends where you draw the line. I think it is about what is clinically necessary and how you define “clinically necessary”. I would hate to go to a system where somebody who was on benefit could not get a crown when they needed a crown, because I think that goes to your quality of life. 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. Not having those sorts of advantages just increases inequalities. I think if it is clearly demand-led and no degree of need, that is not the scope of the NHS. You cannot define that. People might say veneers might be outside the scope of the NHS, but if you have got tetracycline staining from having tetracycline when you were a baby, then a veneer might well be the best treatment for you in that situation. I think the NHS should provide what is clinically necessary. If somebody wants something but does not need it, then that is clearly outside the scope of the NHS. Trying to define it rigidly is virtually impossible.

Q244 Jim Dowd: Indeed. I am not clear what you are saying. You are saying the basic service but that at the margin there should be special circumstances to allow people the option of—

Dr Cockcroft: I think the decision about whether something is clinically necessary is a professional decision which I would expect a dentist to be able to make.

Q245 Jim Dowd: The difficulty with, as you mentioned, somebody who is unemployed, or somebody on benefit, not being able to get a crown, for example, or more expensive treatment, will that not exacerbate the poverty trap of getting people into work?

Dr Cockcroft: If you did that, but at the moment we do not have that. We have a system where people who are on benefit or getting income support, *et cetera*, can get the range of NHS treatment that somebody who can afford to pay charges can get. If somebody comes into a private practice and says, “I want ten crowns”, but they do not need them, that is clearly outside the scope of the NHS. Somebody would have to pay privately for that.

Q246 Jim Dowd: Is it sensible, though, to attempt to maintain the notion that all treatments are available under the NHS?

Dr Cockcroft: All treatments. That is what we are saying, all necessary treatments.

Mr Dyson: We think that is right and sensible.

Q247 Jim Dowd: Is it sustainable over time?

Dr Cockcroft: We have essentially been doing that for the last 60 years, and we have got the budget to do that.

Q248 Jim Dowd: Originally, of course, there were no charges, but that did not last very long and since then the patient contribution for anybody in work has long since become very expensive.

Dr Cockcroft: In principle, I would not want to introduce a change into what people were entitled to that widened inequalities, and I think doing that would do that.

Mr Dyson: We think it is in some way more sustainable under this system, because, as we described earlier, we have removed some of the perverse incentives which existed in the old system for, at the margins, over treatment. I know this is going to sound very theoretical and, obviously, the evidence will come from increasing practice under the new system, but we think that provides all the more scope to make sure that what is clearly clinically necessary is provided. As Barry and as David have described earlier, it is very much the quality measures alongside the counting of access that we are getting PCTs to address through the way they commission services and through the way they work with practices on monitoring, on clinical governance, on preventative schemes.

Q249 Jim Dowd: But Dr Cockcroft, unless I misunderstood you, you were alluding to a number of for instances there which are not clinically necessary and may have a more social dimension?

Dr Cockcroft: That has always been the case, and it is not appropriate.

Q250 Jim Dowd: So clinical necessity is not the only judgment.

Dr Cockcroft: No. I think if somebody wants some (as you would describe them) social crowns, I think the dentist has a clinical decision to make to say that these are not actually necessary for your oral health or psychological well-being. I will do these, but I will do them in the private sector, and that is a completely reasonable thing to decide. If somebody’s teeth are so badly damaged or so heavily filled that they are unable to socialise without embarrassment, then I think that is an issue for the NHS.

Mr Dyson: There are always going to be some very difficult decisions at the margins, but I think it is wrong to pick out those difficult decisions, which will vary, inevitably, from clinician to clinician, and use those somehow suggest that there is a fundamental problem facing the NHS in defining what is clinically necessary.

Jim Dowd: I apologise for the temerity of having raised it!

Q251 Sandra Gidley: A quick question to Ben Dyson. Why are dentists going to be allowed to exercise their professional discretion, which I have no problem with, when GPs are not, and there are a lot of treatments that will have to be referred to a particular panel, or will you be ultimately introducing the same system for dentists?

Dr Cockcroft: I think it is very hard, because you have got the same clinical process or procedure that you are actually going to use. It is the exact same process. If you have a crown on an upper tooth and that is clearly what the patient wants, sometimes it may be appropriate because it is clinically necessary and sometimes it is not. I think in medicine you have the same issue around removing tattoos and all sorts of things which are on the margin. Is this clinically necessary? Is it not? I do not think it has got the same degree of variability. I suspect it probably has if I knew more about medicine, but I do not know as much about medicine. I think sometimes, you know, if you have broken a leg, you have broken a leg. It is very clear. I think the other issues start to get more complex.

Q252 Dr Naysmith: Can I ask why dentists can decide on psychological grounds whether someone should have a crown or not?

Dr Cockcroft: That is something you learn in training. If somebody has got a very highly discoloured tooth, they may be able to eat with that tooth, but, like I say, they may not be able to get a job which is publicly facing, and that is the sort of clinical decision you would expect a highly trained dentist to actually make.

Q253 Chairman: There is difference in cost. Could it be the case that somebody could have a single palate with one tooth on it under the UDA system?

Dr Cockcroft: Yes.

Q254 Chairman: So you have to make the grounds for having a crown as opposed to a tooth on a single palate?

Dr Cockcroft: Or a bridge, yes.

Q255 Chairman: Where do you see the line between what I would deem to be not NHS dentistry and cosmetic? Let us say somebody was eligible to have an NHS palate with several teeth on it and the dentist says say to them, "You can have that. It will cost you X amount of money, but I could do you one in the private sector that will cost you X plus amount of money", could you make the argument that you need that X plus amount of money on the National Health Service?

Dr Cockcroft: It depends on the clinical situation. If you are providing complex treatment or a complex metal denture, you would not provide that under the old NHS unless the person had got very good oral health, had not got gum disease and the mouth was not going to generally deteriorate. If there was a likelihood that a patient might lose another tooth

later, you probably would not provide something that was very expensive and then have to alter it later. Again, it is down to clinical judgment. Although people talk about reductions in complex treatment, there is still a significant number of these going on at the moment and dentists are making those sorts of judgments and, in some cases, providing complex treatment which they think is appropriate.

Q256 Chairman: What would your reaction be if somebody said, "Why can I not have that X plus palate but the NHS pays the cost of the X palate which I am eligible to anyway and the difference in going X plus I make up as an individual"?

Dr Cockcroft: That is what is called a co-payment, and I think at the moment legally you cannot make any other payment in relation to NHS treatment than the statutory dental charges.

Q257 Chairman: On ophthalmic charges I could go to a designer frame, could I not, but I cannot on dental charges?

Dr Cockcroft: No.

Q258 Chairman: I could argue with a dentist that I need the X plus for good reason?

Dr Cockcroft: I think one of the principles about the dental charges is that the old 400 items of service were so complex that patients did not know in many cases whether they were getting NHS or private treatment. One of the great benefits of the new system is that it is very clear whether they are getting NHS or private treatment. The moment you start to complicate it again, patients will not know whether they are paying for private treatment or NHS treatment or what. When I first came into the Department, I had people in the office who had just paid £500 for an NHS crown. I think it is disgraceful. Quite clearly that was way over the statutory charge. The clarity of the existing patients charge, I think, is a big benefit. Obviously we have reduced the maximum charge by half, which is very significant. I think the danger of going to the co-payment system is that you then start to re-complicate something which is very simple at the moment.

Jim Dowd: Can I finish my question now?

Chairman: I thought you had finished.

Q259 Jim Dowd: No, it just seemed like it. There is only one left actually. The last time, we spoke to the Minister of State before the contact was introduced. What became clear is the Department has a reasonable grasp of dental activity within the NHS but virtually none in the private sector. Has that position changed at all? If the NHS has lost practitioners to the private sector, clearly they will be treating a larger proportion of patients now in the private sector. Do we have a whole image, a whole picture of the nation's dental health?

Dr Cockcroft: We certainly do not have data at the moment for what goes on in private practice. They are completely independent. There is no system of collecting that data.

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Q260 Jim Dowd: So when you say there is no reduction in more complex treatments, they could easily have migrated into the private sector rather than being in the NHS now?

Dr Cockcroft: That is a choice patients might have to make. If something is not appropriate within the NHS, they can choose not to have it done.

Q261 Jim Dowd: It would be wrong then to say there is a reduction, other than to say there is a reduction reducing the NHS?

Dr Cockcroft: From our point of view, it is a reduction of provision in the NHS. One of the things I would say is that at the moment the private sector is relatively unregulated, and in the Health Bill we may well look at doing some regulation of private practice because, clearly, it seems to me unreasonable to differentiate how you regulate a professional dependent on how he gets his money. So we regulate NHS people but we do not regulate people who work in the private sector.

Mr Dyson: It is quite difficult. It is one of the things which is part of the Health and Social Care Bill, which is currently out to consultation at the moment, about whether there should be regulation of private dentistry and, if so, what there should be.

Q262 Jim Dowd: It spends most of its time regulating things it does not know. Most governments in the world do that. Simply because they are in the private sector does not mean they are exempt from regulation.

Mr Dyson: But that is something which is being consulted on at the moment as part of the Health and Social Care Bill.

Jim Dowd: Thank you. I have now finished?

Chairman: Could I thank you very much indeed? I am sorry for the delay. I know that maybe at least one of you may be coming back to see us in the next few weeks, but I am sure that you will have a continual interest in this inquiry during the time that it is going to take and also in the outcome as well.

Thursday 21 February 2008

Members present

Rt Hon Kevin Barron, in the Chair

Charlotte Atkins
Mr Peter Bone
Sandra Gidley
Dr Doug Naysmith

Mr Lee Scott
Dr Howard Stoate
Dr Richard Taylor

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

Q263 Chairman: I welcome you to the second evidence session in our inquiry into dental services. For the sake of the record, perhaps you would introduce yourselves and the positions you hold.

Ms Elley: My name is Karen Elley, Consultant Dental Public Health for Sandwell Primary Care Trust.

Ms Delaitre: I am Helen Delaitre, acting Head of Primary Care at Hillingdon PCT.

Mr Harris: I am Andrew Harris, Primary Care Manager at Devon Primary Care Trust and lead for dentistry commissioning.

Q264 Chairman: Some of the questions to which you will be responding will be specific to individuals. I start the session by asking a general question of all of you. To what extent has the provision of dental services changed in your PCTs since April 2006?

Ms Elley: At the moment the level of provision is similar to that in April 2006. We have relatively good access to dental services within Sandwell. The provision has been in a steady state from 2006. I can go on to future plans, but I do not know whether you want me to do that at this stage.

Ms Delaitre: Our position is very similar. We lost one dentist through the changeover and that was a very small contract, so we have maintained steady state and it is very similar to Ms Elley's experience.

Mr Harris: We have begun to see an improving position but Devon started from a very low base in terms of NHS dentistry provision anyway. Certainly, in the first 12 months of the contract we have seen an increasing number of patients beginning to access NHS dentistry.

Q265 Chairman: One aspect of dentistry is that it has always been a little difficult to measure it in terms of what has been happening in the National Health Service. How did your PCTs go about assessing needs for dental services before the introduction of the new contract, and how do they continue to monitor needs? Are there differences here?

Ms Elley: In 2005 the Sandwell PCTs, of which there were three at that time, adopted a local oral health strategy which included a full needs assessment of all areas of dentistry: general dental service, hospitals and salaried dental services. It looked at total needs across the borough and provided a forward action plan for what it needed to do locally to address inequalities in provision in oral health. We did that

at a stage when we knew the new contract was coming in. The new contract then gave us the tools to start implementing some of the change that we did not have under the old contract.

Ms Delaitre: It is exactly the same for us. Our public health team led on the oral health needs assessment which clearly showed areas for future re-commissioning of services to improve provision.

Mr Harris: We have a different approach. First, as a PCT when the new contract came in there were six smaller primary care trusts, so there were different arrangements in existence in terms of identifying needs. We reorganised into a single PCT in October 2006. A lot of what we have done today has been driven basically by access needs and demand from patients, and we are now in the process of developing an oral health strategy with public healthy input.

Q266 Dr Taylor: To pursue exactly that point, so many of the reorganisations in the health service have seemed to be rather difficult for people to cope with. You have told us that you went from six PCTs to one. What about Sandwell?

Ms Elley: Sandwell had three primary care trusts with one health authority originally. We have now merged into one primary care trust. I have always worked for all primary care trusts across Sandwell anyway, but obviously the managers in each organisation have changed.

Q267 Dr Taylor: You imply in your paper that you have a greater consultant dental public health establishment than is often the case. Does that mean you are better able to cope with commissioning than some other PCTs?

Ms Elley: I think various aspects are required for dental commissioning. Obviously, a good dental public health input is important in setting the strategy and identifying the needs, but there also needs to be a team and we very much work as a team. We need to work with commissioning managers and with finance managers, and throughout the organisation we have kept together a team which has had different members. It has been very important to keep together that team and we all have different perspectives. My manager colleagues say that they are pleased they have me—even the chief executive says that sometimes—because they need a public health focus as well as a manager input to facilitate change.

Q268 Dr Taylor: Do you believe that you have weathered the storm of three to one probably better than some others?

Ms Elley: I would not like to compare us with others. I will not say it has been easy. My finance colleague, myself and the senior commissioning manager have been the same throughout. A lot of the managers who have interfaced with general dental practitioners have changed. That is very difficult for both managers and practitioners, but we have been helped by having a stable team.

Q269 Dr Taylor: We have certainly heard comments from others that in some PCTs it has been left to very junior members of the PCT staff to make this happen. What about Hillingdon?

Ms Delaitre: We have probably been fortunate; we were not reconfigured.

Q270 Dr Taylor: You were one of the London ones that got away with it?

Ms Delaitre: Correct. We maintained the staff. I have been working in primary care since 2002, so there has been continuity there.

Q271 Dr Taylor: What we need to know from some of your dentists is whether the whole process has been pretty smooth since you did not have to merge.

Ms Delaitre: It certainly helped the situation. We were not diverted into working on reconfiguring and restaffing arrangements. Similarly, across the north west London sector we established a working group so we could share problems and new issues as they came along. We met on a monthly basis in readiness for implementing the new contract. That worked very well.

Q272 Dr Taylor: Ms Elley and Ms Delaitre—I do not know about Mr Harris—can probably answer my next question. We are trying to get at the proportion of the budget actually spent on dentistry.

Ms Elley: The proportion of the budget we were given?

Q273 Dr Taylor: Yes.

Ms Elley: It was not spent on anything else, if that is your question.

Q274 Dr Taylor: What is the proportion of the PCT's budget as a whole?

Ms Elley: I can tell you that we have spent £18 million this year on general dental services. I do not have at my fingertips the figure for the total spend of the PCT.

Q275 Dr Taylor: Do you know the exact number of dentistry staff, not just the number of bodies but the number of whole time equivalents? The Department of Health cannot tell us the number of whole time equivalents.

Ms Elley: I can tell you the whole time equivalents based on a local survey in 2005. Unfortunately, at that stage not every practice responded because there was no requirement for them to do so. Therefore, the data are incomplete. We are in the

process of developing a West Midlands workforce survey. That is a model we have used before to count not just dentists but also dental therapists and dental nurses. It is a local initiative and I would certainly welcome a requirement to have national surveys of that kind.

Q276 Dr Taylor: Therefore, some time soon you will know the result of that to compare with 2005?

Ms Elley: The survey has not yet been done but when it is, yes.

Q277 Dr Taylor: One of our obvious recommendations is that that sort of exercise should be carried out nationally.

Ms Elley: I would support that.

Ms Delaitre: It would be very useful. I can tell you how many bodies we have but not whether they work full or part time.

Q278 Dr Taylor: It is absolutely ridiculous that we do not know, is it not?

Ms Delaitre: Absolutely.

Q279 Dr Taylor: What proportion of your PCT budget goes on those services?

Ms Delaitre: Our primary care budget is £75 million of which just under £10 million is for primary care dental services.

Q280 Dr Taylor: Are there any comments from your end?

Mr Harris: I do not know the full budget, but I can confirm that as a PCT we spent our full budget for dental services.

Q281 Dr Stoate: Ms Delaitre, I was interested in your experience in Hillingdon. Your submission says that the history of good collaboration between the commissioner and general dental practitioners has meant that many of the problems of the new arrangements reported elsewhere have not arisen in Hillingdon. What problems are you talking about, and how have you managed to avoid them?

Ms Delaitre: I have a dentist in Buckinghamshire whom I visited during this time. She said that she was not communicating with her PCT and had a problem in negotiating what the contract envelope would look like. In Hillingdon where I have been in primary care for a number of years there has been a dental advisory and liaison group for 10 years-plus, and we also go to all the local dental committee meetings. That means we have maintained good relationships. In advance of the implementation of the contract we established a steering group with a number of local GDPs, not necessarily from the LDC, where we shared what we thought would be common issues and problems. We did that in an open and transparent manner, which I believe the dentists appreciated. Where we had perhaps funding issues or problems to overcome in terms of dentists who had atypical earnings in the reference period we could share those with the dentists so they understood upfront where and why we were making our decisions.

Q282 Dr Stoate: But you are also implying that others were not doing what you have been doing. Why do you think that was?

Ms Delaitre: Because of reconfigurations, possibly it was because they had not had time to build up longer relationships and establish trust in the PCT's abilities to commission services appropriately with an understanding of the profession.

Q283 Dr Stoate: Are you saying that if PCTs got their act together we could avoid most of the problems of the new contract?

Ms Delaitre: No. They probably did get their act together, but it was a learning curve for everybody. Due to the fact that PCTs were also going through reconfigurations possibly they could not devote the time and effort it needed.

Q284 Dr Stoate: What I am getting at is whether the contract itself is flawed or whether it is just the relationships between the PCT and the practitioners that are flawed. If you are saying that the contract did not cause problems because you got it right does it mean that if everyone got it right the contract would be fine?

Ms Delaitre: I am not necessarily saying that.

Q285 Dr Stoate: Which bits do you think you have managed to achieve that others would not be able to achieve?

Ms Delaitre: I think it is just a matter of reassurance about the introduction of the new contract and given time we will see how it goes, because at the time a lot of dentists were saying they might leave immediately or would give three months to terminate. It was a question of seeing how it proceeded through the first year. They still had an opportunity to opt out of providing NHS care but there was no need for them to rush and do it at that time and they should work with us and see how we could achieve the contract together.

Q286 Dr Stoate: You also describe the collaboration between Hillingdon and seven other PCTs to provide out-of-hours dental care. How was it done previously? What has changed?

Ms Delaitre: Referring back to the north west London sector which comprises eight PCTs, previously GPs had responsibility to provide out-of-hours care. When the new contract was introduced not all PCTs, including Hillingdon, had allocations in their budgets for emergency dental services. Therefore, we had a zero budget given to us and somehow had to provide care. Other PCTs in our sector were more fortunate and basically we piggy-backed onto the service they provided under an agreement that lasts until March/April 2009 at which time it will be reviewed. We shall probably make a financial contribution to that service.

Q287 Dr Stoate: Do you have any evidence that the new arrangements are more financially cost effective than the previous ones, or have you not got that far yet?

Ms Delaitre: I do not. For us it is financially beneficial because we are not paying, but I am sure that time will tell when next year we come to review the service.

Q288 Sandra Gidley: I have a question for Andrew Harris. We had a very interesting submission from the Devon PPI Forum which claims that as a PCT it allows some NHS dentists to exclude certain patient groups from treatment, particularly benefit claimants and the elderly. Why do you do that?

Mr Harris: We had a number of practitioners who worked under the old GDS contract and provided NHS services for only limited groups of patients, that is, children and exempt patients. Historically, their funding was based upon that pattern of service.

Q289 Sandra Gidley: To clarify, you had a historic situation of not providing adequate care for the elderly and benefit claimants?

Mr Harris: Absolutely. It was a historic pattern of care that those dentists had chosen to provide under the GDS and which they were fully able to do under the old system. Therefore, they had a historic baseline of funding which reflected that level of service. Where that situation arose we had a choice. The choice was that if we required that practice to open up its provision to all groups of patients would that compromise the patients they were currently looking after? The position we have adopted since 1 April has been very clear: under any new service that we commission as a primary care trust and any contracts we renegotiate we shall expect all groups of patients to be offered a service.

Q290 Sandra Gidley: I do not completely understand why you did not seek an opportunity to improve the situation. The submission makes it quite clear that the effect on this group of citizens is a public disgrace and yet the PCTs seem content to allow that to continue.

Mr Harris: Devon comprised six different organisations at the time and therefore there were probably six slightly different approaches adopted, but the view taken, I believe in the majority of cases, was that we had a level of funding to provide a service for this group of patients who were currently being provided for. Did we want that service to continue or for it to be widened to other groups of the population and find that those currently under care could not access the service? The decision was taken that that group of patients should continue to be looked after with the available funding.

Q291 Sandra Gidley: Have you commissioned anything since that has improved the situation?

Mr Harris: We have. We have looked across the whole county at where we have insufficient provision and where we need additional services we have been commissioning those services for all groups in the population.

Q292 Sandra Gidley: Can we put the new service into perspective? It could be a very small number of UDAs.

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Mr Harris: I do not have the figure to hand but I can make it available. To put the restricted contracts into context, 7% of our dental budget was committed to restricted contracts or those limited to children and exempt patients. That was transferred across from the old system. We find that the activity in those restricted contracts is reducing, so there is funding coming out of those contracts and it is being reinvested in the provision of care for all groups of patients.

Q293 Charlotte Atkins: Was not the idea of the new contract that dentists would have to decide whether to go fully for an NHS situation or to go private and in a number of constituencies, including mine, there were many dentists who bribed parents to go private so that their children would be treated on the NHS? In my area basically dentists had to decide whether to stay with private contracts or go fully into the NHS. Why did you not do that in your area?

Mr Harris: I cannot explain. It was felt that given the time and the amount of work we had to do we wanted to get as many people into the contract as possible. We felt there was a real danger we would have a major lack of access for a significant group of our population if we did not contract with those practitioners.

Q294 Charlotte Atkins: I can understand perhaps doing that in the first few weeks, but we are now 18 or 20 months on. It seems to me that the continuation of the original contracts which allowed them to discriminate against certain groups they just did not want to treat is an absolute disgrace.

Mr Harris: Certainly, the PDS contracts can be renegotiated. Many of our contracts are coming up for renegotiation in the next 12 months. As a PCT we would certainly be reviewing the content of our contracts. The view is that in setting up new contracts we are putting in place services for all groups of the population.

Q295 Charlotte Atkins: Are you aware of other PCTs that have made similar decisions?

Mr Harris: Yes.

Q296 Charlotte Atkins: Where would they be?

Mr Harris: I cannot say specifically, but certainly talking to colleagues generally I understand that would have been the case in certain areas.

Q297 Dr Naysmith: I have a couple of questions for Ms Elley arising out of her submission, but before I come to that I wonder whether either of the other witness can help Mr Harris in the situation he is in which obviously does not apply in their areas.

Ms Elley: Within the West Midlands we made the decision that it was certainly preferable not to have contracts for specific groups of patients—child-only lists—and we did work well across that area on some of these issues. I am unsure whether any PCTs did break with that, but we certainly worked together to make sure there were not child-only lists, for instance.

Ms Delaitre: I think the original guidance suggested to PCTs that they should not offer GDPs non-comprehensive contracts, but that guidance was subsequently amended to allow that to happen at the discretion of PCTs. With the uncertainty of not knowing how many GDPs were continuing with an NHS contract it was felt that in some instances this might be allowed to continue until the end of the guaranteed income period when PCTs had the opportunity to re-commission appropriately.

Q298 Mr Bone: You said that the guidance had changed. Which guidance, and by whom was it changed?

Ms Delaitre: The Department of Health's guidance.

Q299 Mr Bone: So, first they said that it should be comprehensive and they then changed it to what?

Ms Delaitre: To say that child-only services could be accepted in certain individual circumstances.

Q300 Dr Naysmith: Ms Elley, to return to the question I want to ask you, it is quite clear from the submission that you have been very positive about commissioning and the commissioning capability of Sandwell, yet your local dental committee has described the primary care trust's approach as "dictatorial" and accused you of ignoring local practitioners. How do you respond to that description?

Ms Elley: I have read that submission which says that we dictate and follow the policy of the Department of Health if there is a dispute. Yes, we do stick to national policy; if there is such a policy we follow it. It is not always particularly liked by some of the local dentists or local committee members, but if there is a national policy we have tended to stick with it. Having said that, we try to have a collaborative approach. We hope they feel that on an individual basis we collaborate. They do not necessarily like some of the outcomes. The new contract really introduces accountability into the general dental service in a way that was not there before; it allows the PCT to commission locally to meet need and that might not always suit what general dental practitioners locally would want to do. Previously, they could decide where they wanted to set up and what hours they wanted to work; if they wanted to increase their income they could work longer hours. That is now not allowed. I totally understand that from their point of view that is a problem, but from a patient and public health perspective the ability to direct service where there is a need is a good thing.

Q301 Dr Naysmith: Do you think the situation is improving in terms of relationships between you and the local dental committee?

Ms Elley: I do not think the relationship ever broke down. We have tried to be collaborative but that does not mean they always get the answer they want. To demonstrate that, originally we said we would not carry forward from the first and second years any activity over the 4% as was allowed under the contract, but, having listened to them, it was very

difficult for them in the first year to model their activity and make sure they came in on the nose or within the 4% tolerance. Therefore, we listened and changed our behaviour. Where dentists had a robust plan to deliver that activity in the second year the PCT changed its policy position and said that, yes, that could be carried forward as long as there was a robust plan. Therefore, we have changed our behaviour. I hope they think that sometimes we try to listen.

Q302 Dr Naysmith: What kind of inappropriate provision were you attacking?

Ms Elley: It is more about new provision in areas of under-provision. Generally, we do not have a problem with access and, to go back to the contract of the 1990s when a lot of private dentistry developed, that has not happened to a great extent in Sandwell. We have areas of historic under-provision, however. Within the six towns in Sandwell some are better provided than others. The new contract will allow us to put more provision into areas that are under-provided. We have done that to a minor extent in, say, the Oldbury health centre where in a LIFT building we have established new dental services, including general dental services, salaried service and also a teaching facility for the dental schools to teach dental therapists. We have been able to make small changes like that. The 9% growth in the next financial year will allow us to commission new services through competitive tendering in areas of under-provision in Oldbury and Tipton. These are the areas identified in our oral health strategy.

Q303 Dr Naysmith: I am glad you mention Oldbury because I understand you have spent over £1 million on the new dental suite. You predicted that at least 4,000 patients would use that facility and so far you have got only 750. Does that mean good value for money?

Ms Elley: The £1 million was PCT money prior to the new contract, so that was the PCT investing money via a new LIFT premises to put it there, but not new dental contract money at all. We have combined a dental contract where a lady was on maternity leave in a test period and so we have invested to make up for what she would have earned in the test period that she would not otherwise have earned. That lady has chosen to work in the new health centre. The dental suite has been open only during this year and obviously it takes some time to get the patients in there. There has been recent media coverage. The dentist has been on local radio and in the local media saying that it is not full and there is NHS capacity here. There is an issue in that the public thinks there is a problem everywhere and we try to address that.

Q304 Dr Naysmith: Therefore, you expect to move towards 4,000?

Ms Elley: You cannot just switch on the number of patients in the day, albeit if there is really limited access you will do so, but we have wider access than

a lot of places. We are trying to attract people who do not normally go to the dentist. It will take time but we are working on it.

Q305 Mr Bone: I grew up under both Conservative and Labour governments. We always had access to an NHS dentist. You never thought about it; the service was just there. My question is really about access. My first question is for every witness and when I come to my second question I will not ask for a response from the representative for the People's Republic of Sandwell and the dictatorship that exists there! Has patient access to NHS dentistry improved in your PCTs since April 2006? Can you also give an indication about the base level? Has it really fallen or gone up?

Ms Elley: It is about the same; it is around 72% or 73% in the past three years, so that is relatively high. It has not gone up yet. From the beginning of April we shall commission additional activity and it will go up. We believe that with the 9% extra funding it will go up even more.

Q306 Mr Bone: When the dictatorship says it will go up?

Ms Elley: I do not think Sandwell is a dictatorship.
Ms Delaitre: The position was similar to the rest of the London PCTs. We did not really have an access problem before, but, given the way access is now measured based on the number of patients seen in the previous 24 months, as of March 2006 there were 130,145 and at June 2007 it was 133,003 patients, so the number has gone up by 3,000 in the 24-month period.

Q307 Mr Bone: You are starting from a level of 70% or 50% NHS patients?

Ms Delaitre: 52.5%.

Q308 Mr Bone: If it is a 24-month period we have something of a problem because it overlaps?

Ms Delaitre: Absolutely.

Q309 Mr Bone: Do you have a feeling for what has happened since April 2006?

Ms Delaitre: It is difficult to say because it is too early to tell given that it is measured over 24 months. Maybe this time next year we will have a better feel for it. We plan for a 3% increase in access from April 2008 onwards given we have quite a large growth in funding.

Q310 Mr Bone: Ms Elley, you had a high rate to start with; it was 70%. In my area there was an enormous exit from NHS into private treatment, making access to an NHS dentist very difficult but also removing whole swathes of people because they took out private insurance, as I had to do. Did you not have any of that?

Ms Elley: We had one practice where the majority was private and for 1,000 patients in that practice the practitioner decided that he would not take up an NHS contract. For those 1,000 patients we needed to ensure there was provision elsewhere locally, so it was only one practice. Dentistry is a market and

private dentistry will thrive in a market situation that allows it to thrive. Sandwell is a relatively deprived borough and consequently that is one of the reasons we have widespread NHS access because there is not a market for private dentistry.

Mr Harris: The background in Devon is probably very different because we have had very long-standing historical issues of access going back to the early 1990s when a number of dentists decided to privatise their practice. Using the old registration measure, the percentage of patients who accessed the service hovered around 45. In some areas of what is now Devon PCT it was as low as 27%. Therefore, we started from a very low base. In March 2006 about 49% of patients accessed a service. We are now approaching 51%, so we are seeing an increase as a result of the introduction of the new contract. Using the 24-month measure, we have seen over 9,000 additional patients treated in the first 12 months of the new contract. Again, that is probably only the tip of what we expect to see because we have commissioned a number of new services during 2007 and it will take a little time for those figures to come through and be reflected in the new two-year measure.

Q311 Mr Bone: You are commissioning new NHS dental services?

Mr Harris: Yes, particularly in areas where we have had long-standing difficulties. In a rural county such as Devon it takes only an individual practice in an isolated location to decide to move out of the NHS to create a problem. I have been involved in NHS dentistry for nearly 20 years. One of the great frustrations we had in the early 1990s was that if a dentist decided to take his practice out of the system the local NHS was left with a problem of access for its population but no means to deal with it because the funds sat in a central national pot of money and it could not do anything about it. The contract now gives us the opportunity to re-provide those services and that is what we are doing actively.

Q312 Mr Bone: Mr Harris, according to a survey in November 2007 there were still 7,700 patients waiting for NHS treatment.

Mr Harris: That is right. We have been operating a waiting list arrangement for patients simply because it is easier to allocate patients to a practice rather than that the first practice opens its doors and there is a flood of people and the practice cannot manage. We have 7,000 patients waiting.

Q313 Mr Bone: To stop you there, you say that these 7,700 patients are waiting?

Mr Harris: They have contacted the PCT and are awaiting NHS service.

Q314 Mr Bone: In my patch an NHS surgery was opened and people were queuing round the block and within 24 hours everything was full again. You go to the waiting list first?

Mr Harris: We encourage patients to come direct to the PCT and then work directly with the practice and allocate patients on a first come first served basis to

the practice so the practice can manage the appointments booked for the patients. That has worked very successfully for us in Devon. I think the figure was 7,000 in October. In the past five and a half months we have allocated over 9,000 patients through this method, so we are seeing patients moving off our waiting list. People have been sitting there for 12 months in some cases and the wait is now coming down quite significantly—it is about six months—and that will continue as dental service capacity comes on line.

Q315 Mr Bone: What happens to these patients if they want urgent treatment?

Mr Harris: For those patients we have separate arrangements for urgent care. We have dental access centres in a number of locations across the county, so anyone who has an urgent problem can always be seen certainly within 24 hours if not the same day he or she contacts our services. They can go to dental access centres. We also have an out-of-hours service similar to the service my colleagues talked about, so if they have a requirement outside normal working hours or at weekends they can access a dentist.

Q316 Mr Bone: Therefore, you did not do what my PCT did, namely say that patients should go out of the county to find treatment?

Mr Harris: No.

Q317 Mr Bone: Ms Delaitre, your submission shows that patient access in Hillingdon has hardly increased, and you also start from a very low base. What has gone wrong?

Ms Delaitre: I do not think it has. The base is similar to the national average and to the London average.

Q318 Mr Bone: The national average is that only about 50% of people have access to NHS dentists?

Ms Delaitre: No—that are accessing them. It does not say “have access” but “accessing”. We presume that the others opt to take private treatment. The capacity that we commission is slightly more than the demand, certainly from the 2006–07 contracting round.

Q319 Mr Bone: Nationally, it is half and half; half NHS and half private. Therefore, we have half-privatised dentistry within the National Health Service, but in Sandwell there is a very high NHS provision—73%—so presumably for some areas access to NHS service must be as low as 25%?

Ms Delaitre: Possibly. I cannot comment. As my colleague Ms Elley said, it is an open market and patients can choose to access a dentist anywhere.

Q320 Mr Bone: They can choose in your area but not in mine; they have to go private because there is no NHS.

Ms Delaitre: I cannot comment.

Q321 Charlotte Atkins: Ms Elley, your submission states that the number of patients seen in Sandwell increased by 10,000 from March 2006 to March

2007, but your local dental committee claims that the new system has introduced both rationing and waiting lists. What is your response to that?

Ms Elley: To my knowledge, we have no waiting list in Sandwell at the moment.

Q322 Charlotte Atkins: What about rationing?

Ms Elley: Most of the dentists were under-providing in the first year of the contract and they have elected and got plans to provide additional activity. There are one or two practices that are full and we can understand why they do not accept new patients, but there are no waiting lists in the others.

Q323 Charlotte Atkins: Did you claw back the money that was not used?

Ms Elley: Where there was no robust plan, yes. In most cases if they were not going to put up a plan they voluntarily gave back the money. I would not say “claw back” which sounds as though they did not want to return it.

Q324 Charlotte Atkins: But if there was a robust plan you did not claw back the money?

Ms Elley: No. Originally, the policy stance was that there would be claw back over 4% but we changed that to recognise they had difficulty in the first year to model their activity because it was as new for them as for us. Therefore, if they had a robust plan we allowed them to carry forward that activity to the next year and provide it this year. That was a one-off agreement, not something we would do recurrently. Because it was difficult for them we changed it and said that if they had a plan they could do it. Some people chose not to do it.

Q325 Charlotte Atkins: Obviously, you represent a relatively deprived area.

Ms Elley: Yes.

Q326 Charlotte Atkins: Sadly, there are people who choose not to access any dentist even if there is NHS capacity. Have you considered what some PCTs do, namely that when you commission a new dentist or practice you provide it with an incentive particularly to access the more deprived communities by suggesting, for example, that 70% of patients should come from deprived areas as opposed to 30% from the more affluent ones?

Ms Elley: I suppose that with Sandwell it is difficult to say “the more affluent”. Relatively, there are some who are more affluent than others but certainly in some cases there is a wider variation between affluent and less affluent areas. We are certainly putting services into areas of historic under-provision knowing that local services are likely to attract the less affluent groups that are less mobile and so less able to travel into other areas. Therefore, it is done by the geographic nature of the area rather than incentivising particular groups.

Q327 Charlotte Atkins: Given there is a perverse incentive for dentists to focus on their more healthy clients, do you recognise the need to commission, persuade or encourage dentists to access those

people who do not choose regularly to attend dental surgeries and, probably more important, for their children to attend?

Ms Elley: We do exactly that. Our oral health promotion unit is very much about making sure there is education and that systems are available so that those who are more deprived within the population and access these services less get to the dentist. It is done through promotion rather than a system to incentivise dentists. We have a scheme for nought to four year-old children where there is a very low uptake of care. We have a baby pack that goes out via health visitors when babies are very young. It is similar to the one in North Staffordshire which I set up when I was there. Mothers are encouraged to take their babies at an early age to get preventive care before there is disease. Similarly, for disadvantaged people with learning difficulties and ethnic minorities in particular there is a lot going on in particular communities via community development to make sure they access the service. It is not done necessarily from the service end but the public “people” end.

Q328 Charlotte Atkins: What happens when the children reach school age? What is done in school? We have not really covered what is done to encourage youngsters who are older to access dental provision?

Ms Elley: Similarly, oral health promotion and interventions are targeted at schools where there is a higher number of decayed, missing and filled teeth. They work with teachers and parents—certainly parents within special schools—and other agencies, for example healthy eating policies within schools, to provide health messages and increase the uptake of dental care. In schools it is very much a targeted approach.

Q329 Dr Taylor: I do not want you to pull your punches in any of your replies because we shall be coming to the dreaded subject of units of dental activity. You can be reassured that we have had only one response to the effect that UDAs are valid and that comes from the Department of Health. Everybody else is fairly critical, so please be as critical as you want. Are they a fair way of measuring the work of dentists?

Ms Elley: I will unpick what units of dental activity are. They are a way of paying according to the complexity of the particular course of treatment. I do not say that the UDA is the answer, but to pay dentists for more complicated courses of treatment is to me a good way of doing it. Whether the UDA is the right way to do it I do not know.

Q330 Dr Taylor: But they do not take account of the number of bits of complicated treatment that a dentist provides?

Ms Elley: The UDA is a measure. We can use the information we now get from the dental practice division not just about the UDA but the number of people who are treated. We also get exception reports about dentists. For example, if there are statistical outliers on particular indicators they are

flagged up by the dental practice division. That does not mean there is a problem with that particular dentist. It may mean that the dentist is in a particularly deprived area and therefore he does a lot more band 3 or band 2 than band 1 treatments, but it gives information which allows us to ask the question. We are then allowed to get the data split down by patient. For instance, if a dentist is doing a lot of band 3 treatments within a short period we are allowed to look at the patient data and can see what that is and we can get behind the data to get more than is revealed by the top line indicators. UDA is a start but it is not the only thing we look at. Certainly, for new activity we are not commissioning just on UDAs; we use UDAs because that is the contract currency, but we also believe that the number of people treated is important.

Q331 Dr Taylor: Did not the previous system give you more data than the current one?

Ms Elley: It certainly gave more data about lots of different items of treatment, and I very much welcome the change in April when we understand the forms will change and we shall get more detailed data.

Q332 Dr Taylor: That will improve things and take you some way back to the old system?

Ms Elley: Yes, but under the old system we did not get a lot of the data at PCT level. A lot of it was available on an individual basis to the dental practice division. Some of it came back to the PCT but under the new system we get a lot more information, the exception reports being an example of that. We know our local dentists and know where the areas of worse oral health are. To have that data and know about individual areas is beneficial.

Q333 Dr Taylor: That is an advantage of being a commissioner?

Ms Elley: Yes. Under the new system we get data; under the old system we did not. I think that the changes proposed will help us.

Ms Delaitre: It is good to have a quantitative measure but it is the qualitative measure that is missing. It is probably a good start. Certainly, it is something that is missing from our other primary care contracts when looking at value for money. Things like quality and health gain are matters that we should also be considering at the same time. The proposal to introduce a balanced score card might help to address those issues in terms of the overall care that a patient receives when he or she goes to the dentist.

Q334 Dr Taylor: I am sorry but to me “balanced score card” is some of the worst jargon.

Ms Delaitre: It is probably NHS jargon. A commissioner will use a number of indicators to look at the overall service provided by a contractor. There could be a variety of indicators.

Q335 Dr Taylor: Are there any views from Devon?

Mr Harris: Across Devon and Cornwall we had quite an extensive amount of PDS pilots going on prior to the new contract being introduced. One of the matters we learnt probably very early on was the lack of a measure, if you like, to determine what we would be getting for our funding of dental practices. UDA is a measure and certainly there are flaws within it. One of my particular concerns had been to do with recognising and identifying differing workloads that practitioners might or might not have depending on the group of patients they were looking after. In particular, you have alluded to a practitioner working in a significantly deprived area where the amount of work required to generate his three units of activity may be significantly greater than for a colleague down the road. At the moment we do not have the information behind that workload to be able to take account of that very easily when sitting down with a practitioner and looking at what he is providing. As my colleague Ms Elley says, with the enhanced data set that has been promised from 1 April we hope to have a much better indication of what practitioners are doing.

Q336 Dr Taylor: So, you are confident that it will be enhanced and you will have that sort of information?

Mr Harris: It will certainly provide us with a lot more information. We have gone from a system which gave us far too much information to a system that gives us next to nothing. As commissioners it is very difficult to understand exactly what practitioners are providing.

Q337 Dr Taylor: How do you think the value of the UDAs was calculated? Is there any basis for it? It seems to us to be a figure almost plucked out of the air. They cannot even multiply by three, can they?

Mr Harris: In our own patch we have had significant variants in values based on the historical patterns of treatment and income of practices. It ranges from as low as £14 at one end to as high as £30-plus at the other.

Q338 Dr Taylor: You are referring to different rates for a UDA?

Mr Harris: Yes.

Q339 Dr Taylor: Therefore, you are allowed flexibility?

Mr Harris: If we are talking about conversion from the old contract to the new one, each practitioner was guaranteed his historic funding for a level of work calculated on a UDA value.

Q340 Dr Taylor: For a particular period?

Mr Harris: It was based upon that period. Therefore, the UDA value would depend very much on what they did in that period and that is why you have a huge variation from as low as £14 to as high as over £30. In my opinion that would be the same in many areas.

Q341 Dr Taylor: You have lost me. I thought they were assessed only on the number of UDAs they did, not the actual value.

Mr Harris: There is inherent value because in the baseline period a practitioner would have earnings from the NHS and for that he would have done a certain amount of work. That work was converted into units of dental activity for that level of funding and that derived a unit of dental activity value for that practitioner.

Q342 Dr Taylor: The fact we are told that for band 1 the unit of dental activity is £15.90 is absolute rubbish?

Mr Harris: No; that is what the patient pays.

Dr Taylor: Maybe I am getting there.

Q343 Mr Bone: Therefore, dentists within the same PCT doing the same unit of dental work are paid vastly different sums of money?

Mr Harris: Yes, there will be variable rates.

Mr Bone: That is extraordinary.

Q344 Mr Scott: Evidence we have received suggests that the contract has led to far fewer complex (band 3) treatments. Should this be welcomed? Should we be concerned about the quality of care being given to patients?

Ms Delaitre: When we started to monitor what had happened since the introduction of the new contract we found a notable reduction in band 3 treatments. We have had claims from our patients that they have difficulty accessing endodontic work which is root canal treatment. I think that is an anomaly of the system and something that should perhaps be reviewed given that a dentist will save time by extracting a tooth rather than treating it. I think that is a concern. They are able to do that within their contracts, although given that in the reference period they were doing a certain amount of complex work without the data and detailed knowledge until April 2008 it is difficult to monitor it.

Mr Harris: There has been a reduction. In PDS pilots the experience was that there was a reduction in the amount of complex work being undertaken, and we have also seen that in the new contract. It is very difficult to draw a conclusion as to whether there were inherent incentives in the old system which generated higher than necessary or more complex work than under the old system or whether the incentives have tipped completely now. I agree with Ms Delaitre to a certain extent in that a dentist may feel that the reward is not there to do as many band 3 treatments as he did in the past.

Ms Elley: I very much agree with what has been said, but band 3 treatment does not always go down in the new contract. We have had contracts where band 3 treatments have gone up and we have had to follow it up to find aberrant patterns of behaviour where individuals are prescribed an upper denture in one course of treatment and a lower denture in another course of treatment. Obviously, that is not what is normally done. Again, the data have indicated that we should look at what the issues are, which is what we do.

Q345 Mr Scott: Are you aware of any reduction in band 3 being undertaken in the non-NHS sector?

Mr Harris: We would not be aware of that.

Q346 Mr Scott: What action do you take if a practice fails to meet its UDA targets? Do you automatically claw back the money previously given to dentists who fail to meet their UDA targets?

Ms Elley: I think I have covered that. If they had a plan we allowed them to carry forward in the first year, recognising that that was a difficult time for them.

Mr Harris: From our perspective, we have certainly met all our practitioners, particularly when there were early signs that they would be potentially failing in their contract, to see if there were any specific reasons why that had occurred. We followed an approach similar to that described by Ms Elley. We have not taken the hard and fast line that if they deliver less than the 4% shortfall we would not carry it over. If they have a good plan for making up that activity in the second year we have agreed that they should take it forward and make it up.

Q347 Mr Scott: Why does the work of vocational dental practitioners not count towards the total UDAs set for a particular practice, and do you think that is fair?

Ms Elley: There was a fact sheet produced in December 2005 on the way money would be allocated and information about the way vocational training would work under the new system. Vocational trainees are recruited into the practices by the deanery; they are not designated, if you like, by the primary care trust. There was a need for advice about how the money would follow the vocational trainee, if one wants to put it that way. The 2005/06 fact sheet said that dentists with vocational trainees would get additional money for their trainees' salaries, their training grants and the expenses of having them in that practice. It also said there would be a locally agreed number of UDAs additional to their contract for that money. It did not specify a number of UDAs; it said it was down to PCT negotiation. All our local dentists wanted the UDAs to be included within their existing contract value but obviously they would be given additional money for that value. Training is very dear to my heart. Training is supposed to be training and in the new era it is not supposed to be, as we have had with junior hospital doctors, just the provision of a new pair of hands; they are people in training. I am very much of the view that we should have a notional, not actual, number of UDAs so if they under-perform because they are slow or they are trainees it does not matter. If they over-perform they have done more but it is not then taken off their boss's contract and so there is no incentive for the dentist to drive the junior hard to make up his contract value. The 1,875 UDAs notional figure came out some time after the introduction of the new contract. It was originally left to PCTs but they were unhappy because they did not want to set different levels. Training is training and is national and the 1,875 UDAs were included in revised fact sheet 6 called fact sheet 6A, but it was

some time after the new contract. Our local dentists did not like the fact that they could not balance them against their contract value.

Q348 Mr Scott: The UDA value contains an element for activity and an element for expenses and premises. Do you think there is a legal basis for claiming back the full UDA value?

Ms Delaitre: I am sorry but I do not understand the question. You are referring to claiming back the full UDA value?

Q349 Mr Scott: Yes. Do you think the full UDA value should be clawed back?

Ms Delaitre: If they do not meet their contract 100%?

Q350 Mr Scott: Yes.

Ms Delaitre: Yes, and we do claw all of it back below 96%.

Mr Harris: I agree. That is the approach we have taken.

Ms Elley: There is an issue about full cost and marginal cost and it works not only with under-performance but also over-performance and the commissioning of additional activity. Certainly, in commissioning extra activity if the premises are there you would not expect to pay for extra building unless there was a need for it, so our finance people do look at marginal rates.

Q351 Mr Bone: If you do not do your UDAs and claw back the full amount you are clawing back the fixed costs which the dentist has had to incur. Is that not grossly unfair?

Ms Elley: I think there should be one rule for over and one for under. I am a dentist and I tend to leave the marginal cost to our finance experts with whom we work.

Mr Bone: But you all claim back the full UDA.

Q352 Chairman: What is the relationship between UDAs and prevention?

Mr Harris: I think there is very little relationship between UDAs and prevention. I can talk only anecdotally but talking to practitioners, particularly those in the PDS pilots, many felt that the pilot arrangement encouraged them to work with patients to promote oral health. They feel that under the new system there is less time to devote to promotion and intervention.

Ms Delaitre: I tend to agree with that; there is really no incentive currently.

Ms Elley: I would want to incentivise the new contracts to do the preventive aspects. Delivering oral health is an available package and I would want new contracts to include that and funding for it within a practice. You can use UDAs to do prevention. We have had a pilot project for mouth guards. Children fracture their teeth when playing sports because they do not wear mouth guards. Mouth guards were never available on the NHS. In Sandwell we have had a limited pilot project where individual dentists have been able to provide up to 25 mouth guards to children at the greatest risk of

fracturing their teeth given the nature of their teeth—whether or not they stick out—and also the sports they play. That was not available on the NHS but we have done it and remunerated it. Twelve UDAs are band 3 treatment for a limited number. I would not want to see that become widespread; otherwise, everybody in England would be walking round with mouth guards, but as a preventive measure for children in greatest need I believe that is a way to use the system.

Q353 Chairman: Where there is a population with a clear need because of its dental ill health is there any way you can use UDAs to do that, or would you need a different approach to bring onto the agenda the prevention of dental ill health?

Ms Elley: I would like to develop a quality and outcomes framework with remuneration like the general medical practice contracts. It is something that perhaps would be easier to do with the new practices we open or the additional activity we commission. I would want the new activity to include referrals to the smoking cessation services and remunerate for that kind of thing. At the moment we offer that to dentists and only one practice has taken it up. We have a local scheme but dentists have not taken it up. I would like to use that. There are ways to give money, whether for UDAs or another outcome, but as a developmental aspect it would be easier with new practices rather than existing ones.

Mr Harris: With our experience of PDS pilots we were able to support some practices to develop oral health educators to work with the local community linked into Sure Start schemes. They have worked with children and parent groups to include promotion. We have carried that forward under the contract. We have not put units of activity against it; we have made it a distinct element of the contract to be delivered in addition to their units of activity. There is a need for measures and you need different measures for that, but certainly the contract allows you to do those things.

Q354 Dr Stoate: As a practising GP I can confirm that QAF is quite a good way. It is not just about driving the amount of work; you can begin to look at the type of work people do, so QAF is a good tool and can be negotiated on an annual basis and tailored to meet specific needs, so I agree with Ms Elley that it offers a better solution and is fairer and more transparent. I want to talk about money. As I understand it, currently about 25% of income comes from patient charges and the rest from the department. Is that broadly correct? The department has acknowledged that there will be a shortfall this year of £159 million on patient charges and that must be a fairly serious worry for you. I know that Sandwell has reported a £92,000 shortfall on patient income this year. How has that affected you?

Ms Elley: When I made the submission to the Committee our finance people forecast that we would be about £90,000 under-collected on patient charges based on an £18 million budget. I went to

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check yesterday because I was sure the question would be asked. At the moment we project being £100,000 over, so it changes from month to month as patient charges come in. There is a seasonal cycle for people going to the dentist. Ours is not 25%. We have an expected patient charge of £3.5 million on £18 million.

Q355 Dr Stoate: It is an average of 25% and it does not apply to all of you.

Ms Elley: It depends on what proportion of the population is exempt and more of our people are exempt.

Q356 Dr Stoate: How is it affecting the other two PCTs? Has it made a big difference to you? Is there a big patient shortfall?

Ms Delaitre: We do have a large patient shortfall. Our expected income from patient charge revenue is 28% so it is higher than the average, and certainly we had a shortfall in funding last year. That was raised with our Board right at the beginning of the year because we expected that to be the case having inherited the historic funding rather than funding according to need. We were fortunate in that the PCT expected that to happen and cushioned the effect. In future years, if the situation continues that money will have to be taken from the dental allocation.

Q357 Dr Stoate: Has Devon had a problem?

Mr Harris: We have witnessed a significant shortfall in patient charges of over £1 million in the first year. We had a £33 million budget including patient charges and the shortfall we experienced was extremely high. I have looked at my colleagues across the South West and the percentage of shortfall has varied significantly, but the average is about 5%.

Q358 Dr Stoate: It is quite significant. The simple question is: what effect does that have on your ability to provide dental services?

Mr Harris: It means we have less funding to commit to dentistry.

Q359 Dr Stoate: Are you moving money from elsewhere in your budget, or do you just have to cut back on what you do in dentistry?

Ms Delaitre: Given that the dental budget is now ring fenced it will come from the ring fenced dental budget.

Q360 Dr Stoate: You are saying that that shortfall will impact on dental services?

Ms Delaitre: It will from 2007–08 onwards but last year it did not in that we were able to cushion the shortfall.

Q361 Dr Stoate: That is quite worrying. When the ring-fenced money effectively runs out after April 2009 what will each of you do? Will you guarantee the same level of dental services or be a bit less upfront about it?

Ms Elley: Currently, our PCT has no plans to strip the dental budget. We get additional money in 2008/09 and I shall work with the team to commit that money recurrently. Obviously, it is a possibility and one can never say never. Last time the Committee was asking whether or not people thought it a good idea to continue to ring-fence the money. As a dentist within the PCT I would have to say yes.

Q362 Dr Stoate: You would like it to be ring-fenced but it will not be?

Ms Elley: As a dentist I would. Here I speak personally rather than for the PCT. There is no intention in April 2009 to start stripping out the money.

Q363 Dr Stoate: Does that apply also to the other witnesses?

Ms Delaitre: Absolutely. I am in the process of putting trajectories into the operating plan which is part of the annual cycle of planning. We are planning year on year for the next three years' growth in activity, which is what we have been asked to do.

Q364 Dr Stoate: Therefore, you are looking to improve things in the next three years?

Ms Delaitre: Yes.

Q365 Dr Stoate: What about Devon?

Mr Harris: Absolutely. We are starting from a less well off position and it is a very high profile matter of concern for both the public and our local Members of Parliament. We would certainly look to continue our commitment to dentistry.

Chairman: I thank all three witnesses very much for coming along and helping us in this session.

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

Q366 Chairman: Welcome to the second evidence session of our inquiry into dental services. For the sake of the record, I ask you to introduce yourselves and the positions you hold.

Mr Smith: My name is David Smith and I am on the council of the Dental Laboratories Association. I am a dental technician and I have a laboratory in Exeter. I should like to focus today on what has happened to band 3 treatments in particular because that matter has the greatest effect on our members.

Ms Sanderson: I am Susie Sanderson, chair of the British Dental Association and also a practising GDP in Sheffield. We have two practices split almost equally between NHS and private provision, so I have a significant NHS contract. Thank you very much for inviting us to give evidence today. We welcome this opportunity.

Mr Hathorn: I am Iain Hathorn, chairman of the British Orthodontic Society. I am a former consultant orthodontist from Bristol working in the regional cleft lip and palate service.

Q367 Chairman: Ms Sanderson, why did the BDA break off negotiations over the new agreements with the department? Did the BDA let down dentists by doing that?

Ms Sanderson: Taking the last point first, absolutely not—quite the contrary. At all times we have a representative structure which is very robust. We consult our members not only through that representative structure but also through surveys and consultations with members. The negotiations towards the new contract took quite a long time. Following the previous Health Committee's hearing, we started in 2001 with the *Options for Change* project. 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 make sure that the quality of care was robust and moved forward in that sort of direction. We thought they were very fine aims and worked with the Department of Health. The negotiations moved through the period when the Health and Social Care Act was launched upon us, rather in indecent haste as we thought at the time. That rather changed the complexity and concept of the discussions we were holding with the department at that time. We were very constructive and we thought we made sensible suggestions for a system that would work towards the aims of *Options for Change*. The field sites were beginning to work with the personal dental services. We suddenly found ourselves losing agreements that we understood had already been made about the new contract. We were told that it would be our job to sell the new contract to the profession, but at the same time our suggestions about a sensible way forward were not listened to either. It was more a discussion group than a negotiating team because negotiations had really stopped by that stage. We were making suggestions and listening on the other side was not

very good, unfortunately. That team sought a mandate from its elected body which agreed it was time to make a public statement and said that things were not going in a way that was best first for patients but also dentists in the way they would deliver care to patients and at that point we walked away. We continued to have discussions with the Department of Health about several issues, for example decontamination and vocational training, so throughout that time we have maintained contact but the department removed any sort of conversation about the new contract and it was finally imposed. Recently, we have started to have perhaps better and more constructive relationships with the Department of Health and we look forward to making progress in that respect. We believe that local commissioning gives us huge opportunities as long as they are sensible and the profession and those who are to provide those services have some sort of input into it and changes are not dictated. At the same time, we have continued to support our members through the transition into the new contract. We know that one third of our members have contacted and on a one-to-one basis had advice from the British Dental Association. We have a regular journal and updates on contract issues. We hold tendering seminars which are always over-subscribed, so we are helping dentists to move towards local commissioning. We have worked with the primary care contracting team and provided information for local dental committees and advice sheets which, strangely enough, have also been welcomed by primary care trusts. Therefore, we have continued to engage. We found the transition into the new contract very disappointing.

Q368 Chairman: You will have seen the evidence we took quite recently from CHALLENGE. Whilst it is a political pressure group, it said it was unhappy with the position of the BDA at that particular time. It argued that it was more representative of the profession in many ways. Do you believe that is the case?

Ms Sanderson: The leading light of CHALLENGE is my predecessor who was chair at the time of the contract imposition, so he knows a lot about the process at that time. I think CHALLENGE emerged out of frustration. The profession felt impotent and it was unable to withstand what has been described as the bullying tactics of the Department of Health in imposing the new contract. I think CHALLENGE has proved to be a useful lobbying group alongside the very vigorous work of the BDA in raising awareness.

Q369 Charlotte Atkins: Ms Sanderson, do you believe that PCTs are up to the job of commissioning local dental services?

Ms Sanderson: It is very patchy. Taking the example of those having an interest in commissioning dental services over the years, today we have already heard of PCTs with joint working groups involving providers and sometimes patients as well. How

welcome is that! To involve patients in choice about how dentistry can be commissioned is extremely valuable. Where it has been in place for a number of years the PCTs have had a head start. Where that is not so and the reconfigurations has disturbed the situation as we move into the new contract it has been very difficult. You have probably heard from three of the better ones today. There are other good ones and also those who are only just cottoning on to the issues of dentistry. We have not even started on proper local commissioning yet and we are still dealing with the transition through the historical activity into changing what should be a service properly aimed at local needs.

Q370 Charlotte Atkins: Do you think dentistry is a sufficient priority for PCTs? It is only a relatively small part of their overall budget. A lot of people decide not to access dentists and some PCTs take the view that if that is their choice it is not a big issue for them.

Ms Sanderson: I have evidence from my own PCT where it is a priority and it works very hard at making it such. It is a high priority within the operating framework as well, so we are encouraged by that. I think you are right. It is a very small part of the budget. Its priority has been raised by all sorts of means to push dentistry to the top of the public awareness agenda, and we have helped with that in the hope that it would become a priority. I think it is patchy.

Q371 Charlotte Atkins: From next year when PCTs take on the full commissioning role do you think they will be able to use that in a genuinely helpful way to assess local needs and then commission services which meet them rather than simply fill in gaps? I am referring to a deprived community, for instance, and paying more for UDAs to attract dentists to be interested in catering for a needy population.

Ms Sanderson: You explored earlier the unit of dental activity and already today you have unpicked one of the difficulties. It is inextricably linked to patient charge revenue and is a constantly changing unit. It is not a unit; it is different for everybody. There are four dentists in my practice. We have two practices and in each we have a different UDA value. That is crazy. We work alongside each other on the same cohort of community and yet the value of our units of dental activity varies by £2 in one case. If we continue to use only the unit of dental activity as the sole measure we have no chance whatever to make sure that dental provision is improved particularly in the disadvantaged cohorts of the population. I do not believe it is disrespectful to say that those parts of the community that do not normally access dental care tend to seek episodic care; quite often it is crisis management. Whereas in my view it is of paramount importance in my practice that we deliver prevention and ongoing care, it is quite difficult to manage episodic care in a business. It is almost impossible to plan to meet a target when patients do not turn up, or come on the wrong day, or arrive on a particular day and demand care because that is when the crisis

has arisen. There must be some sort of imaginative contracting if we are to make real inroads into the dental inequalities in this country.

Q372 Charlotte Atkins: Would you rather see some sort of long-term registration of patients than the situation now where there is none under the contract?

Ms Sanderson: If you are aligning registration to continuing care, I would support anything which encourages patients to have a relationship with their dentist and the other way round. When you are sitting in your chair in the practice it is valuable to talk to patients. 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. That sort of interpersonal care and attention is crucial to make sure that the oral health of the population continues to improve. If registration helps that maybe that is a means of doing it, but the concept of continuing care is the important one.

Q373 Dr Naysmith: I have a series of questions about the supposed effects of the new contract on the dental profession. We have already talked a good deal about UDAs which you described in your evidence as a flawed measure of output, and clearly there has been a lot of evidence to that effect this morning. But you cannot be against the principle of measuring the activity of dentists, surely.

Ms Sanderson: No.

Q374 Dr Naysmith: In that case, how would you do it?

Ms Sanderson: There are various ways to measure and it is not just activity. The buzzword associated with this contract is "access". One of the questions which you see in our evidence is: what is 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? What is it? There is no definition of access and measuring that on an ongoing basis is flawed.

Q375 Dr Naysmith: I am not really asking about access but how you pay dentists for what they do. What do you believe would be a fair measure to do that?

Ms Sanderson: Access is only one of those measures. There must be a level of monitoring. One of the beauties of the old contract, although I do not advocate that we go back to it, was that monitoring was very robust and we knew exactly what everybody was doing. You got paid for items. It must be much more imaginative so you pay for quality, prevention activity and healthcare outcomes. You pay for the number of patients that are seen but what is delivered to them and the outcomes are much more valuable.

Q376 Dr Naysmith: You accept that the old contract had a bias towards treatment rather than prevention?

Ms Sanderson: It measured treatment.

Q377 Dr Naysmith: There was very little in it which helped with prevention?

Ms Sanderson: There was nothing in it which supported prevention. That was one of the aims of *Options for Change*. Unfortunately, it has not been realised.

Q378 Dr Naysmith: Before we leave the UDAs, what effect do you think claw back has had on dentists who fail to meet the targets?

Ms Sanderson: There are two aspects to claw back: the threat of claw back and the anxiety about and reality of claw back. We have very painful and distressing examples of dentists with whom we have worked at the BDA being faced with significant claw back to the point where they have closed their practices and said they cannot manage any more.

Q379 Dr Naysmith: You have evidence of practices that have closed because of claw back?

Ms Sanderson: Yes, we have. In my own practice two of the partners have said they have had enough. One is aged 55 and is a very conscientious, experienced and effective NHS practitioner. That practitioner has just had enough and cannot face the anxiety of meeting targets on a day-to-day basis and the worry that there will be claw back at the end of the year.

Q380 Dr Naysmith: What has he or she done?

Ms Sanderson: She is taking early retirement. That is a huge loss to our practice because there is a big cohort of patients who trust and seek her care. She is always available for any new patients who turn up. We will miss that enormously. It is strange that 47% of dentists did not achieve 96% of their contracts in the first year. One could say that that is just the system bedding in, but with the threat of claw back and knowledge that that is a possibility it seems crazy that 47% of people who own their businesses and who are under threat of loss of money at the end of the year would not manage to do it more easily. It is just a demonstration that the system cannot at the moment seek to punish by taking money back from a dentist who has tried his or her best during the year.

Q381 Dr Naysmith: The Chief Dental Officer has told us that the new contract was showing signs of improving patient access in a number of areas. Do you agree with him?

Ms Sanderson: The figures are contrary to that. The figures are difficult to understand because there are two different sets of data. We started off with the 15-month data previous to the contract and we now have 24-month sets of data which start life before the beginning of the contract. The change management of this process is strange.

Q382 Dr Naysmith: I know that you were in the room earlier when we heard from Devon that things were getting better. Given that there were six PCTs being melded into one, it is perhaps not surprising that it did not work from scratch right away.

Ms Sanderson: That is right. Overall, we know from the department's own figures that there has been a drop of some quarter of a million in access, whatever "access" means.

Q383 Dr Naysmith: Do you have any evidence that experienced dentists are being lost to the National Health Service—you have just told us about one—to be replaced particularly by inexperienced dentists and dentists from overseas? John Renshaw said he was convinced that it was happening. Do you have evidence of that?

Ms Sanderson: I have some figures which happen to be on top of the pile of papers in front of me. We know that there was a peak in 2005 of 1,240 new registrations here from EU countries, and in 2007 the numbers are about the same. There is a little peak and trough. Therefore, there are more than 1,000 dentists coming in from EU countries and others from elsewhere. We are seen as an attractive place to come and work.

Q384 Dr Naysmith: Some of these could be experienced dentists, could they not?

Ms Sanderson: I absolutely accept that, but they are not experienced in UK dentistry. One of the fascinating things about UK dentistry is that it is extremely effective. In particular, under the old contract it could be proved that a huge amount of work was carried out effectively. It was also very cost-effective. 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.

Q385 Chairman: I accept what you say about the culture of the National Health Service not just in dentistry but in many other areas from the point of view of those who come from abroad. Some of these people have worked in practices where it has been very difficult to get dentists. In my own constituency which is very close to yours dentists have come in and worked within practices and been salaried by the PCT for people to access NHS dentists. It is not a situation where necessarily people have come and gained employment on their own, as it were, although there are some examples of that—and, as I recall, a few years ago a not very good example.

Ms Sanderson: Indeed. I think that as the bulge of new graduates comes out of our dental schools it will be important that they can come into the NHS. They have indicated in various surveys that that is what they want to do. I think it is very important that they are able to do that.

Q386 Dr Taylor: I should like to clarify something. I am still pretty confused about UDAs. I realise that patient charges account for only about 25% of remuneration, but you did refer to different values of UDA. Band 1 is £15.90; band 2 is £43.60; and band 3 is £194 up to a maximum of £384. Is that what you mean by the different values?

Ms Sanderson: No.

Chairman: They are the patient charges.

Dr Taylor: I know they are the patient charges.

Q387 Sandra Gidley: You are talking about what you are paid?

Ms Sanderson: Yes. The patient charges are linked to the number of UDAs delivered to the patient. For example, a check up is measured as one UDA and the patient pays at band 1 which is £15.90. If you move to the next section—I must be careful not to get confused—which includes any sort of fillings, root treatments and extractions, that is band 2 and that is £43.60. That rewards the dentist with three UDAs. It is not related to the patient charge in any sort of way; it will be related to the dentist's UDA value. Therefore, if you have a UDA value of, say, £20 the dentist will get £60 for carrying out that band 2 course of treatment and so it moves into the next one.

Q388 Dr Taylor: Is it up to each PCT to set the value of UDAs in that way?

Ms Sanderson: Historically, as we set off into the new contract the UDA values were determined by the previous activity of the dentist and previous contract value.

Q389 Dr Naysmith: It has been suggested in your evidence that vocational dental practitioners are unable to find employment. What is the reason for that?

Ms Sanderson: The real crisis is immediately post their vocational training year. During that year they are encouraged to build that sort of continuing care relationship with patients which is so important to the delivery of dental health and all the things that go alongside that, that is, the courage of the patients, faith in the dentist and their comfortableness in going to the dentist. Unfortunately, it is very difficult for those dentists to stay in their training practice because the PCTs are not able or willing to fund that additional place. Training practices are training practices and the Chief Dental Officer is quite certain that training practices should take on new trainees. However, if there is capacity in that practice in terms of space it seems sensible to keep the vocational dental practitioner on there if there is patient need and the relationships have been built, and that is not happening.

Q390 Dr Naysmith: Why is it not happening? Could PCTs pay for this?

Ms Sanderson: If they chose to.

Q391 Dr Naysmith: Could dental practitioners make provision for it?

Ms Sanderson: If there is space in their practices to do that.

Q392 Dr Naysmith: Therefore, it really needs local agreement as we heard earlier in the session?

Ms Sanderson: That is right. The needs and oral health assessments are rather vestigial in sophistication as yet. You heard three different versions of it earlier.

Q393 Dr Naysmith: If local dental committees wanted to work closely with their PCTs they could improve the situation dramatically?

Ms Sanderson: Yes, absolutely.

Q394 Mr Scott: Mr Hathorn, you state in your submission that “the new arrangements perpetuate the inequality of orthodontic provision around England and Wales.” Why do you say that?

Mr Hathorn: As at 1 April 2006 the new contract was obviously a capping process that froze the arrangements at that time. I think it was said earlier by the PCTs that the funding they received was based on the existing activity in that area. I refer to an area such as the North East about which we know it is an area of low dental and orthodontic provision. There is a compounding effect in such areas of low provision that UOAs which general dental practitioners might be getting for their orthodontic contract have been converted into UDAs because there is a high dental need, which makes the orthodontic provision worse. In that particular area—of high orthodontic need—with the new 18-week pathway coming into the hospital orthodontic departments, there is a whole head of steam, built up in hospital waiting lists which will effectively flood out into the market, into the primary care specialists for treatment. In the North East region there are so few specialists, there will be an acute lack of orthodontic care available. We are aware that there are certain reasonably well provided areas in the country. We have a report from Sheffield University, which gives us quite a good feel for where these areas are. The South East, where a lot of training takes place, is generally well provided as is Bristol, but in the North East and the Midlands there are obvious areas of need and they are stuck. The existing funding is there, but at a low level.

Q395 Mr Scott: Do you agree that there is one orthodontist for every 73,000 people in the country?

Mr Hathorn: Those figures derive from a European study covering 17 countries. We end up 15th in the list. We are different from some other European countries in that we use our general dental practitioners to provide some orthodontics, particularly in geographically awkward areas where there is not enough population in certain spots to sustain a specialist practice. I think particularly of Cornwall. It just does not lend itself to big specialist practices. Therefore, we have this mix, but, yes, as a whole the specialist provision of orthodontists in the UK is low.

Q396 Mr Scott: To what extent has the introduction of the index of orthodontic treatment need led to rationing of NHS orthodontic treatment? Is the NHS denying children with need orthodontic treatment?

Mr Hathorn: As you have seen in our report, we welcome the introduction of the index of treatment need in that the very low end of the spectrum, say, the very mild malocclusions, simply do not get treatment. In truth that was always the case. Even in the days of DPB the very mild malocclusions were

simply not supported, but the bar has been raised and it has gone up to 3.6 on the index of treatment need and that was done in large part because of the high numbers to treat against the low numbers of specialists. In effect, it is a sort of rationing process but it also tended to move out groups of malocclusion which were on the lower end of the scale of need. If we have a limited resource, we should be treating only the more complex treatments. One of the problems with any banded process is that there are people left in a grey area where there may be dispute as to whether they fall comfortably 3.6 and above or 3.6 and below. I think that it has distinct pluses and it has been used within the hospital service for about 20 years, because it was felt that it must focus on those patients with high need. I think it is just shifting the same emphasis into primary care.

Q397 Sandra Gidley: Mr Hathorn, you describe the way that PCTs introduced contracts with orthodontists as having had “disastrous consequences” particularly for newly-established practices.

Mr Hathorn: That refers to practices in transition or new ones working up. A very good example is the document from Ash Dhopatkar from the Birmingham area. In the period of the review process he had 500 patients under treatment but because he was not finishing many cases at that time and the contract was based on the number of completions, he was given a contract for 80 cases. That is just unreal. If you read that particular submission, he was advised and encouraged by the local consultant in dental public health that there was a need and he therefore set up in that period to try to get going. Also in his submission, is the fact that there was a three-year orthodontic waiting list in the local hospital, so there is a very significant need and yet the PCT for historic reasons gave only 80 cases.

Q398 Sandra Gidley: Have any of those problems been addressed?

Mr Hathorn: In some parts of the country, yes. I think that in earlier discussions there was a range of ways to deal with problems with different PCTs. Some PCTs have been very thoughtful and sensitive to the need to change; some, as in Ash’s case, have doggedly refused to make any change. When there is a clear need, where there are waiting lists locally and numbers of patients on hospital waiting lists with the 18-week pathway kicking in, this will bring out a large number of patients into the general mix. I suspect that as MPs you will be getting considerable numbers of complaints from parents and patients.

Q399 Sandra Gidley: Interestingly, I have two PCT areas. From one I get a good number of complaints and from the other absolutely none. Do you have any inkling as to why some are so much better than others? Is it because they have motivated staff who have perhaps taken an interest in commissioning for

some time? Is any of it financial pressures, or is it a mixture of the two? Is there a common theme emerging?

Mr Hathorn: Having listened to what was said two weeks ago—it has been echoed today—there is clear evidence that different PCTs take different approaches. There is no doubt at all that those who put dentistry clearly in their thinking, in terms of planning, have done well. My belief is that somewhere like Sandwell stands out as a perfect example, of a good consultant in dental public health, working well with the providers. The particular passion of the British Orthodontic Society is to encourage its members and providers to get together in networks—general dental practitioners, community orthodontists, specialist orthodontists and consultant orthodontists—to work with the PCTs to negotiate and plan the future for the area. One of the pluses of the local provisioning process is that not every part of the country is the same and therefore this brings a new dimension to planning. I believe it was said two weeks ago and echoed today, that young members of staff on the management side keep changing. We heard of six PCTs going down to one. A whole bunch of people once familiar with the dental input is lost to the system. Education and re-education goes on constantly and that is disruptive and not very helpful.

Q400 Sandra Gidley: One of my local orthodontists wrote to me and said that given her waiting list and the fact that she had to provide a check up the units of orthodontic activity that she had been assigned would go nowhere near meeting even the identified need with an IOTM of 3.6. Is that a universal problem or a local one?

Mr Hathorn: It is a widespread problem in the sense—I hope it answers your question—that the review process took place in 2004/05. Because orthodontic treatments take 18 months to two years, the contract levels were set at a level of activity two years previously. We know from the appendix to the document that year on year there was a 10% increase in activity. In effect, the contract in 2006 was frozen at contract levels of 2004. There is widespread under-capacity in practices that were developing. I know examples of colleagues who have met their levels of UOAs in terms of new patients and are beginning to finish their cases for that year and to keep within the 4% levels, they have to take days off at this time, at the end of the contract year.

Q401 Sandra Gidley: You have orthodontists who have to take days off when there is a huge need out there just because the commissioning is not right?

Mr Hathorn: Historically orthodontics is two years behind. General dentistry was slightly different and there were all sorts of other tensions within general dentistry about whether or not the reference year was a typical year for them. For us in orthodontics, it was based on a date two years previously and year on year there has been a 10% increase in activity which is not reflected in the new contracts. Those mature and well-established practices in steady state

probably do not necessarily have a great deal of capacity, but there are significant numbers of practices that have capacity to take on more care.

Q402 Sandra Gidley: You alluded earlier to areas of low provision, so presumably the commissioning in those places is based on a historic low provision anyway.

Mr Hathorn: Absolutely.

Q403 Sandra Gidley: Therefore, the problem is perpetuated.

Mr Hathorn: It is made worse. It is one of the reasons why we put it high on our list of concerns. Unlike the BDA's frustration, we did negotiate with the department and we do not have a problem with the nature of the contract itself or the way it is paid, but we have 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.

Q404 Sandra Gidley: Have any managed local orthodontic clinical networks been established?

Mr Hathorn: Yes, fairly widely. I will not say that they have always been as effective as they would like to be, but they are beginning in many areas. I know that a number of them have started in Yorkshire. I can speak only for Bristol, in particular, where a colleague is leading the team. One of the exciting parts of the new process is, that for the first time ever, we have general practitioners alongside specialists and hospital consultants talking together about the local service and beginning to work together in a way that is potentially much more constructive. The Bristol lead PCT has done a very robust 'needs assessment' of the amount of orthodontics to be provided and it has been modelled on 35% which represents the high need (IOTN 4 and 5) indicated in the child dental health survey. It was also modelled on 30% need and found out that the 35% model is pretty much what they are providing. They also have modest waiting lists in hospital and specialist practice. The modelling process is already happening in certain parts and if it is done properly it will be to the benefit of the local community. Our major concern, which you may have picked up from the document, is that we believe the means of calculating it is flawed. The Department of Health has said that there is a known 34% which equates to levels IOTN 4 and 5, so they are high need patients. But they also asked parents whether they thought their children needed orthodontics. Without any knowledge of the problem, 50% said that perhaps they could do without the hassle and preferred not to have treatment. That answer has been used as a divider to say, that because 50% of parents do not believe there is a need, the 34% can be modelled down and divided by two to reach 15%. If that is applied universally it will provide a ridiculous 'needs assessment'. I am reassured that in the Bristol setting the calculation has been made based on that original figure of need, 34%. We already have evidence from

a member, that another PCT is using the Department of Health recommended model, of thinking of a number (34%) and dividing it by two.

Q405 Dr Naysmith: I can confirm as a Bristol MP that a lot of good things happen in Bristol. I know the commissioner for dental services very well. Does the money for orthodontics come from the same ring-fenced budget as that for general dental services?

Mr Hathorn: Certainly for the time being. The two are together within dentistry as a whole.

Q406 Dr Naysmith: Therefore, in some places they are really competing for limited funds?

Mr Hathorn: That was the point I made in response to the original question put by Mr Scott. In the areas of under-provision of dentistry as a whole, it is sometimes a matter of robbing Peter to pay Paul—we certainly have evidence that this occurs. In desperation, to try to encourage better dental provision, orthodontic provision suffers.

Q407 Mr Scott: Mr Hathorn, does a newly-qualified orthodontist have difficulty in finding work?

Mr Hathorn: It is certainly not as easy to find jobs as it used to be and many struggle to piece together jobs in differing practices, picking up bits of contracts here and there. Some specialist practitioners have gone almost straight into private practice. They have been trained in the health service and out of desperation have simply gone off independently to work. Ms Sanderson referred to her experience of desperate waste in her practice. If you train good people—to lose them from the system is an appalling waste of people power. There are problems because there are no neat new contracts. I have referred to the North East. If in the North East you trained up specialists with a view to giving them a contract in that region, it would give them some hope for the future and give that area the very thing it wants which is more balanced provision. I believe that, with planning, the difficulties of access to orthodontics they experience could be resolved.

Q408 Mr Scott: My own area is Redbridge. I suppose an alternative is to tell people to go to Bristol which is obviously the land of milk and money.

Mr Hathorn: It is certainly not that.

Q409 Mr Scott: Taking into account that constituents come to me regularly with children who have to wait up to 18 months or beyond to start treatment, is it fair to say that in some cases when those children do start treatment the situation has deteriorated to such a level that it makes it much more difficult or impossible to treat them?

Mr Hathorn: In the introduction to our piece, patient growth and the developing child is a key part of good treatment, because it is best done in a growing child. There is a window of opportunity. I think it is more likely that with a three year wait someone might be kicked out of being the right age for treatment to becoming too old. Yes, there are

potential problems. My real worry is that we already have a system that is frozen in time two years back. Once the 18-week pathway kicks in, there will be a lot of patients coming out of hospital waiting lists and into the marketplace. Where do they go for treatment?

Q410 Mr Scott: My final short question can perhaps be answered yes or no. Do you say that this contract is letting down children?

Mr Hathorn: In particular areas it is certainly letting down some children. In other areas there are examples of reasonable provision. It is not quite yes or no, in some areas it is “yes” for some but it is definitely not working for others.

Q411 Sandra Gidley: You have alluded a couple of times to the 18-week pathway having an impact. Can you clarify exactly how that will impact on primary care?

Mr Hathorn: If we take an area that is underprovided, hospital secondary care departments often have quite long waiting lists. We have made a recent check and some colleagues have waiting lists of six years which is essentially meaningless in the context of the question asked earlier about best timing for treatment. People fall off, are too old for treatment, get fed up and move on. But the 18-week pathway is being introduced for all disciplines—medicine, surgery and dentistry and the whole thing—so when a patient is first referred to the department treatment must be commenced within 18 weeks. It is no longer acceptable to have what is for us an outpatient waiting list. Patients once seen need to be treated. Those that cannot be treated in hospital will end up in the primary care setting.

Q412 Sandra Gidley: Are you saying that the hospital consultants will basically chuck everybody out into primary care so they can meet their 18-week target?

Mr Hathorn: No. I put it differently. Hospital colleagues will treat as many patients as they can and will take on limited numbers just to backfill those that finish, that is, as a patient finishes a new one comes in. They will not be able to have waiting lists of any shape or description, which means that at the moment there is a hidden problem within outpatient waiting lists which has not been reviewed in Department of Health terms. This has always existed and it will now flush out the problem and exacerbate the inequality of provision.

Q413 Sandra Gidley: Would it also have the knock-on effect that orthodontists who work in the community would have to pick up more complex work which might previously have been carried out by the hospital service? They might be taking on work outside their usual scope of expertise. I do not say they are not up to it, but custom and practice means they would not have dealt with those cases.

Mr Hathorn: I would expect not. Most of those in the community orthodontic service are specialist registered colleagues and therefore they are able, as in a practice setting, to treat the full spectrum. I do

not expect specialists in primary care either in practice or in the community to take up the really severe cases—the cleft and palate cases and multiple missing teeth—which the hospital is there to treat. What will happen is that a whole raft of patients will go out. Where the community exists it will perhaps have to take on some more cases, but they are also getting into specific contract agreements and so they too have their own limitations. We will not find orthodontic specialists flooded with additional treatments because they simply do not have the contract ability to take on the additional patients. The real sad consequence is that you as MPs will hear from more patients who are concerned that they simply do not get treatment.

Q414 Sandra Gidley: Have you made any estimate of how many patients this will affect?

Mr Hathorn: We do not have those numbers. We know the range of waiting lists because our consultant group, in preparation for discussion with the department in May, produced the range which in some parts goes up to six or seven years. There are very big numbers of patients hidden on waiting lists at the moment.

Q415 Sandra Gidley: Mr Smith, you have been waiting very patiently. In your submission you state that the new dental contract has resulted in less complex treatment being provided by dentists and this has led to a reduction in the quality of care provided. How do you substantiate that claim?

Mr Smith: We looked at the overall decrease in band 3 treatments. The courses of treatment on our figures showed a reduction of at least 44% and the department’s figures found that under the previous scheme treatments under band 3 were about 8% of courses of treatment, whereas under the new contract the courses of treatment according to their own figures were about 4% or 4.5%. That is just using the broad figure of band 3. Within band 3 there were a huge number of items of treatment. Within that we have found, based on our own statistics, that the more complex treatments have disappeared. Things like complex dentures—metal ones—and bridge work have almost disappeared. There has been an 80% to 90% reduction in this type of item being manufactured by laboratories. There have been reductions in all manufactured items from laboratories except for the simplest plastic dentures where there has been an increase.

Q416 Sandra Gidley: You are saying that the way dentists treat their patients has changed as a result of the new contract?

Mr Smith: Yes. There are drivers in the system. We have talked about drivers that supposedly overprovide; now we have drivers that underprovide. Dentists fully accept that dental practices are private businesses and have to make a profit, pay the salaries of staff and so on. Within the system there is nothing to encourage multiple treatments—the treatment of four, five or six teeth—or those cases where patients

need more intervention and complex treatment. There is nothing to reward or adequately to pay dentists for doing this type of treatment.

Q417 Sandra Gidley: The bottom line is that they are not getting paid for it and so they are not doing it?

Mr Smith: That is one way of putting it.

Q418 Sandra Gidley: You also report an increase in private work of about 18% but that does not seem to make up the difference. Obviously, some switch to the private system because that is what they want; they make a decision about whether that is right or wrong. What is happening to the others?

Mr Smith: There is no natural situation between NHS and private work. Everybody in dentistry finds the way it is provided is quite a difficult or complex thing to breach. The system is definitely not transparent and so patients also do not understand what is available on the National Health Service and what is available only privately. This becomes a very complex discussion and what is happening is not easy to tease out of the system. All we can tell you is what is happening based on what we are producing, and certainly we have not had a volume increase in the amount of private work to replace the lost NHS work.

Q419 Sandra Gidley: Can one argue it the other way? Can it be said that the old contract encouraged dentists to do some of the more complex work but now they will look at a solution that does the job? It may not be the most attractive-looking thing—if you want that you pay for it privately—but from a dental health point of view it fits the bill.

Mr Smith: “Fitting the bill” is an interesting euphemism. When one invests in people’s oral health in many cases it is a long-term investment. We want the treatment to have a long-term benefit for the patient, which is the whole point of doing it. Many treatments are inexpensive but have only a short-term benefit; some treatments are more costly but have a much longer-term benefit to the patient and overall are perhaps better value for money. It depends on whether you measure it today or over a long period of time. John Renshaw said that one wanted dentists to be in a neutral position when it came to prescribing so they do what is in the best interests of their patients at all times and money does not cloud the issue as to which way to do it, other than whether or not it is affordable.

Q420 Chairman: Mr Smith, you said that fewer bridges were being made than before. Is not the advent of implants one of the reasons why fewer bridges are being produced now?

Mr Smith: First, one has to put something on top of an implant. An implant is just something put into the bone in the oral cavity and something goes on top of that. Often that is a bridge or crown unit. Certainly, implant work would not change that type of work; it would probably have the opposite effect and increase the number.

Q421 Chairman: You referred to an increase in the production of simple plastic dentures. I remember being lobbied in this job a couple of years ago. It was not concerned directly with this inquiry. Given what is said now about UDAs there will be a plethora of people coming in for a denture with a single tooth on it because the dentist gets the same amount for that as an outcome, as it were, as he does for putting on a cap. Do you see evidence of that?

Mr Smith: This is the only increase we have found. There has been a massive increase in the number of one tooth partial dentures. Such dentures were things one hardly ever saw. I learned to do them in dental school. Apart from the odd situation where you would make a temporary denture for a short period you hardly ever saw them. We are now making them in vast numbers; they have increased by 76%. Nobody on this table would say that that is the best long-term treatment plan for any patient who has a missing tooth.

Q422 Chairman: Is that related to the new contract?

Mr Smith: Definitely.

Q423 Chairman: What percentage of dental laboratories are members of your association?

Mr Smith: We have over 1,000 members and that probably accounts for about 85% of the manufactured work. We have members over the whole of the United Kingdom.

Q424 Charlotte Atkins: Clearly, you are not happy with the way the UDA system is working for you. What are the solutions? Should patients in future pay dental laboratories direct and also for their NHS treatment? Do you think you need to get out of the straitjacket of the UDA system?

Mr Smith: We should have a system of transparency so that patients have an understanding of what it is they are being treated with and the value or cost of that treatment. The patient should be in the driving seat as to the choices of treatment available. Dentistry is slightly different from many medical treatments in the sense there are several options as to what can be done in a particular case when we come to more complex dentistry. Therefore, the dentist is the neutral prescriber and is empowering the patient with information about what those choices mean for that patient. When one brings in drivers like UDA one sees how they affect that process. We would like to see some process where the patient was back in the system and the choices made were ones in which the patient was involved with an understanding of the cost implication of making those choices.

Q425 Charlotte Atkins: What about patients who are exempt from NHS charges? You said that the patient should know the cost implications. How does that work in the case of a patient who is exempt from all charges?

Mr Smith: What we must not do is prevent patients who even where exempt are restricted in their choice. We will want those patients to have an element of choice as well. The question is how the NHS chooses to subsidise that choice and how one does that is a

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political decision. I still believe that every patient should be involved in the choice process in some way.

Q426 Charlotte Atkins: What would be your preferred option?

Mr Smith: The option would be that the NHS should subsidise an amount towards the treatment and when the patient discusses the choices with the dentist he or she can make an informed choice as between the most basic treatment or a much more complex option.

Q427 Charlotte Atkins: Do you think that given PCTs commission dental services they should also commission work from dental laboratories?

Mr Smith: There is no reason why dental laboratories and PCTs cannot work together and negotiate contracts between them.

Q428 Charlotte Atkins: Do you think that would work better than the present system?

Mr Smith: It would probably make prescribing more neutral.

Q429 Dr Taylor: The evidence of the Dental Technologists Association, not yours, was that there was a drift of dental laboratory work abroad. Is there any evidence to back that up? Do you have any idea of the scale of the problem?

Mr Smith: I went on a fact-finding mission to Shanghai at the end of last year to discover in China what evidence there was as to that. It was very interesting to see how they are gearing themselves up to be a provider of this type of treatment for the world, but at the moment the vast majority of the work they produce goes to the United States and mainland Europe. The NHS has in some ways protected us from that because there is no real cost advantage at the moment in using China. When we looked at the costings of some of the treatments by the time it was shipped there and returned it was found it was possible to source the work in the UK for a similar price. We found no evidence in any of the laboratories we visited in China of any work being done for the UK. I do not say that none of it is done there, but it is certainly not enough to hit our radar yet. I do not believe that at the moment it is a big issue although it will be.

Q430 Dr Taylor: Ms Sanderson, are you aware of dentists sending work abroad like that?

Ms Sanderson: I am aware that it happens.

Q431 Dr Taylor: But not as a major problem?

Ms Sanderson: I am not aware of the scale of it. I was just reflecting that all three of the labs I use for crown, bridge and denture work are within two miles of my practice. For me, it is absolutely paramount that I have that a relationship with the technician who is making the work for the patient. Sometimes the patient goes and presents himself to the technician and says, "This is my smile. Now you can see what you are going to do the work for." It is absolutely crucial that you have that sort of

relationship. Dentistry is a team event. Although there may be moves to send work abroad when looking at the style of dentistry I deliver it is important that I know my technicians and they know me.

Mr Smith: The new contract has already had a detrimental effect on the employment of dental technicians in the UK, but at the moment I do not attribute that to overseas work.

Q432 Dr Taylor: The same memorandum from the Dental Technologists Association says that from August 2008 they will be required to be on a recognised course or to hold a current registrable qualification. Has that not been the case until now?

Mr Smith: No. Registration is new for all DCPs and comes into effect on 13 July.

Q433 Dr Taylor: Quite naturally, they suggest that there should be some help with training and the continuing professional development that they will need.

Mr Smith: Yes. Because of the effects of the contract and the loss of work the situation now is that technicians are being made redundant, laboratories are closing and recruitment into the profession is being affected quite significantly.

Q434 Dr Taylor: The association tells us that Scotland has looked at this and is funding education for dental technologists?

Mr Smith: Scotland has introduced an extremely good VT programme for dental technicians similar to the one in England for dentists. It is very successful and highly regarded by everybody involved. We have approached the Department of Health about it but I am afraid it has fallen on deaf ears at the moment.

Q435 Dr Taylor: Is that something we should look at and perhaps recommend?

Mr Smith: Yes. The Department used to help with a very small bursary to laboratories to help with training. Our training is a little different in that we work with our hands. There is the academic as well as the technical side of training which you can get only within a laboratory. That small bursary has also been removed and we get no funding at all from the department for training technicians.

Mr Hathorn: I agree that both technicians and dental nurses will have to register for the first time. They will be expected to do continuing professional education and they will struggle. Many practices or hospital departments do not necessarily give much study leave support. The model in Scotland that Mr Smith mentions, which sounds a very good one, is one where some commitment is made to help with continuing training.

Q436 Dr Taylor: At the moment the dental nurse who is at the right-hand side of the dentist, or whatever, does not need a registrable qualification at all?

Mr Hathorn: No.

Q437 Chairman: Ms Sanderson, we come from the same part of the land as it were. When we took evidence on this issue earlier I asked about dentistry in future. One of the issues in terms of the build-up of private dentistry, not just insurance, is the ability of people to afford multi-pay policies and to go beyond what the National Health Service currently provides. Many of the latter cases occur in what we call National Health Service dentistry at the moment. Where do you believe dentistry will be in 10 years' time? We are talking now about access. You said earlier that you were involved in two dental practices, one private and one NHS. Which one will still be around in 10 years' time, or will both still be around?

Ms Sanderson: To make one slight correction, one is exclusively NHS and the other is a mixture of private and NHS.

Q438 Chairman: I was intending to pursue that.

Ms Sanderson: I hope to be able to carry on with that sort of model. It really depends on making sure the NHS continues to be an attractive place to provide dental services and to have dental services provided for you and there are quality measures and a real commitment on the part of national government but also local primary care trusts so that dentists are able to continue to provide comfortable, safe choices and options within whatever sector they deliver care. My hope for the future is that dentistry will continue to make inroads into the oral health of the nation. The Department of Health said that the current contract was intended to produce simpler courses of treatment. How one defines "simpler courses of treatment" we are beginning to unpick. What it will do to the oral health of the nation in the long term disturbs me. There are all sorts of different ways to provide care for a person's tooth. The long-term outcome is really important and we need to keep an eye on it. The 10-yearly adult dental health survey was under threat until recently. I understand that it is now back on the cards, but it is being delayed. Unless we keep an eye on what is going on and make sure we are ahead of the game in monitoring I fear for the diversity of care in the country. I think it is moving apart.

Q439 Chairman: If South Yorkshire gets richer—my constituency is richer now than it was a decade ago—will people be more likely to get private dental care?

Ms Sanderson: Do you mean by that question that more private care will be offered, or that they will choose to do that?

Q440 Chairman: It is a marketplace and the question is: what is affordable? Some areas are probably richer than South Yorkshire; there are a lot more private dentists than traditional NHS dentists. NHS dentistry has gone out of fashion. I do not suggest that that should happen, but what if the market does

drive that? Where will you be in your work in 10 years' time in South Yorkshire if it gets richer and more people go to the wholly private side of your practice as opposed to the National Health Service side?

Ms Sanderson: It has to be driven by the need for high quality comprehensive care for all. That comes at a cost and choice comes at a cost. Where the split lies in future years depends on who decides to buy those services. 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 board, but it comes with a cost, and that applies also to services provided under the NHS.

Q441 Chairman: Charlotte Atkins referred earlier in asking questions of Mr Smith to the NHS paying for part of the treatment. Let us say an NHS patient wants a different type of denture or something that is not necessarily medically needed but is cosmetic. A lot of people now go to dentists for cosmetic and not medical reasons. Do you believe that access to dentistry for those people who do not want a better denture or different crowns from those the state will pay for would be better served if there was some sort of system where people could go along to any dentist, whether or not there was a register, and access what the state provided and if they wanted more than the state provision there would be part payment by them? Would that be more likely to secure access to dentistry in years to come, as opposed to letting the market continue to dominate in some parts of the country exactly what type of dentistry is available?

Ms Sanderson: There needs to be clarity about what is available. How that is funded is probably a political decision. My personal view is that all NHS services should be available to everybody.

Q442 Chairman: I do not dispute that at all. I agree entirely with what the Government is doing in its intention under the contract. What we do as a committee is a different matter. The question I pose to you is: looking at dentistry in 10 years' time, would the situation be one where people went for treatment initially but then wanted cosmetic treatment—something that the state would not and should not pay for—but what the state was obliged to pay for as part of that treatment could be set off against the cost of the cosmetic side of it? It would be a political decision. The reason I put it to you in that truncated way is to discover whether it is more likely to mean that everybody will have access to dentistry because dentists will not opt to cease seeing one group of people any more because they are old, or anybody who has to do with the national health, because they are setting up dental practices in the town as wholly private businesses. That is why I pose the question. Would we break down that type of situation? That situation is now happening in South Yorkshire and in my borough. Ten years ago I would not have thought people would be taking that type of decision.

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Mr Smith: But are you not assuming, therefore, that the National Health Service always provides best value for money? I disagree with that. With the patient contribution now standing at £193, some of the items of treatment we are providing cost considerably less than that. If you take a crown, the patient's contribution for each one was somewhere in the region of £60. The patient is now expected to pay £193. Therefore, the value for money element in all this has disappeared because patients are now paying a lot of money for a little amount of basic treatment.

Q443 Chairman: They could go into the private sector. If dentistry moves as it has done in some parts of the United Kingdom into practically a wholly private sector—we have a geographical problem about NHS patients accessing treatment—it does not answer that problem in the medium to long term, does it?

Mr Hathorn: One of the questions asked of the three previous witnesses from PCTs was to do with ring fencing. I believe that once ring fencing is significantly removed and with patchy and differing versions of PCTs commitment to dentistry to a higher level in, say, the South West and to a low level in the North East, I worry that there will no longer be central direction and we may have significant regional variation. I worry that the more private practices there are in orthodontics and general dentistry those without the money will just disappear over the horizon. A fortnight ago there was talk of fluoridation. That is one of the things back on the agenda. We should be doing things to target young patients who do not have the resources for private dentistry. Birmingham is a living, screaming example of how good it could be if we could introduce fluoridation more widely.

Chairman: Thank you. We hope to bring out our report in the not too distant future.

Thursday 28 February 2008

Members present

Rt Hon Kevin Barron, in the Chair

Mr Peter Bone
Jim Dowd
Sandra Gidley
Stephen Hesford

Dr Doug Naysmith
Dr Howard Stoate
Mr Robert Syms
Dr Richard Taylor

Witnesses: **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, gave evidence.

Q444 Chairman: Good morning and I welcome you to what is our third evidence session of our inquiry into Dental Services. Could I ask you to introduce yourselves and the position you hold for the record.?

Mr Green: I am John Green, consultant in Dental Public Health working in Sheffield PCT and in Yorkshire and Humber SHA.

Ms Davies-Slowik: I am Jane Davies-Slowik and I am here with 27 years of experience in Salaried Dental Services.

Mr Smith: I am Melvyn Smith and I am an ex-NHS consultant in Dental Public Health currently working part-time as a senior lecturer in Dental Public Health at the University of London.

Q445 Chairman: I have a general question to all of you about PCTs and Commissioning. We have been told that some PCTs have adequate dental health expertise but others do not. Do you agree and are PCTs making the most of the expertise at their disposal?

Mr Green: I think it is very variable around the country both in terms of availability and possibly the way in which specialists in Dental Public Health are used. Some, like myself, are very heavily involved in commissioning and others not so involved, but there are very large gaps in access to specialist help. The South West of England and the North East of England⁴ are particular areas where we have no colleagues at all.

Ms Davies-Slowik: I would say the same; it is very patchy across the country.

Mr Smith: I would agree. Also there is a difficulty in PCTs which share consultants in Dental Public Health where the consultant is not embedded in the PCT and therefore may be not available, or maybe decisions are made innocently without engaging the consultant. It is a problem where the consultants are shared across several organisations.

Q446 Chairman: It seems to be a general problem. What input did you and your colleagues play in assessing local dental needs before the contract was introduced? Was there any general assessment or how did it work?

Mr Green: Yes, most certainly. This is the core of what we do, whether that is through epidemiological surveys or by much more soft intelligence around patient involvement, feedback from patients, whatever that might be, is a central part of the role, and also not only identifying need but being advocates for that particularly for disadvantaged groups.

Ms Davies-Slowik: In terms of the salaried services, the salaried services are involved in collecting the epidemiological data for the surveys which goes to providing information to assess dental need.

Mr Smith: This assessment has been carried out for many years by Dental Public Health consultants and their colleagues in general practice and practice advisers as well working for health authorities and PCTs. What happened with the new contract was very much a kind of fixing of the existing levels of provision. Although it provided in the contract for growth in areas identified as having problems, the contract simply provided money to pay for the practices where they currently existed with some growth money but very often that was swallowed up in meeting the unexpected difference between the over-estimate in patient charge revenue and what actually was being delivered on the ground.

Q447 Dr Stoate: In both your submissions you seem to be quite pleased with the move towards a primary care-based provision yet you have both said that you are disappointed that the new structure has not really achieved full potential. What do you mean by that and what potential do you think has not been achieved and why has it not been achieved?

Mr Green: The potential would be—and you would probably expect me to say that—to take a more public health approach to the way that services are delivered, in that the practice would look at its practice population, try and assess who are the groups at risk and the problems and then applying prevention to those groups. Rather than dealing with individual patients but taking an overview, prevention, in that context, has much more meaning.

Q448 Dr Stoate: Why has that not happened? What has been the problem?

Mr Green: The problem has been that there has been a focus on activity, so units of dental activity were introduced to make sure that there was sufficient

⁴ Note by witness: The specific areas are Newcastle and Northumberland in the North East of England

activity to provide care. That, in a way, has delayed a change in the culture of new contracts and has delayed that wider approach.

Q449 Dr Stoate: Is that a fundamental flaw with the contract that the UDA mechanism has not really allowed for enough preventative medicine? Is that what you are saying?

Mr Green: I would not say a flaw but is simply a feature of this transition phase.

Q450 Dr Stoate: Clearly it is a flaw. If events are happening and it is not happening and it is because of the UDA structure, clearly there must be something wrong.

Mr Green: I would have to concede that.

Mr Smith: What was useful was for the first time PCTs could look at the local problems and if they saw a gap, a deficiency in provision, then in theory they had the cash to do something about it. The problem has been, and quite rightly, to stabilise the dental work force. Little change has been able to be made away from investing in the practices which are there currently and doing the kinds of work that historically they have been doing and the patients they have historically been seeing. It is all about the availability, freeing up of money from the existing system to invest in the kind of ways that John has talked about. The other issue is, although the PCT had the money, they were using a national contract framework which had some inflexibility in it. I know there was a potential for making changes, to make things more preventively orientated, to try different models of service, and so on, but by and large the PCTs were simply delivering more of the same under a different kind of mechanism.

Q451 Dr Stoate: What we need to do as a committee is to try and make recommendations. You are saying again that it was supposed to produce more Public Health Dentistry but it has not done so. What would you like to see done differently to make sure that it does work in future?

Mr Smith: A disconnection of resources from activity measured by UDAs, because the PCTs have targets to meet in terms of UDAs and the UDAs are getting in the way of being as creative as PCTs perhaps could be.

Q452 Dr Stoate: What would you recommend that we did about it?

Mr Smith: I think the UDAs, as they are constructed, are a very crude averaging system for outputs. We should not be interested in outputs but rather more the clinical, if possible, outcomes, or at least some kind of health-related outcomes, which I think public health has been used to delivering in other contexts outside of dentistry.

Q453 Dr Stoate: You have both said that out of hours seems to have improved but in what way has it improved?

Mr Smith: The difference in out of hours is instead of individual practices taking responsibility for the practice populations, and perhaps half the

population which did not have an out of hours service or where PCTs or health authorities had not provided a good service, there is now a focus on the importance and, in fact, a clear responsibility now with PCTs to provide the out of hours service. The difficulty has been that where the old health authority or the PCTs were not providing anything, and therefore were not getting national funding for it because that is how it was funded, if they had to create a new service they had to find new money out of that dental budget to do that and so there has been a financial consequence for those PCTs who did not inherit a good service.

Mr Green: One of the key things where we have seen improvements has been where there are specific dedicated help lines for the dental out of hours. Patients then do not phone NHS Direct in general but are directed to these lines and are often triaged by dental nurses or other people particularly skilled in dental issues. It is a much shorter process and is often, as is our case in Sheffield, linked directly to the dentist providing the out of hours care. They are booked into slots and there is feedback to make sure that anybody with real urgent needs who may have missed slots is actually given some attention. That has been the key to our improvement.

Q454 Mr Bone: We recently needed an out of hours dentist on a Sunday and we did ring NHS Direct. There were two out of hours available but both of them were outside the county and therefore outside the PCT area. Is there no requirement on the PCT to provide out of hours treatment within its own PCT?

Mr Green: There is a requirement for them to make arrangements for out of hours care. Those arrangements may be on a wider scale than simply their own PCT. For instance—not that we do it in South Yorkshire—in a conurbation there is some sense in making sure there is cross-cover. We have two main centres in South Yorkshire, in Sheffield and Mexborough, Doncaster, and patients flow between those two depending on demand and so on. Northamptonshire is not a conurbation. I lived there for 25 years and I know it very well. I am not quite sure what the arrangements are there. Certainly the PCT requirement is to make arrangements but they can be partnership arrangements.

Mr Smith: The fact sheet of the Department of Health actually required PCTs, almost at that level, to look at arrangements across PCTs because of the need for some kind of financial and technical efficiency in providing services so that dentists were not sitting there doing nothing and were covering a wide enough area to make that viable. The trade-off is the difficulty of travelling distances particularly on a Sunday when public transport services are poor. Certainly if PCTs are in arrangements with adjacent PCTs that was in line with the Department's guidance on out of hours services.

Q455 Mr Syms: It has been suggested that some PCTs have increased NHS dental provision by contracting services from inexperienced dentists and

dentists who qualified overseas. Do you have any evidence to support or refute this suggestion and does it concern you?

Mr Green: It does concern me. Our experience is varied and it is either end of the spectrum. In South Yorkshire we recruited, through the Department of Health scheme, in Poland. I conducted a weekend recruitment event and was very impressed with the quality of people we had for interview and subsequently with their work for us in Rotherham. That is at one end of the spectrum. At the other end are the concerns where there is a skills gap, dentists coming to us from maybe Eastern Europe where their experience is more limited. 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. That is something we can fix, and we did fix, locally through post-graduate offices. The important thing is to identify where the skills gaps are and also through some sort of inductational training programme which we have attempted to do in our deanery. At the end of the day, if we are short of dentists and we have this movement of labour across Europe then it behoves us to make the best use we can of that and also improve the skills when we identify gaps.

Ms Davies-Slowik: I do not have any evidence from the point of view of the salaried services but in another role I work as retaining and returning adviser for the post-graduate office and part of that role is to support dentists from overseas. I think there are two sorts of dentists from overseas. There are overseas dentists from outside the EU who need to take a General Dental Council examination in order to come onto the register. Following that they need to have a period of vocational training or equivalent vocational training. They generally have to be supervised and have a vocational training number. The dentists from the EU, because of EU regulations, are not required to do vocational training. Just as I could go over to anywhere in Europe and work by being registered with the General Dental Council, they have no requirement to take an exam. The difference between these two is for the overseas dentists outside the EU they have the chance to have some supervised training and if they have any problems or deficiencies or any training needs these are met within a period of vocational training.

Mr Smith: We have always had dentists coming here from other countries: 40 years ago it was Australia; we have had people more recently from Sweden in quite large numbers in Essex where I work; South Africa we are getting quite a lot of people from; and now it is Eastern Europe with the broadening of Europe. It is not a new problem but some of the more recent difficulties, particularly around the recruitment that took place from Poland, maybe it was a rather hurried process to meet a target for 1,000 new full-time equivalent dentists in a very short order. Some of the work was commissioned from recruitment agencies and maybe we had people coming who did not know what to expect and did not quite understand the system. Some of the things

which could have been done over there before the dentists arrived here, like occupational health clearances and so on, were not done. Contracts were based on Salaried Dental Services contracts rather than the general dental practice type of contract. It was done in very short order and there may be some technical problems which have made the dentists dissatisfied with the situation they found when they came here from Poland. Like John, the experience is like dentists from anywhere: there are good and bad, and very experienced and people with less experience. The problem may be fitting into the NHS system which is quite difficult for people to understand if they have been working in it for a short period of time.

Q456 Mr Syms: Do you think the Department and PCTs have adequate measures in place to ensure competency of the overseas dentists? As we have already discussed a moment ago, you cannot stop them coming in to do a job but I suspect it is more is there sufficient training and money to ensure that the gaps in their particular skills or experience are brought up to a UK NHS level.

Mr Green: In terms of identification and doing something about it, PCTs do have powers to impose conditions on joining a performers list or remaining on it if they think they have concerns about skills or competence or whatever. There are powers which increasingly PCTs are becoming aware of and beginning to exercise. It has not been particularly clear, at least from my experience, but we are beginning to learn more about how we could do that. As far as the training, or remedial training, to fill those skills gaps, then there is a funding issue there because there is not an obvious source of funding. Post-graduate deans and deaneries do what they can but often they have to be funded by the individuals or by the practices who are intending to employ them. There is no central funding but it is coming from within the profession itself.

Ms Davies-Slowik: I would say that there is a system for assessing dentists' competencies against an agreed framework of competencies and this is done for the overseas dentists and people who do not have a VT number. There is a system for assessing competencies. If a period of supervised training is advised, then very often this is funded from within the practices or the individual dentist. There is not a pot of money available to do that.

Q457 Mr Syms: Is there sufficient money in the practices to cover this?

Ms Davies-Slowik: I cannot comment but it happens that dentists do have periods of supervised training and they get through and they are signed off as being competent.⁵

Mr Smith: My experience, which is still quite recent, is that very often things like language competency was dealt with in a centralised way and there was a

⁵ Note by witness: At the end of a period of vocational training or vocational equivalence training dentists are signed off as having completed this period of training. Their competence is not tested or measured at the end of this period.

very clear requirement on PCTs to accept people who had met a certain level as regards language competencies. Similarly anybody who was appropriately qualified can practise and the PCT could not challenge, because it is a GDC issue, their competence in terms of their practising certificate. The problem then may arise if there is perceived to be a problem of performance. That would be the same as for any dentist wherever they were from and however long they had been qualified. The PCT then might have to put in remedial steps as a way of dealing with that. The difficulty then is a resource issue. It is a financial issue for the PCTs who do not have any money for it. Clearly it has been with deaneries and people responsible for training. The other resource issue is there are not necessarily the courses available in the dental schools, if that is what it takes, to be able to improve somebody's clinical skills in a certain area. There is a bit of a difficulty in meeting those training needs.

Q458 Chairman: Ten years ago any doctor coming in even from what we now call the European Union or the European Economic Area would have had to sit an English language test. That is not the case presumably for dentists coming from the EEA but is it the case for dentists coming from wider than the EEA.

Mr Smith: It is still the case that the PCT has to satisfy itself that there is language competence but that is determined by a central agreement, a national agreement from the Department, which says which tests can be used and what level has to be achieved.

Q459 Chairman: That is an employer's responsibility as opposed to a regulatory body's responsibility.

Mr Smith: It kicks in when people want to get onto the dental list of a PCT that certification has to be shown.

Ms Davies-Slowik: If the dentist comes from outside the EU area they have to take the language test.

Q460 Chairman: They have to do that as medical doctors would as well?

Ms Davies-Slowik: Yes, before they take their registration exam with the GDC.

Q461 Chairman: Coming from Poland, or anywhere else, it would be an employer's responsibility that they can communicate with patients in an adequate way.

Ms Davies-Slowik: I believe so.

Q462 Dr Naysmith: It has been fairly widely recognised that the new contracts had little, if anything, to encourage the provision of preventative care. John and Melvyn, in your replies to Dr Stoa a few minutes ago you made it clear that you agree that there is not much in it for promoting prevention. If we can look a little more closely, what type of preventative care should be provided? Would a QOF-type framework such as applies now to GPs provide at least one way of doing it or do you have other suggestions?

Mr Green: I just want to restate what I was stating earlier. Prevention, as a set of activities, is only of any point if it is set within a wider context of who actually needs it within a practice population. Doing it for everybody is certainly not the right thing. Given that caveat then within it the sort of things might be anything from very active interventions, such as fluoride varnish application or other sorts of active application of fluoride, right the way through to supporting behaviour change. It could also be smoking cessation. We have some practices that have smoking cessation clinics within the practice. It is a range of things but it is set within a philosophy of care for the practice population and care for the whole patient and deciding what they really need. It is providing the opportunity to adopt that mind set.

Q463 Dr Naysmith: That is quite opposed to the new contract. Under the old system people registered with a dentist and they went along regularly for check-ups. Now people are encouraged to come for a series of treatments and that is the end of it. How do you fit all this into the new system? I am not suggesting the old system worked that much better but it did work a little bit better.

Mr Green: When we were in the pilot schemes prior to 2006 then practices were able to do that. We created the space for them to adopt that approach and the reaction of patients was very, very positive. When they said "The dentist has more time for me", what was happening was that was the sort of evidence of a preventive approach. They were able to talk and encourage people to care for themselves better and things like that. That was a real bonus. The issue now has been that the focus on activity has squeezed those things out.

Q464 Dr Naysmith: Would a QOF-type system reintroduce that?

Mr Green: I think the thinking is going down that way. There are things to learn from QOF as well, the good and not so good things.

Q465 Dr Naysmith: Maybe it is not a good day to be talking about QOF.

Mr Green: The idea that you set aside part of the contract as well as part of the time for a preventive approach is key to it. The difficult thing is deciding how to do that whilst maintaining activity, whilst maintaining the charge revenue that goes with that activity. That is another issue of concern to PCTs, doing all of that, but from a public health point of view putting, for the sake of argument, 40% of the contract's efforts and reward into access and prevention or patient health outcomes or however you want to describe it is the way forward.

Q466 Dr Naysmith: It was not done properly before but partially with proper registration with a dentist as you have registration with a GP.

Mr Green: From a personal point of view, I would. I cannot say I have thought it right the way through but there seems some logic, leaving aside the rather temporary nature of the contract with the patient in the present arrangements, if you want a long-term

relationship with patients you need some way of expressing that. The open-ended registration, which is what we have in medical practice, may be one way of doing that. Patients behave in that way. They think, as I do, I know who my dentist is who has always been there.

Mr Smith: Going back to the original question, although there are clearly some therapeutic interventions which we know work, like fluoride varnish applications, fissure sealants and so on, sadly although we know that some patients will respond to the dental team's help and assistance in terms of making behavioural changes the evidence for that is really quite thin in terms of the behaviour changes that we can show happen. There is some evidence around smoking cessation, the brief intervention which we know about in medical practice. In terms of dietary change, the evidence there is slim and it only reflects a short-term change in people's dietary habits. Similarly, despite the efforts of dentists and hygienists, people will soon relapse to oral hygiene measures which are less than perfect. That is why every time you go you will be reminded. It is about changing people's behaviour. The context of that is outside of the dental practice. Your remit here is to look at the dental contract and dental practices but you have to put it in the context of health promotion and what goes on elsewhere. Therefore, you have to be cautious of investing a lot of money into tying in dental practices when there might be other solutions, other ways of making bigger improvements—I know you have considered the role of schools, for instance—in terms of people's behaviour and empowerment to behave differently which would improve their oral health. This is the public health side of it. What I am saying is consider a focus which is not just based within the walls of the dental practice. It could be that dental practitioners have a role in that more publicly focused activity.

Ms Davies-Slowik: In some of the salaried services, in part of their public health input, they have oral health promotion staff who do things like work with health promoting schools and try to target interventions at populations at risk. The second thing I would like to say is that certainly for the patients that we see in salaried services the registration-type relationship with the dentist is really important in terms of knowing them and their habits and where they live, and it is very important in terms of the prevention and being there whenever you see them to reinforce that.

Q467 Dr Naysmith: It has been suggested that the NHS is carrying out fewer band 3 treatments now. Do you think that will lead to deterioration in the nation's dental health?

Mr Smith: If you look at what is within the band 3 treatment, crowns, bridges and dentures, then clearly if somebody needs a denture and cannot function for the lack of that denture then it will have a significant impact.

Q468 Dr Naysmith: Do you think it is a real observation?

Mr Smith: There is very real evidence, and maybe you heard it at the last session, that the amount of work going to laboratories, which is what this is about, is reducing. Whether we can manage without having a bridge to replace a missing tooth somewhere near the back of the mouth, maybe we could, but for those people where there is a clear need for functional restoration then that has a big oral health impact.

Mr Green: I would agree on that. I think there are some concerns from last week's evidence about some of the more inappropriate dentures that have been made in order to secure a band 3 reward. I did put in my written evidence that concerns about patients missing out on that, because the gap between band 2 and band 3, £42 or £194, is perceived as being very large, particularly older patients needing full dentures see that as a very large amount of money to find. I know because I talk to them from help lines and complaints and things.

Q469 Sandra Gidley: I am interested in whether there is any evidence that patients' quality of care has benefited in any way from the introduction of the new contract. Is there any evidence of that from your PCTs or is the reverse possibly the case?

Mr Green: I think the answer is it is too early to tell. It is difficult to get either a benefit or detriment at this stage from what is available to us in PCTs at the moment. We do work very closely with the dental reference officers from the dental services division and they are the ones who are the clinical monitors of care. I am not aware from our local reference officers of particular concerns that they have. There always have been variations in the way that people have provided care but there is nothing at the moment that is particularly unusual or any particular trends as far as we know.

Ms Davies-Slowik: I am not aware of any evidence.

Q470 Sandra Gidley: Melvyn, I think you said there was an inherent incentive in bands 2 and 3 for dentists to under-treat.

Mr Smith: I said the incentive was there; I did not say it was necessarily happening. Every system has a different set of incentives and you have to consider that when you are imposing a new system. Let us consider the case of somebody who needs a lot of treatment which falls into band 2, a mouth full of fillings not involving crowns and dentures, for instance. Clearly if a dentist can be rewarded in the same way for providing one filling as they can for providing ten fillings then there is an inherent incentive for that not to happen or, and this may be a different way of expressing the same issue, for that course of treatment to be split so that a claim can be made from the band 2 course of treatment somewhat later down the road and some other fillings done. That is just an inherent incentive in the system in the same way that capitation systems, for instance, have an incentive for under-treatment. The reason we have all this debate about dental contracts and what the contracts should look like and how the payment system should work is because nobody—and I feel some sympathy for those who have to think about

it—has come up with a perfect system. There were calls for pilots going back to the beginning of this century and people were invited to bring good ideas to be tried as modernisation pilots but there was very little outside of the traditional capitation or fee for item, the kind of things that had already been tried. It is a good question but I do not think necessarily there is a good answer to it. There are incentives in whatever system you operate which are perverse or which would go counter to improving oral health.

Q471 Sandra Gidley: Has quality of care changed with the new contract?

Mr Smith: It is a bit early to tell if you are talking about clinical care. What we also need to do, and we could have got some information by now, is look at the quality of the patient experience: could they get treatment when they wanted it and when they came out of the surgery did they feel their problem had been sorted out. I do not know why that kind of monitoring, in terms of the patient experience and how they feel about treatments being offered, was not built in, in some way, to the new contract or new contract monitoring.

Q472 Sandra Gidley: If I could go back to the comment you made if somebody needed a number of fillings then a dentist would get paid the same amount for a course of one or ten so there may be an incentive to split it up, that would mean that the patient would pay more charges and the patient may not be aware of the way the fee structure currently operates. Do you think the new so-called simple fee structure is clear to patients and they are clear what they are getting?

Mr Smith: If you look at the situation of somebody who is a regular attender and therefore may have a need for a new filling identified every couple of years and they have that filling done then they have to pay a band 2 patient charge. If somebody is an irregular attender, perhaps less assiduous in looking after their teeth, then there is no financial incentive because they will have to pay that same band 2 charge. There may be an incentive there in the system for people to store up their problems and have everything done all in one go because, at the end, they are paying the same patient charge for it. Again, there is a disincentive. This is about the fee system rather than the UDA although it is tied to the UDA. People are trying to get better value for money by storing up their problems.

Mr Green: I would agree with that.

Q473 Sandra Gidley: Last week there was an admission from some of the PCTs who gave evidence that their dental services would suffer as a result of a shortfall in patient charge income. Is that something you can concur with?

Mr Green: Potentially it could be; it depends on the amount of impact. Speaking from my own experience, what happened in the first year was we had something approaching a £2 million shortfall on charge income. That has improved this year but it has not been eliminated. The PCT has put other money in to subsidise to make sure that services are

maintained or expanded in some cases. It is variable and the ability of PCTs to do that, particularly those who are in turn-around, can be compromised.

Mr Smith: John has fallen into the trap which PCTs do of calling it a patient charge shortfall and regarding it as such. It was an overestimate by the Department of Health as to what patient charge revenue would be and it was never corrected.

Sandra Gidley: It is a bit like the GP contract but we will not go into that.

Q474 Jim Dowd: Can I apologise to our witnesses? I have a school party in an adjoining room. I had to spend some time with them and so I was away at the beginning of the session. Can you give us a brief background to the role of salaried dentists, how they work and where they work and your assessment of whether the changes of 2006 have had an impact on both the way they work and the services they provide?

Ms Davies-Slowik: The salaried services were set up a long time ago basically as the School Dental Service and then moved on to the Community Dental Service in response to high dental need. The Salaried Dental Service is now set up to be complementary to the General Dental Services so they work in tandem. They do the things that the General Dental Services do not do. The majority of them are all within PCTs, I think, or they are within the NHS system. They have developed very much on a local level to meet local needs so no two services are the same even in neighbouring PCTs. There are two sets of patients that they are there to treat: firstly, vulnerable groups or priority groups, so children whose parents do not go to the dentist who would not get treatment unless there was a service there for them; adults and children with disabilities, learning disabilities; patients that are inpatients in hospitals, mental health hospitals or rehab hospitals; and various groups like that who are outside the norm who would not normally go to general practice. The second group of patients are the safety net patients. A while ago salaried services set up to treat patients because of access problems, either with emergencies within dental access centres or normal treatment that the GDPs were not providing because of access. Does that answer your question?

Q475 Jim Dowd: There are a couple of points arising from that. The other part of my question was have you felt any effects of the changes on the community dental service?

Ms Davies-Slowik: Yes. It has been a big change for everybody. It is a huge change in the system. In my written submission I said I thought it had effects in four different areas and the first area was for the patients. I think the treatment of individual patients has not changed from salaried services so the patient is a patient whatever system they are in. The dentist would say no matter what the system, there is always the patient there and I do not think the treatment for the patient has changed. However, there have been increased referrals into the service by GDPs. There was a survey that the BDA did with clinical directors and there was a marked increase of referrals into the

services which has a knock-on effect for the vulnerable groups that they might have to wait longer for treatment.

Q476 Jim Dowd: Do you think there have been appropriate referrals? I realise that is a subjective judgment.

Ms Davies-Slowik: Some of the comments made by the clinical directors in the survey have said they have noticed more patients with high treatment needs being referred in, so different patients from the normal ones.

Q477 Jim Dowd: Would it be your professional estimation that these are patients who used to be treated in the non-special sector?

Ms Davies-Slowik: In some cases.

Q478 Jim Dowd: Because of the pricing structure they are now referred to the specialist.

Ms Davies-Slowik: That is a possibility. The fact that services are commissioned as a whole to primary dental care has increased the profile of salaried services. I think GPs know more that we exist and are more likely to refer anyway.

Q479 Jim Dowd: Has it resulted in increased investment, increased expenditure, in the specialist sector of community services?

Ms Davies-Slowik: Referring to the survey done by the BDA, there were a lot of services that were being reconfigured but my feeling is that it was mainly smaller services joining up. The worrying thing was that 30% of the clinical directors said that some of the posts were frozen at the time of the survey presumably because of the NHS spending problems and I have no evidence to say that the services have increased.

Q480 Jim Dowd: Was that part of the general issue over deficits rather than being specific to dentistry?

Ms Davies-Slowik: Yes.

Q481 Jim Dowd: Do you think the NHS generally makes enough use of specialist and salaried dental services?

Ms Davies-Slowik: Yes, but obviously it depends on individual circumstances. I think they are there to do a job. They are there to treat the most vulnerable sections of society and I think they do make good use of that.

Q482 Jim Dowd: What about their use in areas where there is a shortage of traditional dentists?

Ms Davies-Slowik: In some cases it is fine if it does not reduce the service to the most vulnerable people who cannot access treatment. In some cases there have been instances where the safety of the service has increased to the detriment of other patients.

Q483 Mr Syms: Some countries provide oral health care through publicly funded dental clinics staffed by salaried dentists and dental teams, such as Finland. Would you advocate an expansion of these arrangements in England and, if not, why not?

Ms Davies-Slowik: I think there are different services in different countries. The way the dental services are arranged is very different. For me the salaried services do the job they set out to do very well. I am not sure what the advantages are of going to full salaried services as you see in Finland.

Mr Green: The Scandinavian model tends to be salaried for focusing on children more than anything. In fact, that was the model here for many years. It is only from the late '60s or '70s onwards that general practitioners started to see children as part of the family unit. Having worked in what was once the School Dental Service for many years, in those days most of the child dental care was provided in the salaried service. I make no judgment about whether that was better or worse than what we have now; I do not think you can. As far as the salaried service now, the point of someone being on a salary is to give them the freedom from other concerns about business to focus on quite difficult challenging patients. That is the main justification and Jane has described that very well. The dental practice infrastructure we have been created through a business approach and I do not think we could recreate that infrastructure now; it is not affordable. It is being funded mainly by the entrepreneurial world of practitioners. Also they have brought in other income from private practice offering a wider range of things and are able to be much lighter on their feet in terms of business than perhaps the NHS would be. At the end of the day, the practical answer is to do with whether it is really affordable. You decide it might be desirable but it is whether it is affordable. This is one of the great problems about comparing general practice with salaried practice. It is a completely different case load and this is why dental activity is so difficult to try to apply to salaried services. I have colleagues who work all day in the theatre with very challenging patients with mental handicap. They work all day and see two or three patients and end up with four UDAs. The average gain is 15 per session so it is not a sensible comparison.

Mr Smith: It is unfortunate that we use the term salaried dental services. What we are talking about is different models of provision. What is a family dental practice? It is a kind of environment with its own mix of private and NHS patients usually. It is run as a commercial business owned often by an individual who has invested a lot of money in the practice. On the other side we have maybe the need for more—institution is the wrong word. Maybe we are thinking of Darzi's polyclinics here: a differently structured service where people use it in a different way. They can drop into it. Maybe they are not traditional family dental practice users. There are different styles of service provision which suit people in different ways and probably we need both. How the people who work in them are paid in either system, whether they are paid an income every month or incentivised in some way, does not matter, it is more about the style of provision of the service. Whether it is somewhere on the high street people can drop into without any worries about feeling part of the practice, who are not interested in registration

for instance. I would support registration but there may be people who do not want that kind of model. How people are paid is a bit of a side issue to developing a breadth of service. We might be talking about putting out of hours services in there. We might be talking about putting some specialised services in there. It is having different models of service to meet the needs of the population.

Q484 Dr Naysmith: Could I just follow that question up a little bit? Why could we not have a salaried service doing full dental services in a clinic?

Mr Smith: We do.

Q485 Dr Naysmith: But you said it suits different people. Actually what it does is it suits the practitioners to do it the way they do it. You have physiotherapists, pharmacists and nurses working in clinics being paid on a salary basis, why should it be any different for dentists?

Mr Smith: Absolutely right. If you talk to young under-graduates about what their aspirations are, some people would be very happy earning a salary and not having to worry about taking care of business and others would want to own their own premises, who want to diversify in their own way particularly in the private sector.

Q486 Dr Naysmith: There is not the opportunity to be a salaried dentist working in a clinic very much, it is not really offered. You are offered the traditional way of doing it and then for specialised services Jane operates in a different area.

Mr Smith: There is room for everything.

Q487 Dr Taylor: One of the many criticisms we have had of the new contracts is related to the poor collection of data. If I can go to Melvyn first, in your submission you have been very clear. NHS dental data is inadequate for strategic planning of dental services and preventive programmes. The old fee for item contract gave, as a by-product of the payment system, detailed information. Can you expand on how this is making life for Dental Public Health officials difficult?

Mr Smith: Can I give you an example of the headline measure that the Department of Health seem to have adopted, which is how many people have been seen in the last two years. If we have a paradigm that we want to get people orally healthy, we want to give them fluoride in the water or put fluoride varnish in their mouths and empower them in schools about healthy choices around eating and cooking and all the rest of it, and people get good quality restorations which last for 20 years and not two or three years, then the measure we are looking for would be a reducing number of people walking through the surgery door. Yet the Department of Health have chosen the number of people visiting a dentist every two years as a performance measure for PCTs and they have to deliver more and more of that. That to me is an entirely perverse kind of method of counting the success of an oral Health Service. What we could have, and it is back to what I said before, are measures which are actually about

the patient experience and how they feel about their dental care. 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. There has been no systematic approach within the new contract to say that is the kind of data set which would help us in planning services.

Q488 Dr Taylor: How could those be woven into it now?

Mr Smith: If you look at PCTs, they have data collected with the old GPAS (General Practice Assessment Survey) and GPAQ (General Practice Assessment Questionnaire) system for ten years now about patient satisfaction. There is a continuing programme of NHS data collection about how people feel about their services: "Think about the last time you went to see your doctor. Did your doctor listen to your concerns?" Those are the kinds of measures which I think would help us to know if the local services were giving us what we needed and, if not, how we could change them to make them more responsive to user needs.

Q489 Dr Taylor: Are any PCTs putting these measures in place?

Mr Smith: They may well be. Those questions are being asked in terms of the generality of primary care provision but not specifically around dentistry.

Q490 Dr Taylor: Is this something we should recommend?

Mr Smith: It is done everywhere else across primary care. I do not know why it is not done for dentistry.

Mr Green: I agree with Melvyn about looking at patient outcomes: that is really what we are concerned about and the rest of it is all process data. The real outcome is whether the patient feels better and feels they have had a good service and their health is improved. That does go on although not to the extent that would be of most use to us. It is very high level data and does not go down to local neighbourhoods very well. I think that is important. Underpinning it we still do need to know whether we are winning or losing in terms of dental health. One of the concerns I have is about this decennial survey. We have been doing that for 40 years now. This will be the fourth time every ten years we have done it but it does not look as if it is going to happen.

Q491 Dr Taylor: We are going to ask you specifically about that in a moment. Can I move to Jane? Has there been any change in the way you record data?

Ms Davies-Slowik: Since the introduction of the dental contract, yes.

Q492 Dr Taylor: You would have the same criticism, would you, that the recording of data is much worse now?

Ms Davies-Slowik: Local PCTs sometimes have different ways of collecting data for the local services. Salaried services can have different performance measures. For example, some people might collect contacts which are just people through

the door. Sometimes some PCTs use a measurement of case mix which was developed with the BDA which measures the sorts of patients that you have and weights the input to those patients. You do not have an overall view of things getting better or worse.

Q493 Dr Taylor: Previous witnesses have suggested that because of this poor data collection there is less probity assurances within the system and more scope for playing the system. Would you agree?

Mr Green: Potentially, yes. We have a lot less data now so it is very difficult to know what is actually done for the patient unless, of course, we do what is happening which is to go back and look at the record cards. A clear detailed record has to be made of every intervention the dentist has carried out so that is being picked up by the dental reference officer visits to the practice.

Q494 Dr Taylor: How feasible is that to look at a meaningful number of records?

Mr Green: That is a point. There is a capacity issue about how much and how often you can do that but it is certainly something that practitioners are aware of now and would have to make sure there are records to do. Something I ought to say which I do not think has come out today is from April we are about to have enhanced data sets which will give us much more capability to look at more sophisticated weighting of the sort of patient groups that practitioners are seeing, particularly new patients who need a lot more work. We will have the ability to identify that and see what the profile is of the practice. We have very little profile information under the new arrangements at the moment but that is a temporary phenomena.

Q495 Dr Taylor: One of our experts has just passed a very apt comment that these record cards which are examined are selected by the dentists themselves so they are not going to produce any of the bad ones.

Mr Green: You would be surprised. My reference officer colleagues tell me that someone who is perhaps underperforming is unaware of that.

Q496 Dr Taylor: Out of sheer ignorance they might produce some of the bad ones.

Mr Green: That is one conclusion.

Q497 Dr Taylor: Should it not be, as it was in the old days in hospitals, when we were inspected by the colleges you did not know which notes they were going to look at; they picked out an entirely random set. Should this not be the same?

Mr Green: I think so. It is the view of all of us in the PCT governance side of things that it ought to be a more random and probing process. We are taking it step by step. This was quite a big change we have been doing for two years now and I think everyone would think let us move on to the next step.

Mr Smith: I would challenge that statement in the sense that I can remember clinical governance started in the NHS in about 1999 and dentistry was kept entirely outside of it. There is no connection

between the growth of clinical governance within PCTs which has been slow bringing on board the general medical practitioners took time but it happened but there was no connection between that process and that financial support and that resource in terms of audit, peer review and clinical governance developing within practices. None of that was taken into dental practices; it was kept entirely separate. The Dental Reference Service does not have a good technical relationship with the different PCTs and those responsible for clinical governance within it. Something would need to be done there to bring this tremendous resource we have in the Dental Reference Service more into the governance arrangements that already exist and are having to improve within PCTs.

Mr Green: There is a review going on in the Reference Service at the moment and we are contributing to that. These issues are coming up and are being addressed so we should see some changes there. I take a bit of issue with Melvyn about dental governance because I was involved in developing the national model which some PCTs have adopted. It is quite true about the range of what the Healthcare Commission is concerned about and we have tried to translate that into a practical way of assessing the quality of care and the quality of the way in which dental businesses run. Again in Sheffield we have done a lot more work and taken it forwards further in helping practitioners to improve the way their businesses are running because that benefits them as well as the patients.

Q498 Dr Taylor: When the new data set comes in in April, is the completion of the activity data compulsory?

Mr Green: Yes. I cannot see it being anything else.

Q499 Dr Naysmith: A final couple of questions on the procedure that started in 1968 with the national ten yearly adult and child oral health surveys. We got lots of very valuable data from these surveys every ten years but the adult survey has been cancelled for 2008. What do you think, if anything, has been lost by the Department's decision?

Mr Smith: I do not think we have been very good at collecting data on adult oral health and oral health needs. My professional society has done a lot to promote the collection of school-based data, and that is done because it is easy to do, but what we have not done is looked for systematic collection of data on our adult population. The only way that is done systematically across the country is through these surveys. We should have good quality local data but we do not. It is expensive to collect. You can use the national data as a surrogate. 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.

Q500 Dr Naysmith: You think we are losing something valuable with the adult data survey being abandoned.

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Mr Smith: Yes, because without that we have nothing at all in terms of adult oral health. It was very useful data.

Mr Green: I do agree. I add to that what we were hoping when this 2008 survey was being talked about was that it would actually be able to give us more information a bit closer to home. At the moment it is in big super regions in the old days and we were hoping to get down to health regions or SHA regions, but that looks like being thwarted which is a great shame.

Q501 Dr Naysmith: Why do you think it is being abandoned?

Mr Green: I think cost has to come into it. It is a very labour intensive process to clinically examine about 5,000 or 6,000 subjects around the country to add to the interview and qualitative data that is gained as well. It is one of the reasons we do not do those surveys locally in any real way.

Q502 Dr Naysmith: If all the PCTs are collecting data, why do we need a national survey?

Mr Green: Because the data is coming from patients who attend the dentist. It is not looking at the total population so people who do not attend very often, people who are irregular attenders, do not figure and, therefore, it suppresses the scale of the disease levels.

Q503 Dr Naysmith: What is the kind of data that we will be losing?

Mr Green: Over time we have seen the number of people who are without any natural teeth fall from 37%, and we expected it to drop to well into single figures and getting towards 5% this time but we shall not know as things stand at the moment. That is one issue. That gives us an idea of what the likely need is going to be. As people age with all their natural teeth then the maintenance costs to them and the NHS is very considerable and gets even more the older we get. We need to have some idea of what that future workload is going to be. This again is the source of that data other than some sort of modelling exercise. The other bit of information if I can go back to the clinical surveys that are done on children, they are very important. I work in Lincolnshire which has been fluoridated for 35 years, or half of it has, and it gives us a measure of how we are doing and whether fluoridation is still working, which it is, and the degree to which children particularly are being disadvantaged by them not having fluoridation in the area in which they are. There are academic arguments about the evidence but the clinical evidence from dental practices day by day and schools' evidence we have is very clear.

Ms Davies-Slowik: Just on a very practical note to say how we would use the information, for example, as John was saying, over the years more people are keeping their teeth for longer and they are keeping more of their teeth and they are in not as good condition. It helps with planning 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.

Mr Smith: For example, if a PCT has to design a service for the housebound, older people, we need to know how many have dentures, how many have root fillings, to be able to design a service to meet that need. We do not have that data from anywhere else but the adult dental health survey.

Q504 Chairman: John, can I ask you, with your regional hat on, are PCTs collecting data of people who do not use services so they can make a proper needs assessment?

Mr Green: I suppose they are in a way. What they are looking at is in the past it is looking at registered and unregistered and it is now looking at those, as Melvyn says, who have been attending in the last two years and so on but that is very difficult data.

Q505 Chairman: There is no general population data on dental health care needs.

Mr Green: Some areas have done that in part of their PCT surveys but there is not a concerted consistent effort about all that. It might be a good time to make a point about registration or rather the attendance pattern. Registration in the old scheme was a snapshot. Even though we may have had 65% of people attending, the reality was in any two or three year period it was more like 70% or 80% because of the turnover in practices. When we talk about the difficulty of universal registration, then it begins to make more sense because people who actually would be cared for are much larger than the percentage that were declared as registered at any one time. There is also a group of the population who for all sorts of reasons, and some of them very good reasons, only attend symptomatically and do not want registration or come for that regular care. It is not quite the big step that you might think.

Q506 Chairman: Commissioning is patchy and we have heard evidence in past sessions how patchy it is. Budgets for commissioning are ring-fenced at the moment up until the end of the next financial year. Do you think that ring-fencing of those budgets has assisted in the commissioning of dental services under the new contract?

Mr Green: Yes, I do. It has given PCTs a clear message that this is what should be spent on dentistry and what should be devoted to that and many of them wherever they possibly can have done that, certainly in Yorkshire and Humber.

Q507 Chairman: Does it worry you that the cost commissioning is patchy? I do not know the Yorkshire picture that you have part responsibility for but does it worry you that ring-fencing will end at the end of the next financial year?

Mr Green: There is no certainty at the moment. The operating framework talks about extension being considered and I think that is part of the issue. If what we are looking to focus on now is access, then there needs to be some way of underpinning or focusing PCTs on achieving that aim. My reading of

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it is that government is probably more likely to continue that for a while. The important distinction has to be made between ring-fencing as far as PCTs are concerned and protecting the contract values of dentists is that does end after three years and so on. PCTs are not likely to want to greatly undermine the stability of what they have achieved so far in dental practices.

Mr Smith: My concern would be if we have a continuation of emphasis on UDAs and increasingly more patients through the door over a two year period then the gain that PCTs might get involved in to take care of that would maybe compromise services like Jane's where the commissioners know the price of everything and the value of knowing. They would be looking for the cheapest possible way

of delivering a new patient through the door in two years, which is not necessarily going to take care of the people in society who need to be looked after.

Ms Davies-Slowik: I worry that as the BDA survey said 30% of clinical directors said that their posts were frozen that if the money was not ring-fenced then the temptation would be to freeze. Actually some of them said that their posts had been disestablished. If you have got a dental service versus coronary care, and that is the sort of decisions that PCTs have to make, it is not difficult to see which one might win in that case. If funds are not ring-fenced then the danger is slowly but surely funding might leach away.

Chairman: Could I thank all of you for coming along and helping us with this inquiry.

Witnesses: **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, gave evidence.

Chairman: Good morning. Could I welcome you to this third evidence session on our inquiry into Dental Services. I suppose I have an interest to declare here; one of the witnesses is my personal NHS dentist.

Jim Dowd: A chance for you to inflict some pain in return!

Chairman: No quips about "you can rinse your mouth out between questions" or "please take a chair", but I just thought I ought to declare that. We are going to start by talking about access, which has been the Government's big issue in relation to the new contract, and Peter is going to start with the first few questions.

Q508 Mr Bone: My questions really are for Margaret and Sarah, and perhaps I should say I am very pleased that you have come and put your head above the parapet because I understand some dentists were concerned about coming and giving evidence to this Select Committee for fear of retribution from their PCTs, so it is very courageous of you to come. Access seems to me to be one of the crucial issues and we are getting different sorts of views expressed about access across the country. Have you taken on more NHS patients since the contract has come into force?

Ms Naylor: We have always taken on new patients. There has never been a pause in either of the practices where we have not taken on at one of the practices new patients, so we have just continued to take on new patients. The new contract has made no difference to us with regard to access.

Q509 Mr Bone: Right, so you are an NHS practice; you had the capacity to take on new patients; you have continued to do so; and it really has made no difference in your area?

Ms Naylor: It has made no difference to me.

Q510 Mr Bone: In your area have you seen some NHS dentists going over to private patients since the contract has been brought in?

Ms Naylor: Very few. A small proportion of single-handed dentists. The PCT would be able to give you the exact figures.

Q511 Mr Bone: But very small in your area?

Ms Naylor: Yes.

Q512 Chairman: What area is that?

Ms Naylor: I am a general dental practitioner in Rotherham and in Sheffield.

Q513 Mr Bone: Sarah, what about yourself, the same sort of questions: have you been taking on more NHS patients or fewer?

Ms Elworthy: I have had a slight increase in the number of patients that I have taken on.

Q514 Mr Bone: Do you do private work as well?

Ms Elworthy: Yes, I see adults under the private contract and children under the National Health Service up to the age of 18.

Q515 Mr Bone: Right, so you do not have any adult NHS patients?

Ms Elworthy: No.

Q516 Mr Bone: This is one of these problems where we come to working out whether you are an NHS dentist.

Ms Elworthy: I think I read in Derek's report that all dentists are private practitioners but some dentists have NHS contracts. I consider myself a general dental practitioner and I have an NHS contract to treat children.

Q517 Mr Bone: One of the things we are getting slightly hung up on as a Committee is whether we are increasing the number of NHS patients, but perhaps

we are looking wrongly at that; should we just be saying is there a greater number of patients being seen either privately or on the NHS? Is it the total number that we should be looking at rather than getting very hung up whether the number in the NHS is going up or down?

Ms Elworthy: I do not know. Right from the beginning of the change in the contract I wanted to talk to the PCT about increasing access for adults, but with my business model and the model that they came up with, it just was not financially viable for me to take on adult NHS patients.

Q518 Mr Bone: Just going back to you Margaret, obviously Sarah has a system where the adults are private and the children are NHS; is that the same in your practice?

Ms Naylor: No, over 95% of my patients are NHS, both adults and children.

Q519 Mr Bone: Sarah, which area are you?

Ms Elworthy: I am in Cranbrook in Kent.

Q520 Mr Bone: Do you know if your PCT has a waiting list for NHS patients?

Ms Elworthy: I have a waiting list for NHS patients.

Q521 Mr Bone: You do?

Ms Elworthy: Yes.

Q522 Mr Bone: Do you know the number?

Ms Elworthy: No, I am sorry, but I could get that for you.⁶

Q523 Mr Bone: So in your particular case the patient applies to your practice to become an NHS patient and you say, "At the moment we are full"; is that the way it works?

Ms Elworthy: Yes. I have allocated funding for my child patients.

Q524 Mr Bone: This is children we are talking about in your case?

Ms Naylor: Yes, nought to 18 years.

Q525 Mr Bone: So you have got a children waiting list. Adults you can take on or are you full as well?

Ms Elworthy: There is a bit of a wait.

Q526 Mr Bone: So in terms of access there are people waiting just in your practice alone to get treatment?

Ms Elworthy: To be seen.

Q527 Mr Bone: What about you, Margaret, I think you have said you do not have a waiting list.

Ms Naylor: We do not have a waiting list.

Q528 Mr Bone: Because you are able to take people on.

Ms Naylor: Not always immediately. We may make them an appointment in two or three weeks but they will be given an appointment, they will not be put on a waiting list.

Q529 Mr Bone: It is a little concerning that people are still waiting to get treatment; how do you view registration, was that better or worse than the current situation?

Ms Naylor: I think registration was probably better for the patients because they had a sense of belonging and saying, "That is my dentist," and patients still believe they are registered and even though it is gone they say, "I am registered with you," so I think registration was better for the patient. With regard to the dentist, I do not think it really made any difference. I am quite happy not to have registration because what it does mean is that if we have any patients who have wasted a lot of time, once we have finished their course of treatment we have no onus on us to take them back on as a patient.

Q530 Mr Bone: Sarah, what about you on registration?

Ms Elworthy: I feel registration is very important, for one thing just for managing the workload so that I know how many patients I need to allow to care for, and the other is for the continuity of care model. Preventative dental practice is built on long-term relationships with patients and a course of treatment is not a finite thing: you may find somebody presents with no problems say at four years old and then it is educating the parents and the child to make sure they stay that way as they develop because they are going to get more prone to decay.

Q531 Mr Bone: You think preventative treatment would help if you had registration?

Ms Elworthy: I think long-term relationships with your patients are important.

Q532 Mr Bone: You are of course talking about children.

Ms Elworthy: And adults as well. People expect that. They come to our practice and they say, "We would like to register with your practice." You can talk to them until you are blue in the face that you are not allowed to keep a register and they just say, "Can I register?" and they think you are their dentist and they come back to you. Some people do not attend regularly but they still think of you as their dentist. I do not have an issue with that. I am always pleased that people come back because it is another opportunity to maybe help them become more regular attenders.

Q533 Stephen Hesford: I have a question really to Sarah. When did you cease to see adults for NHS treatment?

Ms Elworthy: I set my practice up in Cranbrook 12 years ago and I ceased seeing adults under the National Health Service when the contract was changed previously, I think it was 1992. In the practice at that time I continued to see exempt adults

⁶ Note by witness: I currently care for approximately 880 child patients, pre April 2006 this was 850. The waiting list is 46. The most recent children to come off the waiting list had been waiting for 6 months.

and children and then when I set my own practice up I made a decision that I could not continue to see adults as exempt adults because of the financial restrictions. I used to have no restrictions on seeing children.

Q534 Stephen Hesford: Is there a waiting list for your private adults?

Ms Elworthy: Not so much a waiting list but it is quite a few weeks to get an appointment and I am beginning to think that may become an issue because I do not want to have too many people expecting me to look after them. I would rather have a smaller group of people that I look after really well; you cannot please all of the people all of the time.

Q535 Stephen Hesford: And your pattern of taking on, has that changed at all since this change of contract?

Ms Elworthy: Sorry, pattern of taking on?

Q536 Stephen Hesford: People wanting to come to you as an adult to receive care at your practice?

Ms Elworthy: I think people are pleased that I am still offering NHS care for children because some practices in the area are not offering NHS care for children, so that is a factor, yes.

Q537 Stephen Hesford: In my area, the PCT will not let someone do NHS children and private adults because they see that that is a kind of loss leader, that the reason practices want to do NHS children is to get the adults in, and so my PCT will not allow that to happen. What is your comment about that?

Ms Elworthy: Well, in my experience in my practice, if the adult patients were not happy with what they were receiving then I would not have so many adult patients. The ratio of child to adult patients is relatively small. I may see a mother who wants to register her children but then she will say to me, "I would like my husband to come to you," or, "I have recommended my sister-in-law", not because they feel they have to because I am seeing their children but because they genuinely like the service I provide.

Q538 Dr Taylor: This is absolutely fascinating because we are getting a picture of a north/south difference and I want to really try and explore how you negotiated your contracts with your PCTs. Sarah, from what you have said you could only negotiate a contract for children's care under the NHS because the contract you would have got for adults just would not have—

Ms Elworthy: I did not have an existing adult contract. When they changed the contract—

Q539 Dr Taylor: Did you try to negotiate one for adults?

Ms Elworthy: Yes, I asked what was available and what was available would not fit into my business model.

Q540 Dr Taylor: And was it purely and simply they were not prepared to pay what you required to provide the service?

Ms Elworthy: Yes.

Q541 Dr Taylor: So they have gone for a cheaper service than you would have provided for adults?

Ms Elworthy: I cannot comment on the adult service because I have not provided an NHS adult service.

Q542 Dr Taylor: Can you tell us who is providing the adult service in Cranbrook?

Ms Elworthy: Nobody.

Q543 Dr Taylor: Nobody?

Ms Elworthy: I believe one of my colleagues is still seeing some exempt adult patients.

Q544 Dr Taylor: Right. Margaret, obviously it was much, much more satisfactory for you and you were able to negotiate a contract for all of dental care. How did that go?

Ms Naylor: We are committed to NHS dentistry and we have been since the inception of our practices so we have always worked within the NHS. We were one of the pilot schemes for the first PDS, which bears no relation—

Q545 Dr Taylor: How did you persuade your PCT to accept your prices?

Ms Naylor: I do not think it was a question of persuading. I think that the PCTs, along with advice from the LDCs, gave us a price which we found acceptable.

Q546 Dr Taylor: You have said in the first few comments that really the new contract has made no difference to the way you work and yet in your submission you are really pretty damning of the contract because you say that the tendering process that favours the cheapest tender may provide low-quality treatment, the variability of UDA values penalises some dentists, *et cetera*, yet you have managed to work within it?

Ms Naylor: I do think all those things. To go through them point-by-point, the contract does penalise dentists that work in a poor socio-economic area with no fluoride because we will always be doing more courses of treatment, but it is early stages and we just have to see how this goes. We really had to take what contract was offered to us and see how it went. There was no pilot for this.

Q547 Dr Taylor: We do realise that.

Ms Naylor: And they gave a figure which we felt we could work with, but that was our practice. There may be other practices in the area that are being paid less or being paid more than perhaps are happier or less happy.

Q548 Dr Taylor: Is it publicly known in an area what a UDA is valued at for the different practices?

Ms Naylor: I think so.

Q549 Dr Taylor: And within your area are they different?

Ms Naylor: Yes.

Q550 Dr Taylor: Markedly?

Ms Naylor: I cannot be definite, I cannot remember but it would be about £20 for some UDAs and will go up to about £28 for other UDAs. In different areas, for example in Macclesfield, there are dentists that are getting in excess of £40 per UDA and in Lincoln it can go down to as little as £16 per UDA.

Q551 Dr Taylor: We know that there was a test period that the UDAs were calculated on but how did it end up they were so widely different?

Ms Naylor: I never really understood that because we did not move from the old GDS system to the new contract. We had an intermediate step of what was laughingly called a pilot scheme. I am not quite sure how they historically got to it. I think what they did was they looked at what dentists had done in the past and whether they were a high crown/high volume/high value dentist and based their figures on those, so if you did very little crown work or bridge work and you did small fillings then you would be paid less.

Q552 Dr Taylor: Right, yes. Moving on, Sarah, I think it is in your submission that you say PCTs have a poor understanding of dental practice. Can you give us examples of that and how it affects you?

Ms Elworthy: Yes I have minuted the meeting I had with two people from the PCT. This was because I was not achieving the UDA values that I needed to achieve and I asked them for guidance. I said, "We are following the clinical protocols of good modern preventative dentistry and I do not see how I could increase my UDAs without compromising patient care." A couple of things came out of that. I had been looking at a CD-ROM *Improving oral health with the new dental contract: making the new contract work for you* and there was no mention of how to improve your UDAs on that (because that was what I was looking for) and when I asked the two gentlemen from the PCT what they thought about it, they had not even seen the CD and they did not know anything about it, so that was not particularly helpful. I also found it quite interesting that one of the gentlemen from the PCT asked why I felt it should be clinical guidance that I needed to increase my UDAs in changing clinical practice and I did feel that I would rather take advice from a clinician on how to change my clinical practice than a non-clinician.

Q553 Dr Taylor: Is your PCT one that was reorganised not that long ago?

Ms Elworthy: To be honest I do not know.

Q554 Dr Taylor: Is there a consultant in public health in the PCT?

Ms Elworthy: Yes, a very good consultant and I do know that he has been very supportive. I have to say although that was quite negative about my PCT, initially, if you go to back to implementation, I was aware the new contract was coming in and I decided to be proactive and I went to the PCT before the new

contract came in. In actual fact, I wanted a PDS scheme and I was all set up—I think it might have been similar to something that you would have had, Margaret—to do that and then there was a general election and as I was about to sign a contract, the PDS scheme disappeared. We had made all the planning and all the set-up and Mr Chris Allen, who is the Public Dental Health Consultant for Kent was very supportive, I believe, when he was told of our bid. I am not completely against the PCT; I just feel they have got a very difficult job to do, and if they do not understand about dentistry it is going to make it even more difficult.

Q555 Dr Taylor: Margaret, did your PCT do better?

Ms Naylor: I think that both the PCTs I work for are pretty good and we have always had a lot of support and they have always been very approachable.

Q556 Dr Taylor: Margaret, I think it was in your submission you said that when PCTs have gone to tender for additional UDA provision they have often had multiple bids and had to select a preferred provider. This has usually been at the lowest price and this is where sometimes they bring in non-UK personnel. Is there any evidence that these people do not provide the same quality of care?

Ms Naylor: There is no evidence that they provide the same standard of care.

Q557 Dr Taylor: How do we get round that?

Ms Naylor: What concerns me is that a UK graduate will spend five years in dental school and everything will be checked by the GDC. They will come out of dental school and they cannot work in an NHS practice unless they have done a year in an approved practice with someone that has got the experience to guide them.

Q558 Dr Taylor: To know if they are okay.

Ms Naylor: To mentor them and to make sure they are okay and that they are not a danger to the public and that they provide good care.

Q559 Dr Taylor: So your worry is that these people are probably not trained to the same extent and not vetted afterwards?

Ms Naylor: Yes.

Dr Taylor: Thank you very much.

Q560 Chairman: Just one thing, when we were talking about UDAs and how much PCTs pay for UDAs, you said there are different rates in different PCTs maybe from one practice to another. Are there any differences within practices where you have got more than one dental practitioner?

Ms Naylor: There may be but I do not know of them.

Q561 Dr Naysmith: I was just going to bring Mr Watson in. You were nodding just now when you heard that question. Can you answer the Chairman's question?

Mr Watson: The UDA value was achieved originally by looking at dentists' historical treatment patterns, so if you take two dentists one of whom for example

did several fillings in an average course of treatment and another dentist who perhaps did just a check-up and one filling in an average course of treatment because their patients were in general a lot healthier or perhaps because they were in the different area, the UDA values were derived simply by dividing the money for the average course of treatment by the unit value for that course. For the average course it would be three units for a band 2 course. Stick with me because once you understand this, it is the key to a tremendous amount.

Q562 Dr Naysmith: We are all slightly mixed up about this.

Mr Watson: Your first dentist for example, who would have been paid on average £90 per course, will end up with a UDA value of 30 per UDA because there are three UDAs so it is £90. Your other dentist who might have done £30 worth of treatment in an average course will get £10 per UDA because he on average does less per course.

Q563 Dr Naysmith: Can this be related to the quality of care provided in any meaningful way or is it just someone who works more quickly?

Mr Watson: It was related to the amount of care provided. It was designed to give dentists who historically did more treatment per course more money to pay for it, but the problem is that the dentist who generally does very little per course because his patients are healthy has no potential to improve and cut down on the amount of treatment he does, whereas the dentist who used to do ten fillings on every course immediately starts doing far fewer. There are all sorts of disparities but in answer to the question, yes, it is quite possible that dentists will be earning different amounts per UDA even within the same practice, yes.

Q564 Sandra Gidley: It was that point I wanted to pick up on because you said their workload is probably different because they have got a different cohort of patients who are healthier or in a different area, but to have the quite stark anomalies in the same practice that we heard about last week does seem to be a flaw in the system. How can two dentists within the same practice have such starkly different UDA bands?

Mr Watson: Because they will have different historical treatment patterns, so for example you may well have a practice owner who has been in situ for 20 or 30 years who has a number of patients who have been seeing him for 20 years who are very well controlled. He may have an associate who sees all the new patients—and this again is an issue with this contract—and the patients who come to see him will have very high treatment needs and therefore he is going to require a high UDA value to be able to deal with those patients that he has historically had to deal with.

Q565 Sandra Gidley: Should that not change over time though as they die off—which is no fault of the dentist I hasten to add!

Mr Watson: To a certain extent it is a facet of the three-year transitional period because post-April 2009 there will be some normalisation of UDA values. Once primary care trusts cease to have to pay units for historical reasons and they start to move into commissioning, they will then seek to commission, and the levels at which they commission will normalise, for want of a better word.

Q566 Sandra Gidley: That is going to be a nightmare presumably because all of those who will lose out under that will leave the NHS yet again, so we are going to see a further exodus of NHS dentists in the future possibly.

Mr Watson: We are for that reason and for a number of other reasons very worried about what might happen in April 2009 when the earnings guarantee comes to an end, yes.

Q567 Dr Naysmith: That was very helpful, Mr Watson, we can get back now to the couple of points I was going to raise with you out of your written submission. Why did you state in it that PCTs have a strong disincentive to expand provision?

Mr Watson: For two reasons. First of all, the intention of the contract was to expand provision in areas of high need and to put it bluntly, patients in high need tend not to contribute towards the cost of their treatment and, secondly, because during the period of the pilots, prior to April 2006, the Department of Health underwrote the patients' charge revenue for the pilot schemes and they basically said, "If we have got the calculations wrong and we have overestimated or whatever, we will underwrite any loss," and that guarantee finished on April 2006 so primary care trusts and local health boards no longer have that. Also in April 2006 the dental budget became limited. For the first time a limit was set on it and so primary care trusts who wished to expand provision have two problems. First of all, they are coming up against this budgetary control which they did not have before and, secondly, if they try and put provision where they would really like to in areas of high need, they suffer financially for it.

Q568 Dr Naysmith: So the so-called pilot was not really a pilot at all for what was about to happen?

Mr Watson: There were a number of pilots which paid dentists in various different ways but, as you have heard from various different people, 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. There were some technical problems with that relating to patients' charges because the regulations prior to 2006 prohibited patients paying for their NHS dentistry in one way in a pilot area and in another way in another area so there was no piloting of patients' charges possible. It is likely that it could not have been piloted in its exact form but a lot of people feel that it was not piloted in any form.

28 February 2008 Ms Sarah Elworthy, Ms Margaret Naylor and Mr Derek Watson

Q569 Dr Naysmith: Could I ask you a different question. Does it concern you that the Department will not be conducting the survey of adult oral health that it used to carry out every ten years?

Mr Watson: Yes, we are very concerned about that.

Q570 Dr Naysmith: If so, can you tell us why?

Mr Watson: Because the effect of the contract, and it is something which was telegraphed well before the contract came in, was that it was going to depress the amount of treatment that was being provided, and in fact to a large extent that was intended by the Department of Health. At the time they had a problem of access and without wishing to throw a tremendous amount of resources at the problem, they had a difficult trade-off to make, and in the contract what they did was they traded off more treatments for less fillings, if you see what I mean, more courses of treatment each containing less, so for the patient going along to the dentist the good news was that they were more likely to be able to see a dentist and have a course of treatment but the bad news was that that course of treatment was going to contain less than it had done prior to April 2006. Because we said this would have an adverse effect on oral health we were obviously looking towards the data that they were going to collect to be able to see whether or not it had had a positive or negative impact. Of course we were very disappointed to find that they had for the most part ceased all collection of data post April 2006. In that data vacuum, which is something that the primary care trusts have felt acutely as well, the only thing we really had to fall back on was the certainty that in 2008 there would be a survey of oral health of the country and in fact if the system was a bad system, then it would show up. It may be slightly too early for it to show up but it would show up in that survey, so when we heard that the Department of Health had cancelled data collection right up to and including the ten yearly survey of adult health, we were very disappointed, yes.

Q571 Dr Naysmith: Just finally, you said it was telegraphed and they were going to balance this conundrum by doing less treatment within a course of treatment. How was it telegraphed? What do you mean by that?

Mr Watson: What I mean when I say that is it was possible when the regulations were in their draft stage to do a reasonable amount of analysis of the system and its probable effects, and the probable effects of the contract were known, I would say, as early as April 2005 because, if you remember, it was due for introduction in April 2005 and it was then delayed six months and then delayed another six months so in effect it was delayed for the year, so probably 12 to 18 months before it was introduced, we had pointed out to the Department of Health the problems that they would have with it. When I say it was telegraphed, what I mean is that they had lots of notice of problems that we feel they subsequently have discovered for themselves.

Dr Naysmith: Thank you very much.

Q572 Sandra Gidley: A couple of practical questions to Sarah and Margaret. Sarah, you have already partly answered this because you referred to having trouble meeting your UDA targets. Did you actually meet your UDA targets for 2006–07 and how is it going this year? What action has the PCT taken? In your case, Sarah, it would appear to be nothing. I do not know if there is anything further you want to add?

Ms Elworthy: I did not meet my target for 2006–07. The last meeting I had, which I was talking about when I asked them to help me how to achieve my targets, I have not really had a response from.

Q573 Sandra Gidley: Was that in the 2006–07 year or this year?

Ms Elworthy: The last meeting was in January this year. No, sorry, that was in January 2007—no, that is not right. What I remember is that since last October I have not heard anything from them.

Q574 Sandra Gidley: Okay, so you have had no practical support from your PCT?

Ms Elworthy: They are not asking me about my UDAs and I am treating my patient base.

Q575 Sandra Gidley: Do you think PCTs should be tracking this a little more?

Ms Elworthy: They do not seem to be able to help me achieve my UDA targets.

Q576 Sandra Gidley: Margaret, how about you?

Ms Naylor: We met our target in the first year and we expect to meet our target this year.

Q577 Sandra Gidley: So you have not had a problem? Was that always the case that you were going to meet them or did it look as though you were going to fall behind at one point and you have had help?

Ms Naylor: We were certainly worried when we originally started and we did take on additional dental support, we had an additional dentist start with us.

Q578 Sandra Gidley: So you paid quite close attention to how it was going from an early stage?

Ms Naylor: Yes.

Q579 Sandra Gidley: A question to both of you again: do either of you now provide fewer band 3 treatments than you did before the new contract and, if so, why?

Ms Naylor: I cannot tell you because I do not have that data. In order to find out I would have to go through all the old lab invoices to find out how much we have done because whilst we have it on the computer it is not easily accessible because of the way that we send forms off now. You are either band 1, band 2 or band 3, and we have no idea what we do in each of those bands.

Q580 Sandra Gidley: Let me put it another way: have you noticed any difference in the way you might provide treatment to people particularly in the more

complex band 3 treatments? Have your decisions and your options been changed by the financial restrictions upon you in what you have to do with band 3?

Ms Naylor: No, I do not think so. I think in an area like ours where there is a high dental need and a lot of patients, we have always looked carefully at what the patient needed and not done extensive work which may be unnecessary, like providing crowns on teeth which have no opposing teeth (you provide a crown at the back and it does not actually bite on anything). We have never done things like that. I am not sure it has made any difference but I cannot be definite.

Ms Elworthy: Because I treat children under 18 then it does not really feature.

Q581 Sandra Gidley: It does not really apply.

Ms Elworthy: Because I am really trying to prevent and conserve and unless it is acute trauma, and I can only think of two teenagers that I have had to supply replacement teeth to.

Q582 Sandra Gidley: We have had suggestions put to us that some dentists have been referring the more complex and difficult patients to the hospital because they do not feel the UDA system rewards them adequately. Would you have any sympathy with colleagues who do that?

Ms Elworthy: Totally.

Q583 Sandra Gidley: Margaret?

Ms Naylor: It is difficult. The phrase “swings and roundabouts” keeps coming up but if you are getting all the swings and none of the roundabouts then you may feel that you want to refer more, if you get particularly complex cases.

Ms Elworthy: You talk about UDAs influencing your treatment decisions—the way I set my model up was because of my historical knowledge of my clinical requirements, I knew how much surgery time I needed. I had been in the area for a while and I had a stable pattern of treatment, so once I knew what my finance was for the year (because that is one of the good things about the system, a regular monthly income) I now set certain amounts of surgery time for myself and my therapist and my hygienist and my oral health educators for looking after the children. We did judge that about right. When somebody walks through the door to see me I am not thinking, “How many UDAs will this generate?” all I am thinking is, “This person has got an appointment booked with me in my NHS clinical time; what is in the best interests of this patient for their treatment?” and we provide it. We have been monitoring our hours and this is when it can get very tricky because I am seeing children coming off the waiting list who have not had access to dental care for many years so I am now getting things like decay into adult teeth and even into the nerve in the first molar teeth, which is very difficult to manage and more time-consuming and of course will impact on the amount of surgery time that I have got to allow for.

Q584 Sandra Gidley: So you are starting to see a more complex case mix coming through in what was previously quite simple?

Ms Elworthy: Yes, and with our prevention, once they were rolling along we were not having people coming back with decay.

Q585 Sandra Gidley: It is interesting that you are doing a lot of prevention and you are struggling to meet your UDAs—

Ms Elworthy: It is, is it not?

Q586 Sandra Gidley: Because it has been put to us that there is not space for adequate prevention in the new contract. Do you think the balance of the UDA system is right or should it be modified in some way?

Ms Elworthy: I have to say when I set up the PDS scheme I allowed for the amount of surgery time that I knew I needed for my steady children base and I have not considered or thought how the UDAs work because I knew from the beginning, I could tell by modelling it on my patient base, that I would not get my UDA target. I made that clear to the PCT right from the very beginning.

Q587 Sandra Gidley: Have you any suggestions as to how the UDA system could be modified?

Ms Elworthy: Listening to what people were saying earlier I think that it is a way of counting units of something, and obviously measurement is important, but there are different ways of measuring, and I think it needs a variety of things, I am talking about patient satisfaction surveys and quality assurance-type things. It needs a range of measurements.

Q588 Sandra Gidley: Margaret, would you like to see the UDA system modified in any way?

Ms Naylor: Yes I think so, in the same way as my colleague has oral health educators and therapists, we do as well, but I feel as though that is coming from us. We visit schools and playgroups with the oral health educators but that is our initiative; it is not an initiative from the PCT, so I think it would be nice to have it acknowledged if you are doing (as it should be being done) oral health education and also looking at diet.

Q589 Sandra Gidley: Derek, I have not included you in any of the other questions but, from your perspective, how would you like to see the UDAs modified?

Mr Watson: I think there needs to be a very quick adjustment to five or eight bands instead of three. To get every possible type of dental treatment into one of three bands was really going too far the wrong way. It would not necessarily have an impact on patient charges because you could take the band 2 and split it into band 2(a) and band 2(b), where the more complex intermediate restorative work would go into band 2(b). The patients' charge would be the same, it would be a band 2 charge whether it was 2(a) or 2(b) but at least it would give dentists faced with a patient who needs a reasonably large amount of work within band 2 to do it because it would come

into band 2(b). What that would mean is instead of having a flat rate three units for band 2 you could perhaps have two units for band 2(a) and four units for band 2(b) so there would be a little bit of balancing of the units to be done. Similarly with band 3(a) and 3(b) where someone having one crown done would go into 3(a) and someone having two, three or four crowns would go into band 3(b). Instead of having a flat rate 12 units for band 3 you could have perhaps seven units for 3(a) and 15 units for 3(b). That is a simple thing which could be done very quickly. It is probably a little bit late for 1 April now but perhaps by 1 October, and it would go a tremendous way towards relieving the stress on the system to try and make it work.

Chairman: Jim, did you want to ask a question?

Q590 Jim Dowd: Well I did want to but Stephen asked one of my questions and Sandra asked another one of them! Can I just check with Ms Elworthy, the Cranbrook in which you practise, this is the one near Staplehurst with the golf course?

Ms Elworthy: That is right, yes.

Q591 Jim Dowd: Which is also one of the most prosperous parts of Kent, is it not? You may not be one of the most prosperous residents, but when Richard said he was noticing north/south divisions here, it is a far more complex arrangement. I do not know about Dinnington, Chairman, I am sure you do, and I do not know if you have a golf course and it is the most prosperous part of Rotherham. You say in your submission that you find under the terms of the contract it is impossible to provide "patient centred effective dental care for children." Why do you say that?

Ms Elworthy: Because of the UDA system. For modern effective preventative dental care UDAs do not add up.

Q592 Jim Dowd: Despite your previous response to Sandra about whether they should be reformed, your view is really that they should be abolished?

Ms Elworthy: I am only talking about treating children. That is my area of National Health Service dentistry.

Q593 Jim Dowd: Where do adults in Cranbrook go who want an NHS dentist, Tunbridge Wells?

Ms Elworthy: Not in Cranbrook.

Q594 Jim Dowd: Where would they go; you have no idea?

Ms Elworthy: I do not know. We get a lot of phone calls and we refer them to NHS Direct.

Q595 Sandra Gidley: I think what I was planning to ask has partly been covered, it was about preventative care, and you alluded to that earlier, and I think Margaret picked up on that. I would be interested in what sort of preventative care you think ought to be provided as routine and how that can be incorporated into a decent system.

Ms Elworthy: I just want to refer back to what you are saying because most of the stuff that we do is only band 1. What you were saying about the sorts of things we want to do, for instance, for a child who comes in before the age of six, we will be wanting to take x-rays at about six when their adult molars are starting to erupt, and we would be wanting to apply fluoride varnishes to any vulnerable teeth, and we would want to apply fissure sealants to erupted first molar teeth. The evidence is very strong on how effective that is in preventing decay. All those come under band 1 treatment, so I could see a child and their mouth appears dentally fit and they can go out the door, or I can see a child, do all the preventative measures and I can send them to my oral health educator for instruction in tooth brushing, making sure they are using the right toothpaste and brushing twice a day, and still only get band one that is one UDA. All these very basic health messages which do need to get through to all ranges of society. Cranbrook is a middle-class area but we do have people, and I treat them, from lower socio-economic groups and we do care for them. We are not comfortable with this situation. I do not want to be in it. It is why I am here; I would not have bothered writing otherwise. I could have turned private if I wanted to, as you say, it would not have been that difficult. All the things that we want to do—and I will send my form off and still get one UDA, the same amount of money.

Q596 Sandra Gidley: Margaret, what type of preventative care do you think dentists should be providing?

Ms Naylor: I agree with my colleague. We should be providing for children at risk of all those things. If I have nice middle-class children who I know have a good diet and you can see that their oral hygiene is good, I can see the family is motivated and they will always look after their teeth, there is no point in doing fissure sealants unless there is a clinical reason. I think we probably take more of a judgment on it in the NHS but of course we see the cases of real dental deprivation in our area where almost every tooth in their head will be carious.

Mr Watson: There was no prevention under the old system and there is really no prevention under the new system. The idea that this 5% reduction in workload was going to free dentists up to do prevention is just fanciful. That 5% was more than outweighed by other changes which took that 5% up straightaway. My view and the view of the Association—and it is in our submission—is that there are systems which encourage prevention and they are systems within dentistry which have been well-demonstrated to produce oral health gain. It is no use measuring fillings, it is no use measuring courses of treatment, it is no use measuring patients' visits as it does in the strategic framework now. You have to measure and purchase oral health gain, and the best way to do that in dentistry is to have a system of registration, to make dentists accountable and responsible for the oral health of that cohort of patients, and lastly, as I say, you have to give them

a financial stake, let us not beat about the bush, in any oral health gain made. If you did that, you could revolutionise dentistry and prevention in dentistry.
Sandra Gidley: Right, thank you.

Q597 Dr Naysmith: Mr Watson, you have been very helpful in suggesting ways of doing things this morning. How would you organise this financial stake in preventative dentistry?

Mr Watson: I will very quickly illustrate the two situations. At the moment if there is a certain level of disease in your patients and, let us say, you go out of your way to make them healthy and as a result many of them who would have had band 3 treatments end up having band 2 treatments and the band 2 patients end up having band 1 treatments, basically you are going to fail to hit your UDA target, that is what it boils down to. I think it has been amply illustrated that the very good dentists who really go the extra mile for their patients are really struggling under this system. The dentist who is a good preventative dentist is seen by the primary care trust as a failing dentist, one who has failed to hit their target. Under a system where a dentist was allowed to retain some of the money saved, let us say a dentist had £10,000 worth of treatment that was done on patients and because he is a good preventative dentist he then cut the cost of treating those patients down to £8,000, at the moment what happens is, as I say, that money will be clawed back. If you said to him, "For every £2,000 you save I will let you keep £500 and we will have £1,500 back to put into the general budget," that sort of system works.

Q598 Dr Naysmith: How are you going to measure it?

Mr Watson: You can do it on a population basis but it is not that difficult to categorise every dental patient into an oral health category. That is how it works in the modified capitation plans. You literally put every one of your patients on a scale of A to E, where A is great and E is a dental disaster, or you can give them a numerical value, and you just add the numbers up at the beginning of the year and you add the numbers up at the end and you can see how much they have improved.

Q599 Dr Naysmith: In your submission you also talked about a co-payment system as a possible mechanism in organising dentistry in the future. How would that work and in particular how would it help people under the age of 18 and adults who do not currently have to pay for their oral health?

Mr Watson: For them, things would not change.

Q600 Dr Naysmith: They would stay the same?

Mr Watson: Yes. In the submission we used the word "co-payment" and I think with hindsight that was probably the wrong word because co-payment implies that the patient is contributing toward the cost of their National Health Service treatment. We already have co-payment in dentistry, in fact it was the first co-payment that was brought in in the National Health Service.

Q601 Dr Naysmith: It could have been called a voucher system.

Mr Watson: I think the best way to think about it is direct payment, in the same way as already occurs in social care, so for example, let us take the example of someone who is being cared for by a relative at their own home but has to go into residential care for periods of respite care, what will happen is that person will be given a nominal amount, either directly or indirectly, to go into respite care and that will be adequate to go into respite care in a facility which has been inspected and is regarded by the primary care trust as adequate. Should that person choose to go elsewhere, it is understood that they will then pay the balance themselves and that is direct payment and that really does free people up to take their NHS subsidy wherever they like. The way it works is that if a patient goes to a dentist and under the present and future rules is exempt, they would simply self-certify as they do at the moment. If they go to a dentist and they are not exempt, then first of all they are free to go to any dentist they like and they can either complete the NHS form as they do at the moment, in which case the patient charge is netted off the dentist's remuneration or, as happens in other countries such as France, they take a statement from the dentist as to what has been done to the local post office and they get reimbursed through the local post office.

Q602 Dr Naysmith: I wanted to ask Sarah Elworthy about something that is maybe related to this in a funny sort of way. Do you treat any children as private patients?

Ms Elworthy: Yes.

Q603 Dr Naysmith: Is there any difference in the treatment that the two get?

Ms Elworthy: No.

Q604 Dr Naysmith: None at all?

Ms Elworthy: Sometimes I do not even know (because it is all happening on the computer behind me) whether I have got a private patient in the chair or a National Health Service patient, other than if I am aware what time of the day it is because I have NHS treatment sessions.

Q605 Dr Naysmith: But there is nothing you can provide doing it privately that you cannot provide under the NHS?

Ms Elworthy: Some parents request non-metal fillings in their children's teeth and we do not provide that under the National Health Service.

Q606 Dr Naysmith: So that is quite an important difference?

Ms Elworthy: Very few, it does not feature a lot.

Q607 Dr Naysmith: But it might be important to the people.

Ms Elworthy: It is important to them which is why they request it but not a lot of people are requesting it.

Q608 Dr Naysmith: Does it make any clinical difference?

Ms Elworthy: The reason we recommend amalgam fillings in posterior teeth is because they last longer.

Q609 Mr Bone: Back to Mr Watson, I am very interested and encouraged in what you have said. We are not supposed to agree because it is an evidence session but I do agree with what you are saying. What has annoyed people in my area is they have had National Health dentists for years and years and suddenly they have all gone and they have to go privately. Most of them will have taken out insurance and what they say is, "I am paying my taxes for the NHS treatment but I am also paying for the insurance." For people who are not exempt for treatment, we have got this very strange situation in the NHS. The NHS is supposed to say "At the point of delivery you do not pay for the service" and that is clearly not what happens in NHS dentistry. Is there not a strong argument to say for non-exempt patients there should not be any NHS treatment whatsoever and therefore everyone should be in the same boat as effectively my constituents are and have to either co-pay as you say or provide some sort of social insurance?

Mr Watson: I think patients regard the provision of dentistry on the National Health Service as part of the compact they have with the Government by which they deduct national insurance, and I think to tell the vast majority of people in this country, the ones who demand treatment as opposed to need it if you like, that dentistry is being taken out of the National Health Service, politically would be very difficult. Obviously I would defer to your knowledge on that. The good thing about direct payment is that it gets round that problem of the patient who says "Why am I paying twice?" because they would not be paying twice.

Q610 Mr Bone: We are basically making the argument in a specific part of the NHS where there is already significant charging that a voucher system would be a more equitable system?

Mr Watson: It would be completely equitable and, better than that, it actually fits in with the patients' collective consciousness on this matter because as a practising dentist myself for over 20 years, patients frequently used to come in and say to me, "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," and we used to say, "You can't just pay the difference," and they would say, "Why can't I just pay the difference?" and we would say "Because you can't pay the difference"! That is all we are asking—that they should be allowed to pay the difference.

Q611 Chairman: Unlike a spectacle frame where you can pay the difference?

Mr Watson: Exactly.

Q612 Chairman: Could I pursue this a bit further with you because in your written submission your Association argues that the state should make a core contribution. Do you see that as being very much the cost of a treatment for a need of a patient in terms of needing help with a dental problem?

Mr Watson: Yes, I think it can be related to that patient's need and it would be equivalent to the cost of them obtaining the treatment from a facility which provides it to an adequate standard, yes.

Q613 Chairman: And the direct payment you are talking about or co-payment is in addition to that if you want something that some people would say would be more cosmetically pleasing?

Mr Watson: Yes, that would be an enhanced co-payment in effect.

Q614 Chairman: You also say in your submission that this could be done, as they do presently, where some dentists would work for core fees for patients who are fully remitted or exempt with one basic NHS service and there would be other practices where patients would need to make a larger co-payment? Why could it not happen in all practices?

Mr Watson: It would happen in all practices, but really the practice which is happy to work for the voucher cost, if you like, is the equivalent of the residential home that is happy to take people for the NHS tariff for that service, but the point is that in being able to reclaim what you are entitled to towards the cost of your dental treatment, you will not have to be restricted to going to those practices who provide that level of service. Technically, if you liked—and this does annoy some people—you could take a voucher to Harley Street and say, "I am entitled to £20 on the National Health Service and I will pay the other £980 or whatever myself"!

Q615 Chairman: Would you say that could potentially be an incentive to have access to NHS dentistry in any part of the United Kingdom, that a dentist would have to operate that system and therefore see NHS patients, including exempt NHS patients, running alongside being able to offer direct payment, you say, for this addition? Do you think your members would be happy for you to say that that is the new system and you will have to accept that?

Mr Watson: I think they would. I think that dentists would be very happy to accept this type of system in the same way as if you have a voucher for your NHS spectacles, lenses or whatever, where you will find that you can generally take that to any opticians. I think there would be very few dentists who would not want to co-operate with a system like this. I would go further and say that if a system like this was brought in I think it would be so popular with dentists that it would probably take dentistry off the news agenda full stop.

Q616 Chairman: Do you think it is a form of the state telling them that you shall see NHS patients, some who are exempt and some who may or may not have great need for care, and therefore would take time in their surgeries when they could be dealing with people who wanted a treatment that they were getting paid more, for want of better expression? Do you think they would easily accept things like that?

Mr Watson: Yes I do and the reason why I say that is the relevant words are cross-subsidy. It is shame Mrs Atkins is not here because I know she was particularly exercised about the issue of child-only lists and stuff. The reason why child-only lists came about was because it became uneconomical in certain high-cost areas to treat adults on the National Health Service, and the way those dentists continued to support those child patients was to cross-subsidise the children from the adults, so they used to take some money from the adult profit and put it towards the loss-making NHS child part. That attitude towards keeping the NHS going at a time when it really was not supporting itself, I think would mean that they would be able to integrate the National Health Service back into their private practices, yes.

Q617 Sandra Gidley: I am getting slightly twitchy about this direct payment idea. You used an analogy with opticians. There was a stage with opticians when the only NHS glasses you could get were something nobody in their right mind would wear until John Lennon made them trendy. Is there not a risk that under that sort of system what you would end up with is the NHS rather cannily deciding here is a solution, it would do the job, but most people would not want that in their mouth, they would want something else that had previously been provided and would it not drive down what the NHS provided?

Mr Watson: No, I do not think it would because children and exempt patients would still require treatment and therefore the amount of state subsidy would still have been to be adequate to provide treatment for those people who could not afford to co-pay. Really there would be a floor on the level of subsidy below which they could not go because then you would find a large number of people who were exempt would then not be able to find a dentist anywhere to do their work and that would not happen.

Q618 Jim Dowd: We had this discussion last week about whether you could buy Dolce and Gabbana crowns if we are going to have that kind of system. This alludes to a question Sandra asked earlier about the differences within practices, I certainly know of practices where some dentists within the practice do wholly private work and some do NHS, so although the practice takes NHS not all the dentists within it do. How common is that?

Mr Watson: It is relatively common, yes.

Q619 Jim Dowd: It tends to be the senior partners who tend to do the least NHS work.

Mr Watson: It tends to be yes because it is the only element of career progression there is in dentistry. If you do not progress in that fashion you end up doing aged 63 the same treatment you used to do aged 23.

Q620 Jim Dowd: But doctors have to do that, do they not?

Mr Watson: I think there is a certain amount of career progression in the medical sector but dentists because they came from a piecework system were literately paid per filling, and the first 100,000 or 200,000 fillings are the most interesting!

Q621 Jim Dowd: This explains a lot to me about dentists. At what age do you become too grand to do fillings?

Mr Watson: Well, you start off doing fillings and then perhaps you graduate to veneers or implants or maxillofacial surgery. I was in practice for over 20 years and for me 20 years was enough, so I had a change. I think you have to accept that dentists are not homogenous as a group.

Jim Dowd: I am delighted to see you were so happy in your work!

Q622 Stephen Hesford: To Mr Watson, I want to bring you back to something you said earlier in terms of the run-up to the new contract. You said there was a sort of lead time around 2005-06 where you could predict what might happen.

Mr Watson: Yes.

Q623 Stephen Hesford: Can you furnish us from your Association the submissions that you made to the National Health Service saying, "We think this is what will happen"?

Mr Watson: Yes we certainly can but I have to add the caveat that we are not formally consulted by the Department of Health.

Q624 Stephen Hesford: If that submission exists because this was your prediction, then could you furnish us with a copy of that because that is what you said to the NHS?

Mr Watson: We certainly did say that but due to a clause in the NHS General Dental Services Regulations 1992 we are pretty well frozen out of any consultation as a stakeholder.

Chairman: Could I ask you where do you think NHS dentistry will be in ten years' time? Who would like to start?

Q625 Dr Naysmith: It is an easy question!

Ms Elworthy: I do not know. I have not thought that far ahead. It cannot go on the way it is at the moment.

Q626 Chairman: I do not know Cranbrook in Kent but the suggestion is that you do not do adult NHS patients now and maybe there is not the demand there because people can afford to go private.

Ms Elworthy: That is not the case.

Q627 Chairman: Do you think that is true?

Ms Elworthy: No.

Q628 Chairman: Do you think the reason why there are some parts of the country that have got large private practices is related to the income of the communities that surround it?

Ms Elworthy: I should think, and it is only my opinion, that it is related to the cost of running a practice in certain areas, the higher overheads, and lack of remuneration from the NHS to be able to achieve that and the type of dentistry that you want to practise. I practise a very prevention-based minimal interventionist type of dentistry that is not rewarded by the fee per item treadmill-type systems.

Q629 Chairman: Margaret, what do you feel about ten years' time?

Ms Naylor: I should be very disappointed if there was no NHS dentistry but I feel that it may just be a core service providing the rudimentary—

Q630 Chairman: Do you fear if South Yorkshire gets richer—and it is getting richer now in terms of all the indexes—that people will move away to private practice?

Ms Naylor: It is not necessarily moving away to private practice. I think people are asking for choice, so they ask for choice in what crowns they have, what fillings they have, and what dentures they have, and if they can afford it they will go for something better, but of course a lot of my patients cannot afford it.

Q631 Chairman: Derek, what is your view of ten years on?

Mr Watson: I think at the moment it is looking worryingly as though it is going to be an extension of the last ten years where we have seen this big gap open up in the terms and conditions available working in the private sector, and if that carries on then I think you are going to see a vastly reduced NHS dentistry service, perhaps increasingly provided by organisations in the third sector or commercial bodies. If the sorts of changes we are talking about were made, I think that situation is wholly recoverable and you could undo perhaps some of the drift away from the National Health Service that has already occurred, but it would need to be genuinely innovative and inclusive thinking and not spraying the money hose around and making things worse, which is what we have seen so far.

Q632 Chairman: You have had quite a long experience of both representing and negotiating I assume. I know the headlines that have grabbed us this morning are not about NHS dentistry, they are about general practice, which in terms of how they relate to the service is not dissimilar to Margaret's practice in as much it is a private small business. Within the GP contract, there are things like the minimum practice income guarantee which takes

into account the bricks and mortar, the capital investment. We do not have that in dentistry at the moment. Why is that? Obviously these are questions we will be asking the witnesses who come next week who have had responsibility for this over that length of time. Why have there been things like that involved in the dental contract?

Mr Watson: I think it is because dentistry is an arm's length service, in effect, to the National Health Service and many people do not realise that whereas doctors tend to have things provided for them, dentists had to buy their own premises and employ their own staff and buy their own materials and really they were just sub-contractors to the National Health Service. They are all private businesses and people did not appreciate that difference. What has happened is that they are now being dictated to in terms of what patients they can see and where they can practise, which if they were within the National Health Service the Department of Health might get away with that, but they are not.

Q633 Chairman: Salaried GPs are, but beyond that GPs are not, they are independent businesses, and they get allowances for extending premises and things like that effectively from the state.

Mr Watson: I think GPs are far more tightly tied into the National Health Service than dentists are. Although GPs like to think of themselves as independent contractors and self-employed, in practice there are very many reasons why they are not.

Q634 Chairman: They are very reliant on the National Health Service whereas we have heard in this evidence session that is not necessarily the case with dentistry.

Mr Watson: And also they have a tremendous amount of public sympathy and support which perhaps the dental profession does not, and they had Hamish Meldrum, did they not, at the end of the day. I think the answer is we are in the Health Service but we are not in the Health Service and people find it very difficult to understand how to deal with that.

Chairman: I hear what you say. Jim?

Q635 Jim Dowd: I meant to raise this earlier. This co-payment system that you did not want to call co-payment, whether it is a voucher system or whatever it is, how do you respond to the charge that the first impact of that will be an enormous subsidy into the private sector, people currently not drawing on NHS funds will suddenly use that as the basic level for their health care, which they may well be entitled to do?

Mr Watson: That literally is just a question of whether or not people who pay national insurance should be entitled to the subsidy which they would otherwise be entitled to.

Q636 Jim Dowd: Dental treatment is not based on paying national insurance otherwise nobody under the age of 16 would qualify.

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Mr Watson: I do not think the patients see it like that and I do not think the public see it like that. I was in the chair, as I say, for over 20 years and I have lost count of the number of people who came in who said, "I have paid my national insurance, I do not see why I cannot get this or that in dentistry."

Q637 Jim Dowd: Should the same apply in education?

Mr Watson: That is another matter for another Committee.

Jim Dowd: Should that apply across the piece?

Mr Bone: There is a very strong case for it in education.

Jim Dowd: You cannot make it!

Chairman: Colleagues, maybe we could have this debate in a later session.

Q638 Jim Dowd: I am talking to Mr Watson.

Mr Watson: I put this idea to the Health Select Committee in 1992 and they had the same objection. They said why should a patient who can well afford to go into the private sector take their National Health Service subsidy with them? That is a matter for everybody to make their own mind up about. There is no doubt that some people will end up benefiting from an NHS subsidy who at the moment

pay the full cost of their own treatment, but my argument is that the compact between the public and the people who charge the national insurance is that they should be entitled to some subsidy in return.

Q639 Mr Bone: That argument that is put to you is fairly made in education, and that is a reasonable point, because there is a state system providing education, but where my constituents have no way of getting state treatment, they are effectively forced to pay twice, once through their taxes and once through private treatment, and that is the difference between that and the education system?

Mr Watson: Yes.

Jim Dowd: I do not think it is at all.

Q640 Chairman: We can have that debate later. Derek, have you got that evidence that was submitted to the Health Select Committee in 1992 or should we get it from the Library?

Mr Watson: I can probably dig it out.

Chairman: I would appreciate you getting it to us. Could I thank all of you very much indeed for coming along and completing what is our third evidence session in relation to our inquiry into Dental Services. It will not be too long now hopefully before we have a report to submit to the Government. Thank you.

Thursday 6 March 2008

Members present

Mr Kevin Barron, in the Chair

Charlotte Atkins
Sandra Gidley
Stephen Hesford

Dr Doug Naysmith
Mr Lee Scott
Dr Richard Taylor

Witnesses: **Dr Anthony Halperin**, Chairman, Patients Association and **Ms Teresa Perchard**, Policy Director, Citizens Advice Bureau, gave evidence.

Q641 Chairman: Good morning. Could I welcome you to what is our fourth evidence session in relation to our inquiry into dental services. I wonder if I could ask you to introduce yourselves and the positions you hold for the record, please.

Ms Perchard: My name is Teresa Perchard; I am Director of Public Policy at Citizens Advice which represents Citizens Advice Bureaus throughout England and Wales.

Dr Halperin: My name is Dr Anthony Halperin; I am the Chair of the Patients Association and I am also a practising dentist although not currently an NHS practising dentist.

Q642 Chairman: Could I just ask you about the Patients Association as an organisation? Is its membership based?

Dr Halperin: Patients can become members of the Patients Association but they do not have to be members to be represented. We represent all patients' interests in this country so I suppose we represent them whether they like to be represented or not in a way. What we are basically looking after is the health and care given to patients in this country, medical, dental, optical and pharmaceutical.

Q643 Chairman: How do you engage with patients? Outside of these hearings I never meet anybody from the Patients Association. I quite regularly meet people in South Yorkshire where I represent—patient advocates and PPIs and different things—but how do you engage with patients?

Dr Halperin: That is a very good point. We were founded by our President Claire Rayner probably about 40 years ago and we have a small office staff and we have a helpline where anyone in the country can phone in with any problems they have. I suppose our main contact with patients is firstly via our helpline and secondly via surveys we carry out not only for ourselves but normally sponsored by groups—ie pharmaceuticals, dental groups, medical groups—who want surveys to be carried out, and therefore we interview patients and give a statistical feedback.

Q644 Chairman: Would you call yourselves a representative body?

Dr Halperin: We consider ourselves a representative body; whether the public see us as a representative body I do not know, but at the present time, since most of the patient groups in this country have

tended to be dissolved or have no longer got the funding, really we are probably the only actual national patients' voice left.

Q645 Chairman: There are organisations that represent people with MS that are representative in that sense. If the MS Society contacted me here in London it is very likely I would know members of their Society from my constituency. Indeed I do and I interact with them but not with members of your Association. When I talk about representativeness that is the type of shape I mean. I do not get any feedback of Patients Association members in the Rother Valley.

Dr Halperin: We do have thousands of actual members who are patients or members of the public, but I suppose even thousands is a small percentage. Most people in the country have heard of us because we are almost constantly in the media representing one form of patient or the other.

Q646 Mr Scott: How do you become a chairman? Do the members vote you as chairman?

Dr Halperin: There was an appointment made for trustees and I was appointed a trustee about four or five years ago and then when Michael Summers, the former Chairman, stepped down, I was elected as Chair of the Board of Trustees.

Q647 Mr Scott: How many trustees are there?

Dr Halperin: We have about seven or eight trustees.

Q648 Chairman: You have launched this report on NHS dentistry by PCTs, could you tell us who you surveyed and what were the report's main findings? We do have copies of the report but we have not had time to read them; I have your press release from yesterday so maybe you could talk to us around that.

Dr Halperin: The main findings were that there was quite a variation in the answers from PCTs as to the funding they were able to produce, as to the satisfaction of dentists within the PCTs. We had a 75% response—25% of the PCTs did not respond which they should have done under the Freedom of Data Act—and there was considerable concern from the dentists working for the PCTs as to whether or not they were happy with their new contract. The PCTs themselves seemed to be happier with the actions they were undertaking than the dentists. There were concerns with the orthodontic treatment particularly; access was a problem; there was a lack of patient involvement as well.

Q649 Chairman: One of the bullet points in your press release said that there was widespread confusion for patients about access to dental services in their locality. Did you actually survey patients as well as the PCTs?

Dr Halperin: No, only the PCTs were surveyed.

Q650 Chairman: How do you know there was widespread confusion for patients if that was not measured?

Dr Halperin: I have been informed that it came from our helpline enquiries.

Q651 Chairman: Not from the survey that this press release talks about.

Dr Halperin: Not from the survey, no.

Q652 Chairman: A bit further down you say that the Patients Association calls on the Government to “examine the accepted co-payments system for dentistry as the basis for expanding the availability of treatments elsewhere in the NHS eg non-NICE approved drugs”. What has that got to do with dentistry?

Dr Halperin: I personally did not put that part in.

Q653 Chairman: It is just a bit confusing. Do not get me wrong, I actually think that your survey could be quite helpful to the Committee because outside of the department survey of PCTs nobody else has done it. It is quite wide ranging and I am sure that some of my colleagues may want to ask questions about your survey as well. However, it does seem to confuse matters a little bit when we have things like that in.

Dr Halperin: I not necessarily agree with the view of co-payment; not all trustees think the same way.

Q654 Chairman: I was just wondering what the issue about co-payment about NICE approved drugs or non-NICE approved drugs has got to do with dentistry.

Dr Halperin: I would have said non whatsoever.

Q655 Chairman: Let us move on from that. What do you think in general terms your survey revealed about patients’ access to NHS dentistry?

Dr Halperin: I think it varies. The problem is that although we put out these surveys to the PCTs asking for specific responses from a specific person obviously it was not carried out by that person. We are not sure of the level of expertise of the people at the PCTs that responded to our survey. I am not certain that when they say that patients are basically happy with access where that comes from. I am concerned that our survey may not be accurately based on the PCTs having an accurate survey or whether there was somebody just ticking boxes because they felt that was the right answer.

Q656 Stephen Hesford: Just so we are clear, the report was sponsored or your group is sponsored by Denplan and AXA insurance.

Dr Halperin: Yes.

Q657 Stephen Hesford: In terms of your organisation, you sort of exist as a survey organisation, is that right?

Dr Halperin: No, we are a charity. Like all charities we have substantial difficulty existing because of funding. We have always tried to make it a principle that we do not take government money per se because we wish to be completely independent. If you are a cancer charity or an Alzheimer’s charity or whatever then patients relate to that charity. We have a great difficulty representing patients because although we think we do a good job in MRSA and other matters it is not something for which we can go out with a collecting box. Therefore we rely on our funding from sponsors in two ways. Firstly, sponsors such as the large pharmaceuticals, dental companies or building companies become a sponsor with quite a small amount of money. Secondly, on their behalf and in their specific fields, we carry out surveys. So our funding is from carrying out surveys—a little bit like the King’s Fund carries out surveys—and although we are not survey based we rely on surveys as part of our funding. However, we never take any note of who is supplying the money; our surveys are completely independent and that applies especially to pharmaceuticals; our pharmaceutical supporters completely understand that whatever the results of the survey it is going to be published.

Q658 Stephen Hesford: Do you not think if unfortunate that of all the funders that you could have had to help you do a survey on dentistry that Denplan is one of the funders in terms of looking as though you are independent?

Dr Halperin: I used to be a Denplan arbitrator and do the arbitrations for Denplan. I did the arbitrations totally and completely independent. This was 20 years ago and so no longer applies but I must tell you that I have found them to be completely independent. This is not a push for Denplan but of all the organisations they are as independent as anyone; they have never once tried to influence our decisions.

Q659 Stephen Hesford: In terms of your personal position, looking at your biography, you are the Chief Dental Advisor to Guardian Health.

Dr Halperin: Actually that is now an old one. I just advise all the insurance companies. I am no longer a specific dental advisor for them. I act for all insurers but only in the capacity of an expert witness. I have no paid capacity with AXA or Guardian Health.

Q660 Stephen Hesford: In terms of the timing of the launch of your report, I received an e-mail yesterday from somebody called Vanessa Vaughan inviting me to the launch of your report. I e-mailed Vanessa back about this. As a member of this Committee how does your organisation think I could, with credibility, have gone to the launch of your report

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knowing that we are in the middle of an inquiry on dentistry and about to receive your evidence minutes after the launch of your report?

Dr Halperin: We are an independent report; why would you not want to go? I am sorry; I do not understand the question. If we give an independent report I see absolutely no reason why you should not want to hear what it is. I really do not see any connection between the two.

Q661 Stephen Hesford: Your press release talked in these terms: “Katherine Murphy, Director of Communications commenting on the Report said: ‘Patients are taxed more than ever to provide their health services’.” What is the point of that language?

Dr Halperin: You may not agree with the report, but I believe that as an independent observer—we had Ross Hamberg speaking there who actually thought the PCTs did an excellent job and she was very happy with the work of the PCTs; we had opposing views as to whether the PCTs were doing a good job or were not—we always try to make sure that we have a different point of view.

Q662 Stephen Hesford: What is the point in making a comment in terms of surveying PCTs about the issue of taxation?

Dr Halperin: I did not make that particular one so I will not comment on it.

Stephen Hesford: The woman sitting behind you did.

Chairman: Could we move on because she is not giving evidence here.

Q663 Dr Naysmith: I was rather surprised, Dr Halperin, when you were talking about your survey and you said that you were not sure whether some of it might have been people just ticking boxes because they thought they had to or because they thought it was the right thing to do. How reliable and accurate do you think your survey actually is?

Dr Halperin: I think the survey overall is accurate. It can only be as accurate as the answers we get as with any survey. I think it is the problem with any survey you carry out, you just have to rely on the answers you are given, we cannot go any further than that. We have carried out a survey and we have given the response from the PCTs which are nationally funded bodies and hope that their evidence is reliable.

Q664 Dr Naysmith: That does not mean that you can necessarily be certain that every reply is accurate, therefore the figures you have derived from it may not be accurate.

Dr Halperin: I agree but I think you can say on the balance of probability most of them would be correct. This is the problem with any statistical survey, you can only rely on the answers you get.

Dr Naysmith: You have a refreshing attitude to the results of your survey.

Q665 Charlotte Atkins: Teresa, according to your survey 31% of people who had not visited a dentist since April 2006 had been able to find a dentist in their area. By that I assume you mean an NHS dentist.

Ms Perchard: Yes.

Q666 Charlotte Atkins: How does that compare with the situation before April 2006?

Ms Perchard: You have been bombarded with surveys, including from us actually, and I am very conscious in trying to bring them together to see what direction they are pointing in, some things are saying some things more loudly than others. We advise on 6000 dental problems in local citizens advice bureaux face to face and those are split between access and charging issues; those are the two big issues, the inability to find a dentist and charges are also a bit of an issue for people who come to CABx. When we have most recently gone out and asked the public at large in a MORI survey—which are the results you have just highlighted—the charging issue is not so big for the population at large. To pick up on my colleague’s point about surveys, who you are asking and the context in which you are asking can produce a different result. We have done three pieces of survey work, firstly looking at evidence from bureaux in their advice work, that is the 6000 and then nearly 5,000 people who filled in a survey form on line with Citizens Advice; they were using information that we have on line to try to resolve a problem they had so by definition they are not the people on the streets that you might ask to do a MORI survey who have not really thought about this issue recently, they are people looking for information to resolve a problem. For them the issues of access and charges were much more significant than the population at large. Across all of the bits of research that seem to be around, including the Government’s own figures, I would say there is a really strong message pointing to no improvement in access and take up of NHS dentistry.

Q667 Charlotte Atkins: Since the new contract, is that what you are saying?

Ms Perchard: What is driving this? Is it the new contract or is it the way that services are actually being commissioned by PCTs? We think the root of the problem here is that the new pattern of services really is the old pattern of services because PCTs went into the new contract without really going and looking afresh at what the need was, where the gaps are and how to help fill them. That is what we think needs to happen to address this. There has been no redistribution between PCT areas that have adequate access and those that have inadequate access. That is why we have welcomed the Government’s announcement to retain the ring fence over NHS dentistry spend by PCTs (because without a ring fence it might move into other areas of investment) and to increase by 11% the amount for NHS dentistry which is a more significant increase than for PCT spending as a whole. We think that that, coupled with the new duty on PCTs, makes it their duty to ensure that needs for NHS dentistry in their area are met and should give them the oomph and the cash to do their best to match supply to demand. I think what has been highlighted by the Patients Association’s survey, going directly to

PCTs which we have not done, is the variability in the PCTs' approaches. We think that is where more work needs to take place.

Q668 Charlotte Atkins: Your survey rather alarmingly said that 7.4 million people were being denied NHS dentistry. That was based on extrapolation obviously of your survey of just under 2000 adults and given what you said about variability does it make sense to extrapolate 7.4 million just from that survey of just under 2,000 adults?

Ms Perchard: It is a representative survey conducted by MORI, a well-known independent research organisation. Before we published it we had considerable discussion with the Department of Health about the doing of the survey and the conclusions we might draw from it. We asked a number of different questions. There was a bigger question that found that 34% of the population had not been to a dentist at all in the previous 18 months and that might raise questions about the general use of dental services, private or NHS, and whether there is a growing problem with people not having adequate check ups and the implications for preventing dental health problems arising. Of those who had not had NHS treatment—54%—31% of those said it was because they could not find one; 30% said they did not think they needed to go for treatment. The 31% who could not find an NHS dentist is equivalent to 7.4 million people. The Department knew this and did not raise any objections to our conclusion. Of those, 4.7 million went privately and paid. We could have a long debate about whether they should or should not have. Our real concern is the 2.7 million people who went without, who wanted to go the dentist, wanted to use an NHS dentist, could not find one and then did not go private. They did not go to the dentist at all because they could not find an NHS dentist and presumably could not afford or there may have been some distance issues around access as well; it was just not accessible to them. The Department of Health was thinking there were about 2 million people a couple of years ago who were missing out on NHS dentistry and we roughly got the same numbers; there is not a lot of distance between us and the Department about that, 2 million and 2.7 million. I am conscious that there are a lot of numbers in this debate and you cannot stick them all together because they are asking questions of different people in different contexts at different times. We were very involved in the run up to the reform of NHS dentistry; we were represented on the group led by Harry Cayton to come up with a much simpler system of banded charges which means there is a lower limit for charges. We generally backed the direction of travel here on the reform to the contract, the reform to charges and we are very pleased the Government is now putting more money into NHS dentistry and giving PCTs a duty. We want to see that work; we want to see PCTs get on and do a better job than they are doing. Our evidence is provided really to help people see where the problems may be so that they can do their job.

Q669 Charlotte Atkins: Do you think that the money from the Government to PCTs should be spread evenly across the country in terms of increasing dental access? You have recognised in your survey that there are quite big variations over the country and you also said that present availability of dentists is very much based on a historic model.

Ms Perchard: In our MORI survey—the one we have most recently published and sent you a supplementary submission on—we highlighted the Southwest and the Northwest as being significantly above average in people being unable to find an NHS dentist. Ideally the extra money should be targeted on areas of most need.

Q670 Charlotte Atkins: Do you mean the extra 2%?

Ms Perchard: If the increase in investment is intended to help PCTs address the needs of 2 million—if you are the Department—or 2.7 million—if you are us—people who wanted NHS dentistry and went without because they could not get it, then ideally you should be focussing that on the areas in most need. We are not aware of any mapping that has been done by PCTs themselves or the Government to identify where those dental deserts might be. In the absence of that, making sure that all PCTs feel they have more comfort around their financing in order to start doing that, because all the answers from the Government on this is that this is a matter for PCTs to identify what the needs are in their area and set out to meet them, and they are being given enough resources to do so. We would dearly love to see a map of England and Wales showing where the biggest problem areas are and to see investment distributed accordingly but in the absence of that what can we expect?

Q671 Sandra Gidley: I was at the launch this morning because for the life of me I cannot see the difference between reading a report in the public domain and going along to hear what is being said about a report in the public domain and it all informs the debate as far as I am concerned and we can take our own judgments on that. Dr Halperin, you mentioned orthodontics particularly and that is what I wanted to come onto next, to ask about what your surveys revealed about orthodontic treatment. We have heard some evidence that certain areas or regions of the country are better or worse for orthodontic access. I do not think it is quite as simple as that because in my patch Southampton is abysmal and Hampshire is relatively good; you cross the border and you get a completely different picture. What do the surveys reveal?

Dr Halperin: To question 18a: “Has the PCT put additional money into the provision of orthodontic treatment?” 34.7% said yes and 65.3% said no. I think it is a deeper problem than that. I am not an orthodontist but I have followed what the orthodontists are saying about the problems and whereas before, under the old contract, orthodontists did not have free reign but they were allowed to carry out a very wide variety of orthodontic treatment, our helpline has a number of calls into it now saying that their children just cannot

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get orthodontic treatment because the new criteria means that they have to fall into certain guidelines. The danger from the patient's aspect is that when you set guidelines for what children can receive and what they cannot receive it tends to be very arbitrary. From a psychological point of view one child may not be worried at all if his tooth is slightly crooked whereas another child may be severely traumatised or feel they are being made fun of. Whereas originally orthodontics was, as I said, fairly freely available as long as the Dental Practice Board felt that it was appropriate—and most of the time if the dentist thought it was then it was allowed—under these new guidelines it is not just a question of money for orthodontic treatment it is the guidelines for orthodontic treatment that have been altered. For instance, we have a case where a mother has twins with identical orthodontic problems and, because of a date of a couple of weeks in the new contract, one twin is allowed to receive treatment under the old contract whereas under the new contract when it came in the other twin is not receiving it because they do not fall within the guidelines. I think it is more than a problem of funding; it is a problem of guidelines for what children may receive and I think this does need to be looked at so that children do not have trauma as a result of misaligned teeth. I am not talking just about dental trauma, I am talking about psychological trauma. Children are very aware of being made fun of by other children if something is not right about them. If they have treatment later on it can be far more complicated.

Q672 Sandra Gidley: The answer to question 14c shows that orthodontics is in the top three of the number of complaints received by trusts over the country. Are you convinced that it is just an access problem which forms the basis of the complaints or is it a quality problem?

Dr Halperin: I think it is a quality problem. This is one of the problems I have with the new contract—and not just with orthodontics—that because the quality guidelines have been taken away by the fact that the dental reference officers are no longer able to inspect patients and thereby the quality of treatment by dentists, we are going to have a quality problem under this new contract; there is no question about it, it is there already.

Q673 Sandra Gidley: Teresa, does your survey highlight this?

Ms Perchard: Not specifically on orthodontics but what I have spotted really is an emerging issue around quality and satisfaction. Certainly in terms of people coming to bureaux for advice quality of service is not the issue they are coming about; they are coming about help with costs and finding a dentist. In the online survey we did last year which 5,000 people completed 32% said they were not happy with the quality and we highlighted that in our first evidence submission to you. In some senses people's dissatisfaction seems to be arising from a very busy, pressed service which is looking perhaps to tightly ration what it is that is being offered to the

customer. That may be an impact of the new contract or not and I suspect it is highly variable from practice to practice and how under pressure the practice is. That underlines the postcode nature of this problem.

Q674 Dr Taylor: Teresa, you said in your submission that PCTs “have adopted a narrow interpretation of their new duties”. Is that what you meant when you said earlier that they did not look afresh at how to fill the gaps?

Ms Perchard: Yes, it is.

Q675 Dr Taylor: You said they need oomph and cash.

Ms Perchard: We think that all PCTs should be undertaking surveys to establish how much unmet demand is out there. Even looking at the very simple short survey we have done with MORI it is quite possible to ask people whether they had gone to a dentist, who they went to, whether they prefer NHS dentistry; had they tried and did they find it difficult; you can ask people those questions quite easily. We also think that PCTs should have a look at developing some standards for accessibility of services, particularly focussing on travelling time and distances. In the areas we highlighted where access seems to be the worst—the Southwest and the Northwest, rural areas, poor public transport, dispersed communities—a PCT really ought to have a view about where all the access points for dentistry are in their geography and realistically how potential patients are likely to be able to access their services and if something needs to be improved then to put that in place. Generally we think PCTs ought to be doing some more proactive things around promoting NHS dentistry services.

Q676 Dr Taylor: Would you agree with one of the points in Dr Halperin's paper that one course to action is where PCTs offer an excellent creative commissioning structure they should take over the dental commissioning role of those that do not?

Ms Perchard: I have no comment to make on that.

Q677 Dr Taylor: Is that feasible?

Dr Halperin: I am not sure it can be feasible.

Ms Perchard: If you are giving an organisation a job to distribute public funding and to achieve a certain welfare goal and it is not doing a good job compared to others, we need to know what is going on and take a view on it. Whether you ask someone else to step in and do it if they are failing, there may be other options for remedies. I think consumers would like to know that somebody is keeping an eye on what is going on and taking action to remedy problems.

Q678 Dr Taylor: To change tack for a moment, do either of you have any evidence about patients' attitude to registration?

Dr Halperin: Yes, I have got quite strong views on that.

Q679 Dr Taylor: What about your patients?

Dr Halperin: Having treated patients for more years than I like to think about, patients do care about seeing the same dentist or doctor. I believe that on-going registration which has now been taken away is absolutely vital not only for the relationship with the patient but the relationship with the dentist, that he has on-going, continuous records of treatment; that he builds up a relationship with a patient and the family over many years. What we have now is that effectively as soon as a course of treatment is finished that patient is no longer a member of the practice; it is almost like going into a supermarket and starting all over again. I do not really understand why we have taken that personal relationship away which was good for the patient, good for the dentist and good for treatment.

Q680 Dr Taylor: If there is a problem after that course of treatment the patient does not know where to go with it.

Dr Halperin: They can possibly go back to the same dentist but they are not a registered patient with that dentist.

Q681 Dr Taylor: Would you agree?

Ms Perchard: We have not specifically asked people what they would prefer. I think those points are quite compelling, particularly where people may find it difficult to get treatment and people who have location difficulties or may need more support. Being on a list and somebody keeping the records and there being that track record of your engagement with dental services may be quite helpful for certain individuals. For those people who are happy to go to Tesco or Sainsbury and go to the dentist and those people who are happy to shop around and are very confident to do so then requiring them to be on a list may be inappropriate. For some patients that supportive approach is likely to be in their best interests and in the best interests of the dental health of the nation.

Q682 Mr Scott: The CAB reports that a quarter of people have cited charges as a reason for not visiting a dentist. I believe there was one person who pulled out nine teeth with pliers; they may need more help than a dentist if they are going to pull out nine teeth with a pair of pliers. How can low income earners be helped to meet these expenses of NHS dentistry?

Dr Halperin: I think the problem is that there may be a gap between those patients who are exempt charges and those patients who are not exempt charges but have difficulty in meeting the household budget. I think the other problem is that the bands are really quite poorly understood. I know it was supposed to mean simplification. I am not an NHS dentist but I am a dentist and I have been looking at these bands and even now if somebody asked me to say exactly what falls into what band as far as a charge is concerned I would probably be 75% right. That means a patient is probably only going to be 20% right. It is not quite that simple and probably patients do not understand why one filling would

cost the same as six fillings. It appears to be irrational not only to the dentist but probably to the patient as well.

Ms Perchard: Certainly about a third of all our enquiries in bureaux seem to be concerning problems with charges, and often we are helping people to claim an exemption through the HC1/HC2 system and that suggests to us that there is quite a lot that could be done, particularly now, to improve awareness of the low income scheme. Indeed this is something that this Select Committee has highlighted in a previous report on health charges, looking at prescription charges as well, where it was quite clear that the number of applications under the low income scheme was declining. The general literature that is available on the new dental charges really is quite understated about how you could get an exemption or help with charges. Looking at passporting exemption to people receiving housing benefit, council tax benefit, might be helpful. In London some really interesting evidence came out of the Greater London Assembly report which shows there is a good supply of dentists but people on very low incomes do not go to NHS dentists. It is not about getting more dentists in, it is about getting engagement from the public and part of that maybe that even though £198 is a maximum charge it is too off-putting for some. But there may be help available and the low income scheme could be extended, and also be much more widely promoted in some of those urban areas where there is good access in theory but some groups are not taking up dentistry and not going for check-ups as much as others. We have referred to that briefly in our evidence as well.

Q683 Dr Naysmith: Teresa, your survey reported that 32% of patients who had undergone band 2 treatment were not happy with the quality of care they received. What actually were they saying about it? What aspects of the treatment were they complaining about?

Ms Perchard: I think this is probably our online survey. This is where we have a big body of evidence of comments that people made. I think I would have to go back and have a look at what the main issues were. We have highlighted in the submission a few examples where people thought they were going to get one thing but got another; did not get as many fillings as they were told they would get and felt rushed through the process. We have supported the simplified banding scheme. You only have to look at the 400 different charges that there used to be to see that it is an absolute transformation, but I suspect you have to be quite a canny consumer to get a clean out of the band 1 and not be referred to the hygienist and have to pay £45 and actually to get everything that you are entitled to for your band 2 you probably need to be quite assertive. That is where the PCTs come in in promoting what you can expect from an NHS dentist and also doing a bit of compliance monitoring focussing on evidence from consumers about what actually happened when they did go to an NHS dentist.

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Q684 Dr Naysmith: What are they actually saying? Are they saying that they do not get the number of fillings that they ought to get?

Ms Perchard: To answer you properly we would need to have a look at the free text comments that people made and see where the balance lies. Was it that they thought they would have more treatment or something else.

Q685 Dr Naysmith: Or did they think they were paying for something and they were not getting value for money?

Ms Perchard: Yes, which could be as a result of not having had very much treatment. We will come back to you on that with a bit more information.

Q686 Dr Naysmith: That would be very helpful. Dr Halperin, your submission states that the contract has “excluded care by stealth”. What do you mean by that? Was that something you wrote in?

Dr Halperin: I will give you a very short history of the NHS as I have observed it over the past 35 years. When the NHS first came in treatment was skewed by the fact that dentists got paid per filling per tooth and we saw a number of molar teeth with six separate little fillings in them. Over the years as the contract changed the various types of treatment a small percentage—I insist it is a very small percentage, 99% of dentists acted in a most proper manner—of dentists skewed the treatment. In my experience the treatment was sometimes distorted by the fee scale, ie for the type of filling you did you got a different payment. This was recognised by the Dental Practice Board who brought in very sophisticated monitoring techniques of which dentists did which fillings on which patients and they had quite a large fraud department to make sure that dentists did not do inappropriate treatments. One hoped, when the new contract came in, that this type of treatment geared to a financial reward—I will put it that way—was no longer there. Unfortunately I believe that under the new system that has come in it may be as bad or even worse. I am not talking about a treadmill effect so much as the fact that a dentist is presented with the same fee for one filling or six fillings; he is presented with the problem that if he carries out a root treatment it can take him an hour whereas if he takes out a tooth it can take five minutes. I believe this is an unfair onus on dentists that treatment and reward that they are given thereof is governed by an artificial system of payment.

Q687 Dr Naysmith: How is that exclusion by stealth of care?

Dr Halperin: It is an exclusion by stealth of care in that the patients may not be getting the best treatment under the new system because of the way the UDAs are geared, ie instead of getting the three crowns they need they may not get any crowns or they may get one crown.

Q688 Dr Naysmith: Do you think it is worse than the old system whereby people got their mouths filled unnecessarily?

Dr Halperin: I think it possibly is because there was a survey showing how many dentists they thought carried out treatment that was inappropriate and it was very tiny; it was well under 1%, ie the majority of dentists under the old system did carry out appropriate treatment. What we do not know under the new system from the patients’ point of view—because of the safeguards so far as monitoring patients care have now been taken away because we no longer have any regional dental officers independently inspecting—is the quality of care they are getting. All we do know is that the amount of crown and bridge work has gone down substantially and my view is that patients do need crown and bridge work as they get older. It is by stealth, if you like, the way the contract has been brought in; it may not have been the intention but I think it has happened.

Q689 Dr Naysmith: Thank you; that was a very full explanation. Have either of you got any evidence of patients being referred unnecessarily to hospitals for treatment.

Dr Halperin: I have evidence of one of our patients on the helpline who went to the dentist and the dentist said, “I am sorry, you need a root treatment and I am afraid I am unable to carry this out”. He was an elderly gentlemen, I think he was in his 70s, and he was referred to a private dentist down the road who then carried out the root treatment and charged him £175. He then complained to the PCT who refunded him £100. I do not know under what system he was refunded—I do not know how there was an appropriation in their budget for it—but he was given £100 back.

Q690 Dr Naysmith: The question was really whether he was referred to a dental hospital. Do you know of any cases?

Dr Halperin: No, I do not have any specific cases of that.

Ms Perchard: We have found it is more people taking themselves to hospitals because the PCT has told them they can go on the waiting list to go on the waiting list, or there are seven dentists on the website and none of them will take them. That is why we are interested in PCTs taking a more overt role in promoting the NHS dentistry services that are there and acting really as a proper information clearing house so that people can find quickly who can take them on now so as to avoid that displacement onto the hospital services.

Q691 Dr Taylor: To what extent do PCTs involve patients in determining how dental services are delivered in their area?

Ms Perchard: The things we have advocated around PCTs now, if they have not already, are starting to do some mapping to find out what the level of need is and also looking at setting access standards would engage the PCTs in talking to groups who can represent consumers and might provide the opportunity for more dialogue. The East of England Strategic Health Authority recently circulated a very good briefing to PCTs about promotion of the

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existing services; all calls to the helpline should be given at least three dentists who could take them on and also giving them a bit of a steer about how to set about finding out where the gaps are. I think in day to day practice I do not get the impression there is very lively discourse with consumer groups.

Q692 Dr Taylor: Does the CAB have a view on the change from patient forums to LINKS and could LINKS be more effective in helping, particularly in the dental field?

Ms Perchard: I do not feel able to comment on that at the moment, I am afraid.

Q693 Dr Taylor: Dr Halperin, has the Patients Association made any formal move to try to join in with LINKS which is supposed to link every patient body together?

Dr Halperin: Not as far as I am aware.

Q694 Dr Taylor: Had you beforehand any links with patient forums or patient participation groups?

Dr Halperin: We have had links in the past, yes.

Q695 Dr Taylor: Will you be looking at links with LINKS?

Dr Halperin: The Patients Association will always be interested in working with any groups that promote patients' interests.

Ms Perchard: Some CABs have run patient forums and that is good because the bureaux do a lot of advice in health settings; 1,100 health settings have CABs doing outreach advice so there is a lot of proximity between our organisation and the health network.

Chairman: Thank you both very much indeed for coming along and helping us with our inquiry into dental services.

Witnesses: **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, gave evidence.

Q696 Chairman: Good morning and welcome to the Health Committee. I wonder if I could ask you if you could give me your name and the current position that you hold.

Mr Lye: My name is David Lye and I am Head of the Dental and Eye Care Branch of the Department of Health.

Ann Keen: I am Ann Keen, minister with responsibility for dentistry, Parliamentary Under Secretary of State.

Dr Cockcroft: Barry Cockcroft, Chief Dental Officer for England.

Q697 Chairman: Minister, welcome back. I do not know whether it is game keeper turned poacher or the other way round, but welcome back to the Health Select Committee which you were a member of for a while as I recall. Most of the questions that are going to be asked today are going to be directed to you, you will be really pleased to know. You may want to field them on occasions, but that is the general direction of this evidence session. I would like to start and ask you questions about implementing the contract. Looking back at this now, it is now nearly two years since it was implemented, do you agree it was a huge mistake to introduce the new contract at the same time that primary care trusts themselves were being re-organised in 2006?

Ann Keen: Thank you for your kind remarks at the beginning. It is good to be back; I enjoyed my time immensely on the Health Select Committee, a very important Committee, and I really welcome your report. I want to start by saying that today because I think it will be very helpful to us. In relation to your question and was it a good time, the reforms had been long planned and the legislation was passed in 2003, so having that continued delay was causing uncertainty within dentistry. Was it the best time?

When would there have been a best time? I do acknowledge, without question, that when re-organisation was taking place within PCTs that did cause PCTs to have extra work and obviously then a much more challenging time.

Q698 Chairman: One of the things that has puzzled me and other members of the Committee as well over the weeks that we have been taking evidence now is that the form the new contract was agreed it was not piloted. In a sense you did not know what the reaction to the new contract would be either by the profession or by patients as well, particularly because of the changes in patient contributions. Why was it not piloted in a way that would have held it together a bit more than it has done?

Ann Keen: I understand where you are coming from with that question, but the legislation on patient charging made that difficult. To actually have had two different parallel charges at the same time would have been difficult and in fact, from my understanding, it would have been against the legislation.

Dr Cockcroft: I was involved a lot with PDS from 1998 and the whole thing about pilots is to learn what works and what does not work. We certainly learned a lot about PDS and some of it is coming true now in terms of simpler courses of treatment and better working with PCTs. However, we also importantly learned what did not work. When we had PDS pilots without a common currency for one year with only 25% of dentists we lost £60 million in patient charge revenue because there was no currency to monitor contracts. That was only with having 25% of dentists in PDS. We also learned that everybody wanted prevention but if you just let people do it without any guidance they did a lot of things which were called prevention but there is no evidence base to say that what they were doing was

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actually doing any good. Obviously the simpler courses of treatment did actually come true and we can see that what we thought would happen and what we learned from PDS pilots is happening now and we were able to say that under PDS we had simple courses of treatment and patient health did not suffer as a result of that. You do not just pilot what works, you pilot a range of things and find out what works and what does not work, and then implement on the basis of that.

Q699 Chairman: I accept entirely about piloting different things and that seems a very sensible approach, but when you went onto the new contract you had not tried it out. Was that because you just felt that the charging regulations could not be changed in an area so a pilot could be done in a comprehensive manner? Why is it?

Dr Cockcroft: Obviously it relates to implementation as well and we were keen not to delay any further in terms of implementation because the fundamental benefit of the contract is that it gives the NHS control over where services are and prevents the development of deserts like the CAB referred to. We were very keen, because of the significant benefit of local commissioning, to introduce that as quickly as possible and had we introduced another pilot without local commissioning in some way the existing situation would just have gone on for longer.

Q700 Chairman: Was it the charging regulations that restricted you, do you think?

Dr Cockcroft: We could not have piloted the exact scheme in one area and left the other scheme working in another area because that would have been against the law, to have different patient charging schemes in one area compared to another. We could not do that. We could have introduced it—which is what we did—and the regulations are very flexible so we can amend and adjust within that flexibility that is there. We continue to do that.

Q701 Chairman: Was there no flexibility to change the law to make sure that what you were going to introduce nationally could have been proved?

Dr Cockcroft: The regulations are incredibly flexible. There is an overarching framework with flexibility within it and obviously at the moment not as many people are being flexible as they want. Once you have changed the law to give PCTs a duty to do it then beyond that you can actually amend the regulations when you actually want to. The fundamental principle was to get local commissioning in as quickly as possible so that we can start to target some areas where there were difficulties.

Q702 Sandra Gidley: I would like to pick up on something Dr Cockcroft said. You said you had had the trials for a year.

Dr Cockcroft: Since 1998 they have been piloted.

Q703 Sandra Gidley: You said patient oral health had not suffered. Can you just clarify how you know?

Dr Cockcroft: My own practice went into PDS in 1998 and the incidence of interventions of item of service had gone down quite significantly. When the NAO did their report on dentistry in 2003 or 2004 they did a little research project comparing the health of patients in my practice and the other two practices with similar practices in Nuneaton (a similar demographic area) and we had less intervention. The NAO did a quick and dirty—I think they call it that—bit of research involving Birmingham University and found that the health of the patients attending in Nuneaton did not suffer from the fact that they had less intervention at all.

Q704 Sandra Gidley: It was very small.

Dr Cockcroft: Yes, it was very small and some of the pilots that started out were very small, but the NAO felt comfortable enough to publish it in their report.

Q705 Dr Naysmith: Good morning, Minister; it is a pleasure to have you before us today. I would like to ask you a few questions about primary care trusts and commissioning. We have had quite a lot of evidence suggesting that there is wide variation between the way some PCTs do it and others. Do you accept that some PCTs are actually currently incapable of properly commissioning dental services?

Ann Keen: What I could say is that there is a variation; I would agree with you. “Incapable” may be a bit strong for the PCTs but there is very, very strong evidence that some PCTs need much more support. It is the NHS devolved; areas are doing it so well and sharing that best practice is so important.

Q706 Dr Naysmith: We had evidence from Sandwell PCT and they have been employing dental consultants within the PCT to try to assess the needs of the patients in their area and so on. That sounds like very good practice.

Ann Keen: Absolutely.

Q707 Dr Naysmith: What are you doing to try to make sure that is happening in other primary care trusts?

Ann Keen: The first thing we have done is make sure that dentistry is in the operating framework of the NHS so therefore PCTs have to take this very, very seriously. I have spoken at conferences with the BDA and with PCT commissioners to stress the importance of how we want to work with them. I do not think we cannot take responsibility for saying that we have changed a contract that has been in place for over 50 years and then not give them support and help. Also a piece of work is now going to be done within our commissioning department at the Department of Health to give much more support where it is needed. I think we have to listen

and learn from where it is very good practice, as you pointed out, and where it is not, to make sure that those PCTs are very well supported.

Q708 Dr Naysmith: Do you approve of PCTs using ring fenced money to make-up shortfalls in patient charge income rather than to commission new services?

Ann Keen: In the new world of commissioning we want it to be world class; we want this to change. As you raised ring fencing, I am sure the Committee will be aware that this week I have encouraged, since I have taken up my post in July, I suppose the best way to describe it is that ring fencing will continue now until 2011. One of the many aspects I have picked up with this new portfolio and in particular on dentistry was the anxiety around when ring fencing would end in 2009. To be fair to everyone I felt that that was too soon when there has been such a big shift in the way service was to be delivered. I was pleased to be able to get the support of the Secretary of State within the operating framework and now, very recently, to have been successful in saying that ring fencing will continue until 2011. I am sure that the profession will welcome that.

Q709 Dr Naysmith: It was just a coincidence that that came out a day or two before you were due to be before this Committee.

Ann Keen: As a former nurse I am sure you would trust me. It takes time to get agreements and I have been working on this agreement and have been able successful to be able to say it this week by coincidence.

Chairman: It is not the first coincidence we have had of things happening prior to ministers coming along to this Committee.

Q710 Charlotte Atkins: Now that a Tory peer suggests that nurses are not perhaps as trustworthy as they might be I am a little bit concerned about your comments.

Ann Keen: I could go on about that but I am sure you will not want me to. I hope the Committee will at some other stage.

Q711 Charlotte Atkins: I want to move onto patient access. We are told that a quarter of a million fewer patients received NHS care in the first year of the contract. Does that demonstrate that the new arrangements are a failure?

Ann Keen: Wherever patients cannot get treatment of course that is seen as a failure but I think we have made great progress. Some of the figures are not the present figures, what is happening today, in the last few months and will be happening throughout the rest of this year. Perhaps Barry would like to comment on this.

Dr Cockcroft: The figures that we produce on access are two year retrospective figures and actually cover the period when we introduced the implementation and we lost 3.6% of service which was equivalent to 960,000 patients. That loss will feed through two years on from when those patients last saw their dentist before April 2006. That retrospective data

reflects that loss. If I can give an illustration, the day after I spoke here on 21 February I opened two new practices, one in Tame in Buckinghamshire and one in Banbury in Oxfordshire. Both those practices have got several thousand patients now on their database. They are brand new, very high quality practices, but the patients who are now accessing services there will not actually register on the access data until they have been seen, they have been completed treated and the data actually starts to factor in. The full effect of new practices—I am opening practices all over the place at the moment—will not show for two years after their opening. The access data that you are showing at the moment does not reflect what is happening now, it actually reflects the long term impact of the loss of service that we had in April 2006. We took a very high profile media hit on losing 3.6% of service in April 2006 and we are now taking the hit again for the same patients as they show up in the data. 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. However, the picture on the ground now is not reflected by what that data represents.

Q712 Charlotte Atkins: The Department was clearly so worried about the issue of access that the original decision not to allow dentists to go private but to treat children on the NHS was at some point rescinded and you allowed that to proceed. Why was that?

Dr Cockcroft: I think the issue was that we were not starting from a clean sheet of paper. Under the old system you had a significant number of children who were seeing dentists privately either because their parents were in a private scheme or because they were told they had to. We certainly do not want to grow any more child only contracts—I do not think they have a place in long term commissioning plans—but if we had actually said you cannot do that there would have been a loss of access for some children.

Q713 Charlotte Atkins: You did say initially that you could not do that.

Dr Cockcroft: It was in the original proposals but we realised that if we implemented it like that it would cause more difficulty. The decision was taken before we published the regulations.

Q714 Charlotte Atkins: When was the change made?

Dr Cockcroft: We always knew there would be some loss of service and it did not turn out to be as big as some people predicted, but we also realised that if we did that we would lose children and children would lose access. The NHS would have the ability to re-commission and the Patients Association report today shows how well PCTs did at finding new places for people. There would have been discontinuity of service for children at that point. It was a pragmatic decision. If we were starting from a clean sheet of paper we would not have allowed restricted contracts I do not think, but we had children who were already in that situation and to make those contracts not allowable would have

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actually disenfranchised a significant number of children at that time. In the long term they would have found new places, but I think it was felt that that was not the right thing to do over the transitional period. We are now trying to get more stability and certainly people are not now agreeing new child contracts anywhere.

Q715 Charlotte Atkins: They are not agreeing them or they are not allowed to agree them?

Dr Cockcroft: They are not agreeing new ones. PCTs are very clear that they are not agreeing to new child only contracts.

Q716 Charlotte Atkins: Is that against the rules or are they just choosing to do that?

Dr Cockcroft: PCTs have discretion to do that where they think it is appropriate. I have had many e-mails from PCTs saying that they are not going to invest in any more child only contracts. I think that is one thing that is quite clear. I have said that lots of times; in our guidance we have said that lots of times. The contract that offers services that are restricted, whether it be child or whether it be ability to pay or something like that, I do not think has any long term place in the PCTs' commissioning plans.

Q717 Charlotte Atkins: You mentioned in the press that you thought there had been an increase in private practice, especially for cosmetic treatment. I think you were talking about a number of young dentists leaving the NHS. Given that the Department does not collect statistics on the private sector how did you arrive at that conclusion?

Dr Cockcroft: First of all, that coverage yesterday was based on the income of 53 dentists who are young principals and certainly not representative of the vast majority of young dentists. I go around and I am always visiting practices, I have good connections with the dental schools and anybody understands there has been a growth in cosmetic dentistry over 10 years and that is not a bad thing. I think the important thing is not that every dentist stays in the NHS; the important thing is that there are enough dentists to provide the NHS services that PCTs want to commission. Everybody keeps going on about what a bad contract this is, yet every time a primary care trust goes out to tender now there are dentists queuing up to provide those services. The big corporates have said they are committed to the NHS; there is no shortage of people wanting to grow their NHS commitment. I see that all the time. Certainly there has been an explosion in the private sector, most of it in terms of cosmetic surgery such as whitening and implants; you cannot be a newsreader these days unless you have sparkly white teeth, but it is not appropriate for the NHS to do that. I do not see any problem with that, especially now that the growth in the private sector does not mean a reduction in funding in the NHS.

Q718 Charlotte Atkins: Can we also now go onto the issue of waiting lists for dental treatment. The Department does not think it is necessary to record

waiting lists despite the fact that many NHS dentists are full to capacity and therefore are not recording a waiting list. Do some PCTs keep waiting lists or do they not?

Ann Keen: PCTs have many helplines and many ways of helping patients to access dentists; there are some very imaginative ways of helping them to access dentistry. However, it has never been felt necessary to have the waiting list system incorporated into dentistry. When I looked into this the evidence that comes back to me is that there is no need for that waiting list because you should be able to access a dentist that week, therefore keeping a waiting list is not appropriate. Barry has done some work on this.

Dr Cockcroft: Waiting lists relate normally to when there has been a referral to secondary care; individual people make a judgment about when they want to go to a dentist. You would not have a waiting list to see a GP. There are many PCTs in the country now where access is available immediately and we have a lot of examples now of PCTs advertising. I was in Plymouth the other week where the PCT advertises both through NHS Direct and in the local newspaper saying, "Ring our helpline and we can provide you with care". It is not something that every PCT needs to do anyway. I think the important thing, where there has been a shortage and we accept there has been in many areas, is that PCTs keep a database of people who want to access care there and then the PCT can then provide them with those spaces. The idea of having a waiting list for primary care which people do not get referred to but just decide when they want to go does not seem to fit comfortably with a model of waiting lists and hospital referrals.

Q719 Charlotte Atkins: If you have a town in a relatively rural area it is not surprising for people to be waiting for maybe 10 years for an NHS dentist. I even have a waiting list on my books as an MP. Devon PCT has told us that they have 7,700 patients on a waiting list.

Dr Cockcroft: They used to have 50,000. Where they need to do that, holding a list of patients who want to access services centrally is a very good idea. Most PCTs are doing that when they are growing their services. The idea of just having a national scheme for waiting lists does not seem to us to be reasonable.

Ann Keen: There are also dentists who are advertising for patients. In Lewisham and Nottingham they are advertising for patients to come for dental care. What we want is for you to get your appointment when you want it.

Mr Lye: Lewisham is a really interesting example because if you look at the access figures from March 2006 when the new system came in then the access in Lewisham is actually slightly down—not hugely down, but slightly down—but the PCT says they have 36 practices who are able to take on new patients. I think we talked about this issue last time we were here, about how you marry up the patients with the access availability that you have.

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Q720 Charlotte Atkins: Meanwhile my PCT is very concerned about introducing a new dentist in such a way that they do not have a queue going a mile down the road.

Dr Cockcroft: Having to queue round the block is not a good way to access the system. You may remember in 2003 there was a well publicised queue and we produced some guidance for PCTs which said that it is not right and it does not reflect well. If people want to access services they should come in, the PCTs should hold a database, they know when they register their interest so that people can be treated in the order they were seen and can be managed well at primary care trust level. The vast majority of primary care trust level where they have that issue are actually keeping waiting lists and have actually got dentists who all the time will say that they can see some more patients now and then the PCT directs them to those services. I think we were nowhere near that three or four years ago. I think the way that has developed over the last three or four years has been a really excellent feature of PCT commissioning.

Q721 Dr Naysmith: There is no doubt that there are now dentists who are looking for patients and there is more NHS dentistry available. At the same time there are still some dentists who are switching over to purely private treatment; there is one in my area who has just done it recently. Are we winning or losing on the balance?

Dr Cockcroft: That happens and that has always happened. The big difference now is that there are no questions about workforce. Everybody accepts that the workforce situation is sorted. I was in Plymouth last week where they are advertising for patients. They did have a practice do that. I spoke to the NHS Commission and she said that it was disappointing, but they were able to find places for everybody with other practices who wanted to grow their services. We know that the level of commissioned services by the PCT is now much higher than it was before April 2006 so, as I said, we know the thing is growing now but it will take some time for it to show through in statistics. There is no workforce shortage and there are enough people who want to provide services if the PCTs offer them for tendering. The disappointment in some ways is the pace at which PCTs are actually doing that. I think the pace is disappointing and I think that reflects the difficult relations in the profession over the last year as well.

Q722 Dr Naysmith: That is very encouraging but I caution you when you use the phrase "it is sorted", particularly if you are referring to workforce planning in the National Health Service.

Dr Cockcroft: I was told there was no such thing as workforce planning.

Ann Keen: I think 170 extra dentists will actually graduate each year. That is so encouraging and in the next two to three years we will see a huge change in our dental services. It is worth putting on record now the work that people are doing to work this contract, the way our dentists have worked with us has been tremendous. Yes, I know the media has

given some interesting publicity at times and I was at the forefront of receiving this, especially the gentleman who removed his own teeth with a pair of pliers. That is media sensation but the reality is that 170 new dentists graduate every year and that is just great news for our national health service and the dental service.

Mr Lye: Barry has made the point that the access figures look back over two years. He has been talking about what is happening now. Then we look forward to next year and beyond with dentistry and the operating framework and with the 11% increase in funding. What we will see towards the end of this month are the plans that the PCTs submit to the SHAs to show what they intend to commission. We have been getting out and about to see what is happening and certainly the inclusion in the operating framework is raising the importance of dentistry alongside the importance of the extra money that is going in. Some SHAs are really starting to grip this now and they are actually requiring the PCTs to do some of the things that I know members of this Committee are concerned about like going out and doing the oral health needs assessments and consultations and actually doing their commissioning in a planned way. We need to see what comes in in March but I think the message is there that this is important, we are taking it seriously and we are going to performance manage it.

Q723 Stephen Hesford: I understand there is a new dental school opened in central Lancashire.

Dr Cockcroft: There is one in Plymouth and one in central Lancashire which has links to Liverpool.

Q724 Stephen Hesford: They are the first for about a hundred years.

Dr Cockcroft: I could not find any data relating to when the last one was opened.

Q725 Stephen Hesford: In terms of workforce planning what is the expectation that they will add to the system?

Dr Cockcroft: We had a workforce review in 2004 which showed a gap between need and supply and we made a decision then to increase the workforce. Part of that was the increase in undergraduate expansion that Ann talked about. The existing dental schools initially took the whole tranche so that we could implement the 170 increase straight away and it has taken time for the two new dental schools to open; they are open now. The 170 extra UK graduates every year will have a very significant impact on growing our dental workforce. The other thing is that at both the two new dental schools the clinical teaching actually goes on in the community in primary care, so in Plymouth you have four outreach teaching units. In Lancashire they are based in Carlisle, Blackpool, Accrington and somewhere else that I cannot remember and they are co-located with other services. Even while the students are being taught services are being

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developed at the same time in the locality. This is the right thing to do because 95% of dentists end up in primary care anyway.

Q726 Chairman: Obviously with the opening of new dental schools we are going to have a bigger dental workforce. We have it at the moment with medical doctors; you will be aware of changing the regulations and everything else. A note has just been passed to me about a comment from a former head of the dental section of the World Health Organization that a hungry dentist is a dangerous dentist. Given that there are going to be so many of them, are you worried?

Dr Cockcroft: I think people made that comment in the mid-80s and subsequently closed two dental schools in 1988 and we have been reaping the rewards of that decision. I think everybody thought it was the right decision to make at the time, but clearly it was the wrong decision to make. Making assumptions like that are very simplistic. As the older population continues to retain its teeth the need for services will continue. What we need to do is get the workforce appropriate to the need. A wild oversupply or a wild undersupply is bad in different ways; we need to get it just about right.

Ann Keen: Maintaining your own teeth is so important. I believe there are statistics around that in the 1970s one in three of the over-60s did not have their own teeth. There has been a massive change in the importance of oral health.

Dr Cockcroft: Under the old system a hungry dentist was a very dangerous dentist with an item of service based system.

Q727 Chairman: The other thing that Doug mentioned a few minutes ago was the issue about the profession. The relationship with the profession has certainly not been good. We took evidence both in this inquiry and a previous inquiry about the Department's relationship with the profession. Is it any better than it was two years ago when you walked out of the negotiations?⁷

Ann Keen: I hope so because I have met with the BDA and we have had a very good meeting. In fact somewhere in this pile of papers I have the letter thanking me for the meeting and saying that we are now where we are and they are looking forward to working with myself and officials to progress the contract. I think it is very important that we recognise how difficult it has been and that is what I was able to do as a new minister coming into the contract. They gave me the courtesy and accepted that. I accepted an invitation to a conference. I want to work with the BDA along with other professions related to dentistry the same way as I work with

every other part of the NHS. What is so important is that we actually recognise the importance of their work. It is not just about drill and fill—as is often said—it is much more than that. We do recognise the professionalism of a dentist, the quality of the work they do and also, by us having regular oral checks, other more serious conditions can be diagnosed by the dentist and the rest of the oral health care team. This has a different standing; it is a very professional team and the public are recognising that. Our 12 year old children's teeth are the healthiest in Europe. We are doing work around fluoridation and we are working together with big companies like ASDA. ASDA are working with me and with the BDA on looking at how they can promote fluoridation varnish with children. We are working very positively together and that is the relationship that I and officials now have with the BDA, recognising there was difficulty but I do believe the BDA would say that we have started to overcome that.

Dr Cockcroft: Although we have had a very sticky relationship with the BDA over the last couple of years, when you actually get out a lot and meet the individual dentists who are growing their services and making the thing work, the relationship is a lot better there. The practice I opened on 22 February would be very happy for any member of the Committee to go and visit them and speak to them. In the Chief Dental Officer's update which I published this week there are examples of providers who have been able to say that this has worked really well for us, this is what we are doing and we are taking it forward. I do not get any negative vibes when I go and meet the profession and I do that on a very, very regular basis.

Q728 Chairman: So you think it has improved.

Dr Cockcroft: Yes. I think it was a very fraught time and whenever I go and meet dentists I always say that I realise how difficult it was, there was a lot of misleading propaganda, there was a lot of stuff that made people worry, inappropriately worried about 2009 and we have started to address that now. I was really pleased that the Patients Association's report published this morning showed that 92% of primary care trusts were actively involving dentists in the development of service. When that happens that is when you get the really good relationship. I was not expecting to welcome the report but if you look not at the conclusions—which did not seem to be based on the report—rather at the data and the returns from primary care trusts it is very, very positive—the number of PCTs who have found places for people who have lost access, the amount of money that is being retained in dentistry—it was a very positive report.

Q729 Chairman: Barry, you said you were recently in Plymouth. The southwest is one of the areas that we have been told where, along with one or two other areas, access to orthodontics is not very good. Can you tell us what the Department is doing?

Dr Cockcroft: Orthodontics is one of the trickiest issues because the inequality in orthodontics services was much greater under the old system than it was

⁷ Note by witness: Building on the underpinning principles set out in early 2004 the Department and British Dental Association engaged in a series of discussions to finalise details of the arrangements for the local commissioning of primary dental services. These discussions broke down in Autumn 2004 and despite further informal exchanges between the parties the BDA were unable to resume discussions. The BDA issued a press release on 7 December 2004 saying it had formally suspended discussions with the Department.

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for general dentistry. 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. That was caused by the old system. PCTs now have a duty to provide and commission orthodontics. We know from our own data there is a very significant increase in commissioning of orthodontics going on because that is appropriate. It has to be based on need, not just open access for anybody who just thinks they have a slight twisted tooth that needs straightening. My deputy yesterday met with the Consultant Orthodontic Group to talk about 18 weeks. They were very positive about taking this forward. Most orthodontics needs go on in primary care. It is about developing local clinical networks and Tony was speaking to a consultant from Taunton who was saying how well it was going, developing a local clinical network down there. The old system got us into a really sticky situation around orthodontics, even worse than generalist dentistry, but we have given the PCTs a duty to sort that out and they are sorting it out. The fact that orthodontics is in the 18 weeks thing would actually give an added impetus to people to actually improve that.

Q730 Chairman: Are you measuring what is happening?

Dr Cockcroft: Yes, we have commissioning data for orthodontics and we know the extra commissioning for orthodontics is going on now.

Q731 Sandra Gidley: We heard last week that with the 18 week target there was a possibility that patients would be bounced back out of the hospital system and referred back into primary care. I spoke to a person in the Southampton PCT who commissions dental work and orthodontic work and historically they have a very poor provision level. I am extremely worried that a system that is not coping with primary care at the moment will be put under extra strain when the figures are fiddled to achieve the 18 week target. That is not exactly what they said, but that is certainly the gist.

Dr Cockcroft: The PCTs have a duty to provide bits which they did not have before April 2006 but it will take some time to grow it. What we will need to do over time is see a redistribution of orthodontic workforce. Clearly bumping people out of secondary care into primary care where they cannot access services is not acceptable.

Q732 Sandra Gidley: But it is going to happen.

Dr Cockcroft: We are working very hard with orthodontists. We have a relatively good relationship with them and a very good relationship with the British Orthodontic Society. From the meeting that Tony had yesterday with the Consultant Orthodontic Group the indication they gave was that it would take a bit of time but it can be sorted.

Q733 Sandra Gidley: What do you mean by “a bit of time”?

Dr Cockcroft: You do not want me to make a pledge, do you?

Q734 Sandra Gidley: I would like an indication. “A bit of time” could mean all things to all men.

Dr Cockcroft: It takes time to create new services and it takes time to relocate people but PCTs have a duty to do this and I will not commit to a specific time because it will be quicker in some areas than it is in others.

Q735 Sandra Gidley: Minister, would you accept that it was actually a mistake to allocate resources to PCTs based on their historic level of NHS activity?

Ann Keen: No. We gave a commitment to maintain contract values for existing practitioners and therefore had to allocate resources on historical spend. We had to start by honouring existing contracts and maintaining existing levels of service. That was very important. I believe during the committee stage of the Health and Social Care Standards Bill we were asked to give the important guarantee that current spending will be protected and we gave that commitment.

Q736 Sandra Gidley: That does not help those areas that have a low provision. How is access going to improve in areas like mine, in the Hampshire part of my constituency which has relatively low access? Southampton is fine; they have above average access but that was the historical position that each of those PCTs inherited. In my home town there is no access to NHS dentistry. How is that going to improve if there are no extra resources going into those PCTs with a historically low level of provision?

Ann Keen: I think we would have created chaos had we not honoured it and we gave that commitment in the Bill. I think David wants to say something.

Q737 Sandra Gidley: I want to know how it is going to improve.

Mr Lye: There is a slight analogy with the earlier discussion about children only contracts, that it is not necessarily something we want to have but to have moved away from the historical funding would have destabilised places where there were NHS services in place. The question about “how” I think is how you actually allocate the growth money that is going to be going into dentistry. We made a start this year by using populations as part of the criteria for allocating the 11% that is going in and I think that is the way we have to do it. We have to do it by adjusting the growth so that you move towards a fairer population based system of allocation over time.

Dr Cockcroft: Some of the 11% we have announced is not distributed on historic allocation basis, it goes out on population basis. Areas that have more dentists and a better service get slightly less and the areas like your 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 now. Under the old system you

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would not have had the slightest chance of doing that because it would still have been dependent on dentist drawing down the money and in your area where you have access difficulties that would never have happened. So there is a possibility now to make access fairer.

Q738 Sandra Gidley: I am curious as to how this money is going to be allocated because according to the survey that was released today presumably it should be on an assessment of need but I think a third of trusts have not done an oral needs survey.

Dr Cockcroft: I do not know when that survey was done but we have certainly asked all PCTs to do surveys.

Q739 Sandra Gidley: Were these done fairly recently?

Dr Cockcroft: I think it was last year some time; I do not know when.

Q740 Sandra Gidley: September or October.

Dr Cockcroft: We would certainly want them all to do oral health needs assessments.

Q741 Sandra Gidley: How is this money going to be allocated? Is it for PCTs to apply for the money and what criteria are you going to use to boost areas with low supply?

Dr Cockcroft: Areas of low supply will automatically get more funding because it is based on population and not on historical spend. It will happen automatically. It is up to them how they spend it, based on their needs assessment. They do not have to apply for this money; this money goes to them on an allocation basis.

Mr Lye: It is a piece of work that we still have to do.

Q742 Sandra Gidley: So it has not been decided yet.

Mr Lye: We do not yet have a formula to decide how dental funding should be devolved in the future.

Q743 Sandra Gidley: Any idea when we can expect this magic formula?

Mr Lye: No; we need to do that. I would think we need to have at least an idea of how we are going to do it in time for the next round of financial allocations, ie next year's financial allocations.

Dr Cockcroft: It has been refined this year and then as we get the needs assessments done they will indicate areas of higher need it can be refined further. We will be funding on the basis of population this year.

Mr Lye: What we did this year in allocating the 11% was that we allocated a 2% slice of that to the SHAs instead of direct to the PCTs and actually gave them some flexibility to make a judgment about how to allocate that money and some of them have done that on the basis of addressing a particular need and hotspots.

Q744 Sandra Gidley: That does not fill me with confidence. We have heard in this inquiry that most SHAs struggle to find anybody who will admit to taking on responsibility for dentistry.

Mr Lye: I think that is changing.

Q745 Dr Naysmith: Is it an unreasonable question to ask you why you have not got a formula yet?

Mr Lye: No, it is not an unreasonable question.

Q746 Dr Naysmith: What is the answer?

Mr Lye: I cannot give you a totally reasoned answer, but first of all we were, until this year, concerned primarily with keeping the stability as we moved from the old system to the new system. We have now made that move and we do recognise that there are these gaps both in terms of access and in terms of historical funding. We need to put that right and we do need to develop a formula.

Q747 Chairman: So you will give us an undertaking that you will get on with it as soon as you get back to the office.

Ann Keen: I can give you an undertaking that that is definitely what will be happening and thank you for highlighting this to me today in the way you have. This will be very seriously looked at.

Q748 Stephen Hesford: To come back on the idea of access and workforce planning, the CAB said there were two main areas in the country where access was difficult, the Northwest and the Southwest. We have heard about the new dental school in the Northwest. Am I right in thinking there is going to be a new dental school in the Southwest, in Truro?

Dr Cockcroft: The dental school hub building is in Plymouth and that has four outreach clinics, one is in Truro, one is in Exeter, one is in Devonport and the other is in Plymouth. These are outreach teaching centres.

Q749 Stephen Hesford: When will that come on stream?

Dr Cockcroft: The students started this year. The first one to come on stream will be Exeter; I am visiting Exeter tomorrow, that is opening tomorrow. There is a big capital investment gone in there and they are building them in a rotation basis because they do not need the full capacity because these are four year programmes and in the first year you only have a quarter of the full complement of students, so you only need build the full clinical teaching capacity over the next four years. I think the Devonport one might be the next one and then it might be Truro, or it might be the other way round. That is a growing programme over the next four years. I have visited the school myself last week and I am very impressed with the way they are planning and developing it.

Q750 Dr Naysmith: Minister, the impression has been given this morning that things are getting better and I think there is a lot of evidence that that is the case. However, how do you account for the fact that there has been a 60% increase in calls to NHS Direct from patients requesting dental related advice and are complaining about tooth related pain? That is between 2003 and 2007. Why do you think that is happening?

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Ann Keen: I think that is an awareness problem that PCTs have in the main now started to address. The public do use NHS Direct very well and we thank them for the work that they do. For many people it is their first point of enquiry, whereas there is so much activity with PCTs that have public meetings, information meetings, information leaflets in libraries, in bus stops, advertising posters, on buses. We have got through the worst of people not being aware how to contact someone for dental treatment.

Dr Cockcroft: In many ways the increased use of NHS Direct is actually a good sign of commissioning working. I went to Manchester where nine PCTs have commissioned triaging of out of hours care through the centre just outside Bolton so that anybody who needs care out of hours is directed to NHS Direct. NHS Direct triage those calls and then re-direct them to the Wong Practice in Greater Manchester which has a contract to provide out of hours service or, if it is not urgent, directs them to open access slots in other contracts which the PCT has agreed. In Plymouth the PCT are using NHS Direct in their advertising for patients to ring NHS Direct so that they can signpost them to practices which are accepting patients. So far from the growth in calls to NHS Direct to say it is not working, it actually shows how well PCTs are doing. In Manchester I went to the call centre with the local PCT and with the dentist who has the contract to provide services and they showed me the number of calls that they handle. They are all disposed of appropriately so the patient gets the treatment they need.

Q751 Dr Naysmith: Is there any record of why they are ringing up?

Dr Cockcroft: Many of them, like I say, are directed and a lot of out of hours lines use NHS Direct to triage. If you wanted we could try to dig a little bit deeper and speak to NHS Direct.

Q752 Dr Naysmith: If there are figures it would be useful. The other aspect of this of course is that some people complain of facial pain and dental related pain so it may actually be a lot more than a 60% increase. It would be nice to know what is going on.

Dr Cockcroft: We will try to get that for you.

Q753 Dr Taylor: Minister, I have a terrible fear I am living on a different planet from everybody else. I do not know how Dr Cockcroft can go—unless he is wearing his rose tinted spectacles—and say he gets no negative vibes. Every time I sit in the dentist's chair I get negative vibes and we have heard the same from other members. I want to explore UDAs because we have heard of a lot of problems with UDAs and I want to know what you see as the flaws with UDAs and then if you do not pick them up I will pick them up. What flaws have you seen?

Ann Keen: I am not wearing any rose tinted spectacles or rose tinted contact lenses in my case. What we are seeing is of course a much more simpler payment system from that very complicated system with hundreds and hundreds of different payments. I think most patients feel very confident that they

know what they are paying for. I know that Barry and possibly David want to talk about a particular aspect of this because they have brought this together and therefore their knowledge on this particular aspect is better than my own. I do want to say straight away that of course there are variations in the dental contract but we have come through the worse aspect of it. That is what we believe and we know that there is much more to do in some areas, in particular around this particular question of the UDAs. I know the work that David and Barry have been doing they would want to share with you today.

Q754 Dr Taylor: Can I pass onto you a suggestion that we had last week because there are very severe criticisms of the banding and the amount that has to be done under number 2 band, for example. One of our witnesses last week made what struck me as an incredibly sensible and easy to carry out suggestion, that we should move to either five or eight bands. He suggested splitting band 2 into 2a and 2b; this would not cost that much more because band 2a would only get two UDAs whereas band 2b would get four UDAs. Then again splitting band 3 into 3a with seven UDAs and 3b with 15 UDAs which would allow for the huge differences that at the moment fit within the same bands. Could there be any consideration of that sort of widening of the bands?

Dr Cockcroft: We have had a lot of suggestions ranging from expanding it to five bands to expanding to 400 like the old SDR. I think what we need to do is to let it settle down as it is. To come back to your first point, I certainly do not look at this through rose tinted spectacles and I completely appreciate how angry dentists felt at the beginning. What I am saying is that when I go out now it is a much less aggressive workforce that I am talking to; people still have issues about this and I am sure things will need to change in some areas as time goes on.

Q755 Dr Taylor: So you do still get a few like that.

Dr Cockcroft: Absolutely, especially from people who are in child only contracts who are feeling particularly squeezed at the moment. I think what we learned from PDS was that you need a currency; that was agreed. When we did the framework document in 2003 the BDA said that we needed a clear, identifiable currency and we came up with weighted courses of treatment. 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. The UDA is just a measure of the weighting. This is not about creating units; it is about providing treatment based on courses of treatment. You talked about splitting band 2 into 2a and 2b; that would mean raising the value of 2b and dropping the value of 2a. There are far, far simpler cases in band 2. If I went to the British Dental Association or indeed to the dentists and said that we are going to reduce the simpler

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courses of treatment by X there would be another riot because they would say they do more of those and only do a few of the others.

Mr Lye: The more you increase the number of bands then potentially the more you complicate the system of patient charges.

Q756 Dr Taylor: That would not alter patient charges at all; they would stay the same.

Mr Lye: It potentially would because if you are basing the patient charge rates on the current bandings—which is certainly what we do at the moment—it would be quite difficult to calibrate the patient charges when you have all these different bands.

Q757 Dr Taylor: If they could stay on just band 1, band 2 and band 3 they would not have to alter. We were told again last week that UDAs for some dentists are worth precisely £16 and others are worth over £40.

Dr Cockcroft: The value of the UDA as it started is purely a construct of how dentists worked under the old system and all it does is illustrate how differently dentists worked under the old system. My own view is that the main problem with UDAs is that people have actually focussed too much on UDAs. There are other issues that you should look at in commissioning a quality service, we have some PCTs now looking at saying, “The value of your UDA could be £10 but we will actually give you the rest of your contract value according to quality, access, working with the PCT, clinical governance”. That is completely doable within this system without making any regulatory change at all. 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. As the Minister said at the beginning, some PCTs are starting to do that and do it very well now but some are clearly not. The dentists were actually told by their leaders that this is a rigid target based system, yet in June 2007 the BDA produced a guide to innovative commissioning which I thought was a fantastic document.

Q758 Dr Taylor: So if the test period when contract barriers were arrived at was a very poor one, for instance you were on maternity leave—

Dr Cockcroft: With maternity leave you would have got the money and your contract value would not be changed at all.

Q759 Dr Taylor: I have received an e-mail this week from one of my dentists: “I was pregnant at the beginning of 2004; I was on maternity leave for the majority of the test period when contract barriers were arrived at. I ended up with a very low UDA value which often means that the treatment I provide literally leaves me out of pocket.” Is there any way round that?

Dr Cockcroft: If somebody was on maternity leave and getting maternity payment, the maternity pay would have been built into the contract value.

Q760 Dr Taylor: So maternity pay should have been built into the contract value.

Dr Cockcroft: If it was what they earned at the time.

Q761 Dr Taylor: Thank you; I shall take that up locally.

Dr Cockcroft: If she had a break in service then obviously the PCT can look at that. She will need to discuss that locally with the PCT. Certainly in some areas now PCTs, because of their 11% growth in areas where access is not a problem, are looking at some of the low UDA values and seeing what they can do. They have the flexibility to change that. It is not about just giving somebody extra money; it is about giving extra value in return for what you are doing, so it works both ways.

Q762 Sandra Gidley: Would you accept that one of the perverse effects of the UDA system has been that in cases of high dental need patients are losing out because there is disincentive for the dentists to carry out complex work? I can give you a couple of examples. We heard from the dental technicians, I think it was, who said that there has been an increase in the number of plates with a single denture and a corresponding decrease in crowns and other more complex and expensive work because sometimes the dentists cannot afford to do that work on the new contract. The survey released today shows that a third of PCTs said they were aware of particular treatments ceasing to be offered by trusts, for example 89.7% of those trusts mentioned root canal work, half of them mentioned bridges, and so it goes on. Is that right? That is a question for you, Minister.

Ann Keen: That is a very technical question and, to be fair, I want this to be answer correctly and this is why Barry is here today, to answer the technical side of dentistry.

Dr Cockcroft: Dentists have a responsibility to provide what is clinically appropriate for their patients. It comes back to Dr Taylor’s point that everybody will complain that they cannot do a root canal economically under the new systems but nobody complains that they get paid £70-odd for a very simple course of treatment only involving one filling. It is about swings and roundabouts and not looking at every individual course of treatment in terms of what you get. I would expect a clinician to rise above that sort of thing and to provide clinically appropriate treatment for their patients.

Q763 Sandra Gidley: But this is impacting on patients.

Ann Keen: On that point, if it is impacting on patients it is my responsibility and it is not technical. It should not be impacting on patients and I would be concerned about the ethics of that practice.

Q764 Sandra Gidley: My understanding is that it is fairly widespread.

Dr Cockcroft: I think there are two issues here. One is that there is bound to be a reduction in complex treatment because there was a clear incentive under the old system to do more complex treatment because of the item of service based incentive in that

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system. The reduction in very complex treatment is appropriate if it is clinically appropriate. The Dental Laboratories Association keep going on about these single tooth dentures and when we raised that at the key stakeholder group none of the dental members on the key stakeholder group recognised that situation and I think it might be apocryphal. I think the other situation is that the Dental Laboratories Association—there is a similar situation in America—where globalisation of supply and movement of laboratory supply to China, to Turkey or to other areas like this is seriously impinging on dental laboratories at home. I had a letter from a dental technician this week who is not politically astute or knowledgeable who actually said that the contracts had an impact, something else had an impact but the main impact on his business is the fact that dentists are now sending their technical work abroad. That is a big problem and it is exactly the same problem in America; American technicians have got exactly the same problem. That might be an issue for us because you never quite know who is going to guarantee the quality of that. However, a reduction that is appropriate is appropriate. If somebody is not providing what is clinically appropriate—root canal is a classic example—that is a governance issue, that is an issue for PCTs and ultimately it is a breach of contract.

Q765 Sandra Gidley: I would just challenge you that it is apocryphal because I would not like to think that we had people coming before our Committee providing apocryphal evidence.

Dr Cockcroft: Some of the stories I have heard have been apocryphal, I know that.

Sandra Gidley: There was evidence to back up this strange coincidental increase in the number of single denture plates with the introduction of the new contract. That may or may not be apocryphal, I do not know.

Q766 Chairman: Do you think that UDAs are the best way of paying for a dental practice to invest in its capital and everything else? When dental practices are used as outreach training practices they are also just paid by the UDA system as well, or am I wrong on that?

Dr Cockcroft: We said in our PCT guidance that we published in January that value for money looks different in different situations. This is a classic around the salaried services where a salaried service can spend a whole morning treating two autistic children. That is incredible value for money for those children but it would not generate very much in terms of UDA. It would be completely inappropriate to performance manage that sort of service using UDAs. It is there as a monitor because you know what patient charges should be. With undergraduate education we have examples of outreach teaching in Sheffield; we have visited two practices in Sheffield where they are working with the PCT and the dental school and a part of their contract is to provide outreach teaching and does not have to be monitored by UDAs. The patient charges need to be provided like that. It has not

actually stopped the development of outreach teaching. People are finding ways to get round it flexibly locally.

Q767 Chairman: My understanding is that the payment of UDAs to these practices is reimbursed by having these students getting experience.

Dr Cockcroft: I do not know the particular case and I know you took evidence from Mrs Naylor, but certainly I went to a practice in Sheffield where they have a well-developed outreach centre and they have got UDAs built into the contract but there is other stuff beyond the UDAs in the service level agreement for trainee students.

Q768 Chairman: You believe it is a right and proper way of reimbursing a dental practice for having students.

Dr Cockcroft: I do not think undergraduate training should be directly linked to UDAs, no.

Q769 Chairman: Mrs Naylor's practice is next to the GP practice in the village in my constituency. The GP practice within the GP contract gets money for running that practice or paying its bills etc. Mrs Naylor does not, why?

Dr Cockcroft: This is something we are addressing now in the next stage review. One of the things we will be talking about is around capital and how you invest in premises. Dental premises have been under invested from a capital point of view for years. But doctors' good will was bought out in 1948 and dentists' good will was not bought out in 1948. The mix of NHS and private in dentistry makes it sometimes difficult but clearly getting the NHS to invest capital in improving dental premises is a huge priority for me. We have made £100 million directly available over the last two years; that is very welcome but I think the NHS needs to invest more of NHS capital in improving the NHS dental estate. It was much trickier under the old system because of the contractual arrangement; it starts to become a lot easier now.

Q770 Sandra Gidley: Dr Cockcroft, picking up on something that Dr Taylor said, he has heard that different dentists within the same practice have different UDA values. Correct me if I am wrong, but a PCT has an allocated number of UDAs they can use.

Dr Cockcroft: No.

Q771 Sandra Gidley: They do not, okay. Something that is happening now is that the activity of dentists who are leaving the service is being reallocated, new dentists can tender for it. It is coming in at a much more expensive price. To give a practical example, a dentist who was on a very low UDA value of something like £16 or £17 (which is much lower), when he retires and the PCT re-tendered every bid that came in was well over £20 for the same work. You only have a fixed pot of money so the amount of activity will surely decrease. How is that going to increase access to dentistry in the long run?

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Dr Cockcroft: I do not think the amount of activity would decrease.

Q772 Sandra Gidley: There is a cost to this.

Dr Cockcroft: One of the complaints has been that newly tendered services are actually cheaper than the existing ones when they do that and that would actually increase the availability of service because you would be able to commission more work. I think the important thing about tendering in UDA values is that it is quality first. A low quality service is not value for money. Again we are well aware in some early stages that some of the tenders did not go like that, and it is not about lowest price wins the tender. It has to be a quality service.

Q773 Sandra Gidley: How can you assess quality before it is provided?

Dr Cockcroft: I have certainly been to some practices which have gone through the tender process and they are providing a service. How can you assess quality before a service has started? You can look at people's plans, their recruitment plans, their facilities and things like that, and also look at their track record. I think it is very important to look at the track record of the provider before you actually give them a new service. If I could just come back to the Chairman's point about capital, the money that goes to dentists is gross money and an element of capital investment is included in the gross contract values. There are expenses that go out of that and some of that expense is to actually cover capital investment that historically dentists have made.

Q774 Chairman: Are there also professionals working within that practice as well?

Dr Cockcroft: Do you mean nurses?

Q775 Chairman: Yes. That is not the same for GPs at all.

Dr Cockcroft: GPs get 70% of their expenses reimbursed and the dentist pays the expenses of his staff and it has always been like that. I think it is 56%.

Chairman: If that is a moving picture, if there is anything more in the next few weeks I am sure this Committee would like to have a note on it.

Q776 Dr Naysmith: Looking at the public health aspects of dentistry, every 10 years since 1968 there has been a survey of adult and child dental health in this country, but for this year it has been decided that it will not happen. We had some very prominent experts here at the Committee last week who said that the data they get from these surveys is invaluable and they have recommended to the Department that it should not happen but you have gone ahead and are not holding the survey this year.

Ann Keen: I really do not understand that at all because we are desperate for this survey to take place. The Department wants this survey to take place.

Dr Cockcroft: The responsibility for surveys has moved to the Information Centre. They have a business plan which has been delayed because of that re-organisation but we certainly are absolutely desperate for this to go ahead.

Q777 Dr Naysmith: Do you think it will still go ahead?

Dr Cockcroft: I am hopeful that it will go ahead in 2009. There has been a delay because of the re-organisation but I do not know where you got the impression that we wanted to stop this; we are desperately keen for this to go ahead.

Q778 Dr Naysmith: So you are saying that it has just been delayed.

Dr Cockcroft: Yes, absolutely.

Q779 Dr Naysmith: You recommend that it goes ahead.

Dr Cockcroft: Yes. This is the best quality research for overall dental health in the world. We do a child dental health survey every 10 years and an adult dental health survey every 10 years. We have had significant internal discussions with the Information Centre about moving this forward as quickly as we possibly can. It has been delayed because of the re-organisation in their funding but there is absolutely no doubt that the Department is desperately keen that both decennial health surveys—child and adult—continue as they have previously. I do not know where you got the impression that we did not want this.

Q780 Dr Naysmith: You must know where we got the impression because you are complaining about it being delayed.

Ann Keen: What we are trying to say is that we desperately want this survey.

Dr Cockcroft: We have certainly had very positive discussions with the British Dental Association; the British Dental Association know that we desperately want this to go ahead, they have written to the Information Centre.

Q781 Dr Naysmith: You still have not got the go ahead, that is the point. One of the things that was said last week was that we could do with a lot more better data collected by primary care trusts on oral health.

Ann Keen: Definitely.

Q782 Dr Naysmith: Are you pushing for that as well?

Dr Cockcroft: It is in the public health regulations; they have to do appropriate surveys. We have good data in some areas and in other areas it is not.

Mr Lye: Just to come in there as well, SHAs in the East of England have written to all their PCTs requiring them to carry out these oral health needs assessments as part of the commissioning process. I am glad to see they are on the case as well.

Q783 Sandra Gidley: The way that UDAs are now calculated makes it impossible to collect data on the individual treatments that are carried out. Would

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you accept that a vital probity assurance mechanism has been lost and that accountability of public expenditure on dentistry has been reduced by this change?

Ann Keen: I do not know that evidence would show that at this stage at all. What we are aiming at, half way through a contract, is still looking at it and doing a big stock take on this just to see exactly where we are, where we are going and where we will be within the five to 10 year span that we need to have. On the last point that Dr Naysmith raised in relation to collecting that data, it is a requirement that the PCTs collect the data and to continue with that.

Dr Cockcroft: On the first of April we are moving to introducing an enhanced clinical data set. The BDA know about that. It will be introduced on the first of April so we will know more data about what goes on within the individual courses of treatment. It will be item of service, but I have always been confused about the value of item of service data. All it does is evaluate what you have been paid for; it makes no mention of whether there is any health benefit or not. We clearly recognise that PCTs needed more information, dentists need more information because, as you were saying, they need to be able to demonstrate that to the PCTs in discussions. So that will be introduced from the first of April and it will include the two items of evidence based prevention that we know can actually be done in practice and will work. For the first time ever we will be recording preventive activity on an official NHS form.

Q784 Sandra Gidley: I think we are coming onto preventative activity later. Will you accept that the data is different so it is going to be much more difficult to compare what is happening after the introduction of the contract with what was happening before?

Dr Cockcroft: We certainly do not have item of service data. A lot of people go on about the research value of item of service data. I do not think there is any link between oral health and item of service data and we are comfortable with that. We need to measure oral health, that is the important thing. The reason we had such good data on item of service was because that was how we paid the dentist previously and everybody agrees it is an inappropriate way to pay dentists, especially without ever improving oral health. A lot of people comment on that but I think their argument is fundamentally flawed.

Q785 Sandra Gidley: So what is the role of the Dental Reference Service going to be in the future?

Ann Keen: Enhanced.

Q786 Sandra Gidley: We had evidence from John Taylor who said that it was exercising an increasingly pastoral role.

Mr Lye: They have just carried out a consultation on the way they plan to change their role. They have talked to us and to the Welsh Assembly Government and they have talked to the NHS as well. What they are proposing to do is to move towards a system which is a sort of risk based approach to monitoring.

Let me put that into plain English. It is where they actually look at the information that is coming in so, for example, the information that they get from the clinical data set, from the FP17 forms, from the information they get through the claims they receive for payment online, any intelligence they get from PCTs and so the routine inspections and monitoring that they used to do will be on a less random basis and more on a basis where they identify that there are things that alert them to the fact that there may be potential issues there that need looking at. They are still going to be doing an awful lot of work out there in terms of the clinical records. They will be looking at a hundred thousand clinical records a year; they will be doing a thousand surgery inspections a year and they will be targeting particular ones; they estimate they will be doing 500 targeted visits a year where they have evidence that there appear to be anomalies in the information they are receiving. So they are going to have an active role out on the front foot. The other thing they are doing as part of the internal restructuring is to make sure that the dental reference officers who are the clinicians who actually do these visits will be doing less administration and actually spending more time on visits and assessments.

Dr Cockcroft: John Taylor left the DSD in 2006; this work has all gone on since John left the DSD.

Q787 Dr Taylor: We were told last week that the dental reference officer examines records but the records that they examine are selected by the dentists themselves.

Dr Cockcroft: That is what went on through the PDS piloting. They are going much more now to targeting and requesting named records rather than just asking them to supply the ones they like.

Q788 Dr Taylor: So in the future they will be able to go in and pick out any at random.

Dr Cockcroft: Yes.

Dr Taylor: That is reassuring, thank you.

Q789 Charlotte Atkins: I want to move onto the issue of preventative care but first I would like to congratulate the Minister on the announcement on the fluoridation of water supply because I think that will be a huge step forward for oral health and we will see the impact of that in just a few years' time hopefully. Witnesses have been saying to us that the dental contract should contain extra incentives to dentists to provide more preventative care because at the moment that is obviously not covered by UDAs. Are there any plans to modify the contract? I know that Barry Cockcroft was talking earlier about the fact that there are developments outside the UDA framework, but what sort of modification of the contract are you going to be introducing to ensure that you are not just relying on the good PCTs to actually explore that preventative area but actually to introduce an OF-type system for dentistry because clearly we cannot expect the worst PCTs to come up to the best immediately and we do

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have to provide the wherewithal for dentists to be able to provide that preventative element, particularly in areas of very poor dental health.

Dr Cockcroft: Preventative activity is within band 1 so it is there and it is expected to be provided. A lot of the evidence based preventative stuff that is in our guide that we sent out can actually be done by DCPs, by dental nurses and fissure sealants by therapists and things like that. Developing the role of skill mix is a key part of what we are actually doing. Like I said earlier on, within that enhanced clinical data set that starts on the first of April the two best evidence based procedures—fissure sealant where there is a clinical need and the application of topical fluoride—will be recorded on the clinical data set. So a PCT that may not be actively monitoring will actually get a report from the DSD which actually says that none of the practices have actually done any prevention. As the Minister has said, there is variation but this will be so blindingly obvious to them that something is not actually going on that they should, as good commissioners, be challenging that. What we are actually doing is working to develop preventive things with people who traditionally do not access care. The Minister talked about the initiative with ASDA which we are working on at the moment to try 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.

Ann Keen: I think a QOF-type system would be a very positive way forward. Lord Darzi in his review is trying to bring dentistry into the mainstream of primary care and that is where I personally feel it should be. The fact that it has been seen as separate is not acceptable any more. The inequalities in dental health are still so very, very obvious and the only way I think we can go forward with this is to bring it right into the centre of the primary care setting, whether that is back to capital spending on where the dental surgery is, and it is something that when we go into a clinic we expect to see the entire primary care team there and that that is quality measured. The dentist sits in the centre and the hygienist and the nurse and the entire dental team sits in the centre of the primary care team.

Q790 Charlotte Atkins: I very much agree with you but very often the issue is for dentists to be able to find the appropriate premises and they do not really get much support. I know from a new dentist in my patch, trying to find the appropriate dental premises, having to compete maybe with a property developer for the same property, and also what incentives are there to ensure, once they have a premises with sufficient space, to actually encourage the use of a range of other dental professionals to do that important preventative work. At the moment there does not seem to be very much incentive for that to happen.

Ann Keen: That is an area we want to work on. I think Lord Darzi's review will assist us in doing that, along with your report that will assist us in being able to do that.

Dr Cockcroft: I completely agree with what you are saying about capital. It has been a longstanding problem in dental premises being under-invested in capital for a long time. I think there is an opportunity to do something now. You were talking about QOF and one of the things you could do within QOF is include something that says, "Do you involve dental care professionals in your preventive work? Are you doing that now to provide better service to patients?" PCTs could decide that locally and it can be done. Topical fluoride varnish can be applied by dental nurses if they are competent and trained; it does not need a dentist to do it. Obviously fissure sealants can be done a therapist. It can be developed locally. If you have an area of high need as well you can actually include in the contract a targeted incentive on people of that postcode area and you can put some extra money in to support that if you wanted to do it. I think in West Yorkshire they provided free fluoride varnish for their practitioners in the worst area in Kirklees so that the dentist has at least a bit of financial support right at the very beginning; it was a small drop but it was going in the right direction.

Q791 Charlotte Atkins: We all agree that we must have evidence based policy.

Dr Cockcroft: Yes.

Q792 Charlotte Atkins: So how are we going to make sure that the preventative programme is actually properly measured and monitored to make sure that we have an even-handed approach across the country and we particularly focus on those areas of great dental inequalities?

Ann Keen: That is where the QOF system will be very positive and very helpful to us.

Q793 Charlotte Atkins: When do you think we will move in that direction?

Dr Cockcroft: That depends on the pace at which PCTs move.

Q794 Charlotte Atkins: We all know that PCTs up until now—although I think it is changing—have not given the proper priority to dental health simply because it is a small part of their budget and because generally people do not die of dental inequalities. What are we going to do to make sure that we raise it up the agenda and then we monitor PCTs and dentists to make sure that we are actually addressing the preventative agenda? You rightly pointed out that clearly the whole climate of dentistry is changing because the nature of our dental health is changing and we have much greater oral health, so we have to look at preventative areas, particularly for the areas of most inequality.

Dr Cockcroft: The last time I was here I think I said that we had commissioned a work which is evidence based prevention, what actually works in primary care. We have given a copy of that to every single practice in the country and it is available on line. In April we are bringing the dental deans from all the undergraduate schools and anybody else interested in education to a big event in London to talk about

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incorporating the evidence based prevention tool kit into undergraduate training so that focussing on evidence based prevention is not something you learn after you qualify, it starts to change the way of thinking of undergraduate students before they qualify. That day is actually being led by two dental deans who are very enthusiastic about doing it. As to monitoring it, the two fundamentally important things—topical fluoride varnish application and fissure sealants—are included in the new enhanced clinical data set so we will have details about every practice and how they are embracing the new evidence based approach to prevention. We have actually got sufficient interest in PCTs in many areas in doing that already, but it is the sort of thing that comes with the development of quality commissioning.

Q795 Charlotte Atkins: What are you doing in terms of schools in terms of preventative dentistry? We have not really addressed that as yet and if we are going to be talking about good oral health in the future we have to start obviously at the baby stage but also follow it through in terms of school dental services.

Ann Keen: This is really our public health agenda. When you look again to the review that is on-going at the moment that Ara Darzi is due to report back on at the end of June, when we have gone out to public consultation and we have asked people what they want, they want a personalised service such as screening (the prime minister has talked about the importance of screening) and prevention at every level and therefore you have to start with the child and you have to start with school. We are actively encouraging health visitors, school nurses and the programme of obesity on caring for yourself, being fit at school, so part of that work will definitely be around oral health as well.

Q796 Chairman: Minister, have you had any discussions with other ministers about working on oral health issues with pre-school children through the SureStart network?

Ann Keen: Very recently actually. The children's centres have very much of a strong health input. We are working very well across government with the Department for Children, Schools and Families. On Monday we had all of the SureStart and children's centres gathered together at the Festival Hall on the Southbank, over a thousand there, from early years right across to health professionals, knowing that that is where you really address inequalities. Even the mum at pregnancy, the investment in her with healthy eating, with the family nurse partnership in particular with young mums who are working with them who have never had the education at home as to how to be healthy during pregnancy. The nurse stays with the mum from pregnancy right up to the child being two. It is a big investment in those inequalities and the evidence is already showing the change in lifestyle. It is not about lecturing people that have very low income as was typical in the past when we just lectured them to be healthy. It is really about genuinely working with families and

encouraging them to very much look at how, if we can look after ourselves differently, we can have a different quality of life.

Q797 Chairman: Do you have any evidence of SureStart schemes that have people with experience in dental health prevention actually working?

Dr Cockcroft: We have a scheme called Brushing for Life which is linked to SureStart where in some areas PCTs buy packs that we provide and then they are distributed through the SureStart network with some oral health advice as well. The thing has been evaluated; I am not absolutely sure what the findings were but certainly the take up is very good in some areas and we need to do more of this. We re-launched the scheme a number of years ago and we are pushing that very hard in local communities.

Q798 Chairman: Would you mind letting us have evidence on that?

Dr Cockcroft: I will do that.⁸

Q799 Chairman: Why did the Department decide to remove the registration requirement for patients and how do you respond to suggestions that the requirement should be reinstated?

Dr Cockcroft: Registration as a paid concept was only introduced in 1990; it was not there before. It was introduced in 1990 because there was a link between out of hours cover and registration, so you could identify which patients were the responsibility of which practice so they could provide out of hours cover. I was in practice from 1975 to 2002 and for the first 15 years of time in practice there was no registration, yet my patients considered me to be their dentist and I considered my patients to be my patients. The only difference the introduction of formal registration did was to link registration to out of hours cover. If you asked my patients before 1990 who their registered dentist was they would all have said it was me. I do not think the fact that the Government takes away formal registration makes any difference to that. People can have a list of patients, they can recall their own patients and we certainly want to encourage on-going continuing care. There is a lot of evidence that the less you move around on the whole between dentists the better care you get. This is one of the areas where the significance is far less than people would have you believe. A lot of people will say that there is no sense of continuity now, but I had complete continuity with my 2,500 patients for the 15 years before registration was introduced; I expect it to be exactly the same now. I know people make the point, but I think it is an over-emphasised point. Dentists still have their own patients and they can recall them appropriately. Also, they can actually prioritise their own patients; that is not discrimination. If they have their own patients they can prioritise their own patients. If a dentist says to somebody they are full but somebody else has got in, that is because he had

⁸ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085672

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seen them previously and that is completely appropriate. So there is an ability to prioritise patients you have seen before in your services.

Q800 Chairman: Some professionals argue that registration actually fosters good relationships with their dentist and fosters good oral health.

Dr Cockcroft: I think what fosters good oral health is the on-going continuing care relationship which you should have whether you have registration as a term or not. I think that has been over-emphasised and I think it has been over-emphasised for political reasons.

Q801 Chairman: Would it not help you to know who is and who is not accessing dentist health?

Dr Cockcroft: We can provide that in relation to practices. If they want to see a list of their patients we can do that on a regular basis.

Chairman: We were talking earlier about waiting lists and we do not know whether you should have or should not have waiting lists and everything else, I would have thought registration would have been an easier measurement.

Q802 Dr Naysmith: You said it was introduced in 1990 to help with out of hours work, so what has happened to out of hours stuff now?

Dr Cockcroft: Out of hours is now the responsibility of primary care trusts. In some areas it works incredibly well.

Q803 Dr Naysmith: Any patient can turn up.

Dr Cockcroft: Whether you are seeing a dentist or whether you are not you have just as much right to out of hours care. That is being handled in many areas very, very well.

Q804 Dr Naysmith: Is it being handled better than it was before?

Dr Cockcroft: I think the service is better. One of the earlier PDS pilots was on out of hours in Newcastle and it showed that of 100 calls to NHS Direct only 19% required a conversation with a dentist and only 5% actually required a consultation on that day. What we have learned about improving out of hours is that the vast majority of people are happy if they have pain relief if they are in pain and we can provide them with access to a routine dental appointment the next day. The demand for out of hours care is going down because the availability of open access slots in existing contracts is there. I was a practising dentist for 27 years and sometimes if you are dealing in an emergency situation out of hours without the regular support I think there are some governance issues there as well. I think centralising out of hours care and dealing with it like this is much better and safer.

Q805 Sandra Gidley: I am curious about it being okay before 1990 so it is okay now; what percentage of the adult population had access to an NHS dentist in 1990?

Dr Cockcroft: The level of access has never gone above 60%.

Q806 Sandra Gidley: You would accept that the access has decreased over the past 17 years.

Dr Cockcroft: The other thing is that registration historically was reduced in 1996 to 15 months. We would certainly like to grow access to services; we are not content with where it is now. It will never reach 100% because there will always be a proportion of the population who do not want to go, who are too frightened to go or who want to access care privately. What we need to make sure we can do is to ensure there are enough services there commissioned so that everybody who wants to and needs to can do.

Q807 Sandra Gidley: Will you accept that in 1990 there was not a problem with access to dentistry.

Dr Cockcroft: There was no problem with access to dentistry effectively until there was a new contract that was introduced and that caused some difficulty.

Q808 Sandra Gidley: Was the real reason that registration with a dentist was dropped was so that in theory you could turn round and say that everybody had access to an NHS dentist and to fulfil an election promise.

Dr Cockcroft: In many ways, because of the time lag factor, if we introduced registration now we would not have the time delay that we have with the backward figures. Our figures are actually looking much better now because the growth that is happening now would show much earlier. If we had retained registration the data would actually look a lot better now because the 10,000 people who are already on the database in the past in Tame and Banbury would already be showing on the Department's statistics. I think too much is made of registration. I think the important thing is an on-going continuing relationship with a professional that both of you treat as an important and valued thing.

Q809 Dr Taylor: You are saying very glibly that the removal of registration makes no difference, do dentists throughout the country feel the same way as you do, that they are expected to keep their own patients even if they are not registered?

Dr Cockcroft: Some of them have made the point that this is a terribly bad thing but all the practices I now visit still recall their patients on a regular basis, they still have their own patients; in effect it should make little difference to them.

Q810 Dr Taylor: We will need to watch to make sure that it does not. Moving on to the financial issues, I think I am right in understanding that for the funding of dentistry 75% comes from the Government and the other 25% comes from patient charges. In 2006–07 there was a shortfall from patient charges of £159 million, we are told. How did that happen? How was the prediction so wrong?

Dr Cockcroft: There were a range of factors. One was that there was very little carry over from the old system to the new system. Secondly, the important thing to say first of all is that the data for this year is looking much better.

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Q811 Dr Taylor: We are nearly at the end of the year.
Dr Cockcroft: Dentists have another two months beyond the first of April to submit forms so we will not have full data on that until June. There are a range of things that happened in the first year that were quite anomalous. There were two or three items that were actually banded in the wrong band; dentists did not lose out but the patient charges went down and that cost about £30 million. We addressed that in the second year. There were also some changes in patterns of behaviour and some anomalous reporting. There were an awful lot of what are called continuations of treatment.

Q812 Dr Taylor: What things were in the wrong band?

Dr Cockcroft: We got it right for the dentists because we spotted it before the contract started, but we had already made the financial calculations and were not able to change them in time for the first year, but we changed them in the second year. These are very complicated things like using a pre-fabricated post to retain a crown or something like that; one was about incomplete periodontal treatment. They were very technical things. Also, in the first year there was a large amount of what we call continuations of treatment which are exempt from patient charges. We introduced a checking system at the DSD in January and the incidents of continuations of treatment dropped by 50% just by checking that there was a particular treatment to continue.

Q813 Dr Taylor: Continuations of treatment, would that include orthodontics?

Dr Cockcroft: No, orthodontics is irrelevant to patient charges. The other thing was that there was a shift to more exempt people accessing care. We anticipated that and we factored in a 4% increase in people previously unable to access care who could not afford private care. Actually the increase was 7% and that had an impact on patient charge revenue. There has been a high incidence of some other charge exempt categories of treatment and we are working on that to identify what the new challenges are about the new PCR system. We have also reduced the proportion that PCTs expect to get from patient charge revenue for the second year. The biggest factor at the end of the day is under delivery because under delivery on contracts will obviously hit patient charge revenue. It does not hit the PCT because they do not pay out the money at the end of the day because there has been some under delivery, so that impacted as well. There were a range of factors that made the first year very different. In April last year there was virtually no patient charge revenue submitted because there was no carry over from the previous system and we expected there would be. This year there was a pretty average incidence of patient charge revenue in April so the figures will automatically be better this year. It is something we are watching and it is very significant. It was certainly a problem for PCTs in the first year because they had a net and a gross budget and that put them under some pressure.

Q814 Dr Taylor: Orthodontics is irrelevant because they are virtually entirely with children.

Dr Cockcroft: Yes.

Q815 Dr Taylor: We have been told that this year, 2006–07, with the deficits that some of the money that should have come from patient charges was actually removed from the commissioning budget to lessen the commissioning budget.

Dr Cockcroft: The commissioning budget is a net element from us and a gross element from patients and it all makes one commissioning budget. In some areas that was certainly true last year; in some other areas PCTs put money in from their general allocation. We know in Sheffield they certainly went to a significant extent. 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. I know the British Dental Association wants us to fund the gross element as well but that is about £600 million and if we funded that directly there would be no incentive on the PCT or the dentist to actually collect the appropriate patient charge which has always been there. Like I say, it was a problem last year, we clearly accept it was a problem; we think it is much less of a problem now.

Q816 Dr Taylor: You are pretty well guaranteeing that 2007–08 is going to be nearly the amount predicted.

Dr Cockcroft: It is much, much better than it was last year.

Q817 Dr Taylor: I gather the ring fencing has gone on from 2009 to 2011; does that mean the income guarantee for dentists has been extended as well or does that end in 2009?

Ann Keen: It is the same.

Dr Cockcroft: It still ends in 2009.

Q818 Dr Taylor: That ends in 2009 even though the ring fence continues.

Dr Cockcroft: Yes.

Q819 Dr Taylor: Does this risk that some dentists will leave at that stage?

Dr Cockcroft: We do not expect that. Obviously some people may decide to move. The important thing is that you have dentists who provide the services that they do, 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. We do not expect a significant leaving, especially of NHS committed dentists. I think there will be some people who still have very small contracts, who are child only, who will leave at some point. Quite frankly, if the PCT can re-commission those services I am quite comfortable about that.

Mr Lye: Most PCTs are commissioning for extra levels of activity next year because of the extra money that is coming in so I think there is an

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incentive for dentists to stay in the system and possibly even those who are outside the system want to come in.

Dr Cockcroft: I was speaking to a PCT in the Northeast earlier in the week about how they want to extend their PDS agreements and they were asking if it was all right for them to extend their PDS agreements with their NHS committed practice for five years. I was slightly disappointed that they were asking me the question because of course it is okay, but they felt they needed a bit of reassurance. GDS contracts are open ended but PDS agreements have got a time limit and there is now a lot of interest in PCTs in extending those PDS agreements for a much longer period. The one in the Northeast was looking at five years for all its PDS agreements where they are performing. They were actually only going to offer one year agreements to child only contracts.

Q820 Dr Taylor: So you are pretty confident that by 2009 they will be hitting their agreed UDA targets.

Dr Cockcroft: Yes. Child only contracts have some particular difficulties because they did incredibly well out of the old system because they were treating the dentally fit children of private patients. Where the calculation has been made we expect work from some of those contracts and there may be some small child only contracts that decide not to go with it. Like I say, the PCTs have plenty of people who want to grow services to meet that.

Q821 Charlotte Atkins: Can I address the issue of co-payments? The Dental Practitioners' Association said that such a system would improve access over night where basically NHS patients can sort of top up their treatment. On the other side of the picture other people are concerned that actually you will increase the division between those people who have poor dental health and those people who want to pay up front for cosmetic treatment but actually want the NHS to pay a big chunk of it. What is the current thinking within the Department?

Ann Keen: I think most dentists currently mix NHS and private and that system seems to work well for people. If you are talking about more and more cosmetic work then balancing out patients' needs or aspirational needs will be more difficult. I think most patients accept the co-payment system as it stands.

Dr Cockcroft: There is obviously a lot of disagreement about a lot of stuff in the contract but I think the underlying principle of local commissioning almost everybody says it is a good principle and enables the NHS to control where services are so that you do not end up like we did under the old system with dentists controlling where the services are and you end up with these pockets of areas where there is no service at all. Once you enter a co-payment system like that, especially in vouchers, all it would do would be to take away any possibility at all of the local PCT locally commissioning services, so you are completely back to where you started. If you are talking about a voucher system I think that would work fantastically in private practice because they would be getting NHS money as well as their private money; it would

do nothing at all to improve the provision of NHS services where people can actually have a private course of treatment if it is clinically appropriate with consent. I have absolutely no interest in moving down that route at all.

Q822 Charlotte Atkins: Do you think it is a way that private dental practices will try to grow their practice on the back of the NHS?

Dr Cockcroft: Clearly, yes.

Q823 Chairman: Did you look at that as a way of extending NHS dentistry when you came to renew contract negotiations in 2006? Parts of the country did not have NHS dentists by then because dentists were walking away wholly into the private sector. Did you look at anything like that?

Dr Cockcroft: We had a patient charges working group which was chaired by Harry Cayton who was then the director of patient public involvement and it involved the BDA, Citizens Advice Bureau and people from the Department. Harry's group looked in depth at all the different methods of payment and came up with the three banded system that we actually ended up with. CAB and the BDA were on that group and the report which was published and consulted on—a full public consultation for three months—considered all those things and came down in favour of the particular system we have. Harry looked at all the alternative ways of paying; that is still available if people want to look at the patient charges consultation document.

Q824 Chairman: It might be useful if we could have a copy to see what the outcome of that was.

Dr Cockcroft: I will send you a copy.⁹

Q825 Chairman: To pursue this a little bit further, what about if somebody was actually having treatment with a dentist and decided that the crown that was offered by the National Health Service was something they wanted to upgrade, for want of a better expression. If that happened now they would pay the full amount for that upgrade; there is no co-payment as such, the state do not pay anything, do they?

Dr Cockcroft: The NHS should pay for what is clinically necessary.

Q826 Chairman: They would not pay for a crown that is not inserted.

Dr Cockcroft: No.

Q827 Chairman: That happens now in what we call NHS Dentistry.

Dr Cockcroft: Sorry?

Q828 Chairman: What I am saying is simply this, that if somebody may need a crown and may need a crown on the basis of getting it on the National Health Service, if they wanted to get a different type

⁹ See <http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH—4120073> (includes summary of consultation responses)

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of crown from a dental lab that costs a lot more money, they would be charged the full cost of that crown.

Dr Cockcroft: They would pay a private fee for that.

Q829 Chairman: Within the NHS.

Dr Cockcroft: If it is outside the NHS as long as it consent, that has always been the case.

Q830 Chairman: This is where the confusion comes. The dentist who sat in your chair last week happens to be my dentist. She is an NHS dentist and 25% of her patients do this form of upgrading for cosmetic reasons—I accept that entirely—but they do that.

Dr Cockcroft: The charges that you can make in respect of NHS treatment are the three banded charges as set out in patient charge regulation. To make another charge in relation to NHS treatment is a breach of contract.

Q831 Chairman: This is not NHS treatment. You refuse the NHS treatment because you do not want that crown.

Dr Cockcroft: Then that is fine, that is a private treatment.

Q832 Chairman: Everything else in that practice is not, is it? It is not the same as if you go into a private hospital where you pay for everything.

Dr Cockcroft: I think it is about giving patients choice as well.

Q833 Chairman: Do you pay for the dentist's time as well.

Dr Cockcroft: If it is a private contract then you are paying a gross fee just like you get a gross contract value from the NHS. We have no power to regulate private fees at all.

Q834 Chairman: Do you measure the amount of money that a dental practice makes from people wanting more than what the NHS offers.

Dr Cockcroft: We know what dentists earn from the NHS and we have Inland Revenue data retrospectively about what they earn in gross terms, but we do not collect data in relation to private fees.

Ann Keen: Maybe we should.

Q835 Chairman: It is not a part of assessment of UDAs for dental practices.

Dr Cockcroft: No.

Q836 Stephen Hesford: Finally, NHS dentistry in 10 years, how is it going to look?

Ann Keen: In much better shape. Everybody in this room is aware that this contract has been difficult. I started this position and am 15 months into it. I have spent time learning a complex area to be able to articulate to you today; I am pleased that Barry and David are with me because I cannot articulate it all because it is very technical. At the same time we knew it was a shift of need, of change, of the importance of oral health from children right the

way through to our elderly population who now mainly still have their own teeth. I want to see our dental practice bang in the middle of the National Health Service with facilities that are of the best; that you no longer go into establishments that really are not fit for purpose; that it is a modern facility; that our dental schools' team has grown expertise and the skill mix within that team is doing more. I want to continue with fluoridation and other aspects of care to have the best oral health care in England which our 12 year olds already have. We know the expectations and aspirations of how people want to look; that is always going to be challenging, especially when you have, as the Chairman just pointed out, a very vibrant private sector. You have dental tourists now—you cannot open a Sunday newspaper without seeing where you can go and have all sorts of things done to yourself and people are wanting quick fixes—but at the same time they are wanting very good national health dental care. We want to recognise that it is more than just a good smile; it is actually about caring for our health and I value our dentists who are doing that. I want this contract to work for everyone, and in particular I want it to work for the people who are performing dentistry, our dentists and dental students. We have mentioned today that part of the curriculum has to change, to look very much at the inequalities and prevention. We have a long way to go with the inequality issue on most aspects of our work, in particular on this subject that you are doing and your report is going to enhance this so it genuinely is welcomed. I have asked the Department to give us a five year analysis as to where we expect to be and we want to share that openly and honestly with people. There is a lot of scaremongering about where it has gone wrong and in some places where it has gone wrong it has gone terribly wrong, but also we have to say what is so good about what has happened and we can only improve on it.

Q837 Stephen Hesford: Your five year projection that you have just spoken of, is that going to be in any way adjacent to our report? When might that be available?

Ann Keen: I have only just asked for this. We are half way through the contract. I think it is my responsibility to say that I want to monitor it more closely, I also welcome what you will have found and work with that and work with the Department to do a serious piece of work to see how we can have learned, listened, which I did. That is why we have got the ring fencing changed to 2011, that was very important to me. I have tried as much as I can to go out and listen to as many people on the positives and of course the negatives connected to this contract and to work with the BDA. I think we are just starting to turn that corner; I recognise that is what we are doing.

Chairman: Could I thank you all very much indeed. I think this is the last evidence we are taking on this inquiry so I do not expect to see you back with this hat on, Minister. Thank you very much indeed for attending.

Written evidence

Memorandum by John Taylor¹ (DS 37)

NHS DENTISTRY

[1] My perspective is administrative, regulatory and managerial. I am not and never have been a dentist. No member of my family is or ever has been a dentist. I have never had or sought private dental treatment. I am not and never have been a member of a political party. My standing ground in this matter is one, 50 years experience of payment systems in manufacturing industry and central government, and two, 60 years experience as a NHS dental patient.

[2] I can not argue that the new arrangement will fail because I do not know what is expected of it. It may succeed. It is possible for blind men to be on the right road. I do argue that the way it was introduced fell short of established good practice, not least in the absence of testable objectives; that risks were taken that need not have been taken; that foreseeable consequences were ignored; that if they come about, some of these consequences will be difficult to manage; and that safeguards for patients and taxpayers have been weakened.

ON REFORM

[3] All change has unwelcome consequences. The bigger the step change the more costly in time and money and opportunity and reputation is the recovery if it turns out to be a false step. That is why innovation by gradual reform is preferable to innovation by abrupt revolution. Abrupt revolutions, even when there are happy outcomes, leave legacies of distrust which can take the form of resistance to future innovation. Gradualism is a conventional managerial wisdom and a conventional democratic responsibility. In our democracy governments are expected to seek the greatest good for the greatest number, to serve citizens by preferring solutions that avoid worst outcomes rather than attempting to maximise best outcomes. Governments are to be cautious. Haste is justified only to prevent catastrophic failure. Whatever were its shortcomings the previous payment system was stable. It had not failed catastrophically nor was it about to.

[4] An established arrangement is a store of wisdom. It is the result of contributions by those with experience over a long time, through many changes, additions and refinements. A fish realises that it lives in water only when it is already on the bank. Common sense and good practice lie in penetrating why things are done as they are and only then considering whether any misfit with present conditions can be accommodated by small improvements and small refinements thereby avoiding the need to sacrifice healthy babies because to a sensitive nose their bathwater has become offensive. There was no need for abrupt change. A stable and well understood system with known and containable shortcomings was overthrown for an untried system. Their distaste for its shortcomings blinded its opponents to foreseeable consequences of its replacement. This is the mark of revolution not of cautious sound governance. The next time the payment system is changed gradual reform should be preferred to abrupt revolution because it is better governance.

ON CONSEQUENCES

[5] In human affairs it is impossible to remove one inconvenience without incurring another. All payment systems have perverse incentives. Payment by time with a requirement for a measured amount of work to be done, a system that I know as measured day rate (MDR), has replaced payment by item of work done, a system that I know of as payment by results (PBR). In PBR systems there is a bias to over activity, cheating by doing. In MDR systems there is a bias to under activity, cheating by not doing. It is more difficult to demonstrate the latter than the former.

[6] During the period leading to the change, opponents of the previous system claimed: that driven by PBR most treatment was unnecessary; that there was a problem of access to NHS dentistry; that PBR, which might have been useful once, became perverse because it did not encourage preventative treatments; that the fee scale was complicated; and that patients did not understand the co-payment arrangements. I do not know of any clear definitions for any of these concepts that could be used to establish the relative merits of competing solutions or the success or failure of any innovation.

[7] There is a minority strand of opinion that, under PBR, in the General Dental Services (GDS) of the NHS most treatment provided was unnecessary. In the period before the change in payment system that opinion prevailed despite the weight of evidence that the level of over treatment, though significant, was small.² It is not clear how the new arrangement will increase access to NHS dentistry. It is at least arguable that all dentistry is prevention but in any event there was nothing to stop prevention being added to the scale of fees. There were some 400 items of service in the fee scale. A few minutes observation in any supermarket will demonstrate that people have no difficulty when faced with thousands of items. It is not at all clear how the new co-payment method is easier to understand than the old. In short a system known to deliver high productivity at low unit cost was replaced by one likely to deliver low productivity at high unit cost without any obvious compensating benefits.

[8] Effectively, contractors can work on salary for the GDS alongside private item of service raising the opportunity for cross booking. Foreseeable consequences include: (i) a steady and eventually very large fall in the amount of dentistry provided in the GDS, due in part to the collapse of the work measurement system that replaced priced items of treatment, under the strain of bargaining between dentists and Primary Care Trusts (PCTs); (ii) a shift in the mix of GDS and private practice as dentists take advantage of a once in a lifetime three year opportunity to build private practice at public expense; and (iii) a shift in the mix of patients treated in the NHS and in the treatments provided for them. There are likely to be fewer and different treatments provided to a different and gradually shrinking population of GDS patients.

[9] All may be well and the outcome a happy one but that seems to depend crucially on the disputed hypothesis that under the old system most dentistry in the GDS was unnecessary. If that hypothesis is false the consequences could be difficult to manage. If dentists reduce their GDS work, either there will be more untreated dental disease or there will have to be more dentists and an increase in the total cost of GDS dentistry. A lower, if potentially (though not actually) variable, total cost of GDS dentistry will have been rejected in favour of a higher but more certain total cost. But this will not last. Experience shows that under MDR total cost is only certain in the shorter term. In the longer term total cost increases as productivity falls while salaries at least keep pace with inflation.

[10] Moreover the new patient charge arrangements make low income patients relatively less attractive to a dental practice. Where demand for dental treatment exceeds supply it is possible that at the margin it will be those exempt from charges or who have their charges wholly or partly remitted who are squeezed out of treatment. Further the new co-payment arrangements have few bands: this means reward gradients on either side of the grade boundaries are steep. The relationship between the cost of treatment and the co-payment is loose. The relative attraction of various treatment combinations to dentist and patient is altered. The next time the payment system is changed a thoroughgoing assessment of unintended consequences will be a priority.

ON REGULATION

[11] Treatment and other data were a base metal by-product of the previous payment system. They were turned into golden information by the alchemy of dental, statistical and computing knowledge and made available to NHS managers, dentists and academics. As a result, in the GDS, more than anywhere else in the NHS, it was possible to know. It would have been possible to conduct experiments and pilot studies and pursue a practical phased introduction of the new arrangements. This would have made it easier, quicker and cheaper to recover if things look like going wrong. It would have been possible to perform a before-and-after study of the effects of a change in a payment system for independent contractors introduced alongside a change in co-payment arrangements for taxpayers and patients. A rare opportunity to study a major national episode of social engineering existed and was spurned.

[12] These data were used also to protect taxpayers and patients by the prevention and detection of fraud and other abuse within the GDS. This protection is weakened. Barriers to abuse are lower. Abuse is harder to prosecute. Consequences of all this will take time to emerge. Unless new arrangements for data collection, storage and use are made, patient and taxpayer protection will be permanently diminished. From 1948 dentists financed treatment and took the risk of bad debt. With the new arrangements risk and expense are shifted to taxpayers. All in all this looks like a significant lowering of the protective wall around taxpayers and patients in the GDS.

REFERENCES

¹ John Taylor BA MBA C Mgr FCMI

Chief Executive, the Dental Practice Board for England and Wales, 1987–2006

From 1948 the DPB was the non-departmental public body accountable to ministers for services relating to the General Dental Services of the NHS in England and Wales. It had three primary functions: (i), to give to or withhold approval from dentists' claims for payment; (ii), to make payment for approved claims, efficiently, effectively and economically; and (iii) to prevent and detect fraud and other forms of abuse. In 2006 the DPB was dissolved and its functions merged into the Business Services Authority. John Taylor oversaw the preparation for the new payment system and the transfer of work to the BSA.

² Dental Reference Service

For over seventy years officers of the Dental Reference Service independently examined patients before and after treatment. These examinations were a key component in protecting patients in the GDS from poor or unnecessary treatment. In recent years the DRS was managed by the DPB. Results of all this work can be summed up as there being a small but significant amount of over treatment in the GDS. This is just the conclusion reached by the Schanshief Inquiry and it is what would be expected in a PBR scheme. This is the weight of evidence opposed to the assertion that most treatment is unnecessary.

Memorandum by Sandwell Primary Care Trust (DS 38)

DENTAL SERVICES

The Committee is holding an inquiry into NHS dental and orthodontic services, examining both General Dental Services (GDS) and Personal Dental Services (PDS). The inquiry will examine the principles underlying the reforms to dental services which took effect in April 2006 and the extent to which the changes brought about have been consistent with these principles. This evidence is laid out under the subject headings of the specific focuses of impacts of the reforms identified in the terms of reference.

1. EXECUTIVE SUMMARY

- Sandwell PCT considers that the 2006 dental contract is successful in facilitating the direction of service towards areas of dental health need and under provision. The PCT supports water fluoridation alongside service change to promote oral health.
- The 2006 contract gives the mechanisms to improve the quality of dental care. Providing good quality dental services will improve oral health.
- The 2006 contract will give opportunities to improve dental premises and skill mix. Local dental commissioning was implemented at a time of NHS organisation change which may have delayed the speed of progress in making changes. Given the capacity and capability in PCT workforce to deliver changes along the lines of world class commissioning the contract will provide the tools.

2. ROLE OF PCTs IN COMMISSIONING DENTAL SERVICES

2.1 Sandwell PCT welcomes the development of local commissioning for dental services. The PCT has an oral health strategy developed in 2005 and these reforms give the tools to facilitate implementation of that strategy to improve oral health and dental services.

2.2 The reforms have allowed development of a commissioning plan to enhance NHS dental provision in areas of historic under provision. Arrangements are in hand for commissioning additional activity in year and long term of activity through tendering processes.

2.3 The dental reforms have allowed the development of a new dental suite in Oldbury in an area of historic NHS dental under provision which includes General Dental Services (GDS), Salaried Dental Services (SDS) and dental teaching facility in a Local Improvement Finance Trust (LIFT) facility. Many dental premises in Sandwell are in converted premises, often above shops. The reforms and funding possibilities will allow movement into superior premises co-located with other health staff and other agencies through the 2010 initiative.

2.4 It was unfortunate that dental reforms coincided with organisational change for PCTs which has resulted in staff changes; loss of expertise in the area and lower levels of staffing at the time at which the changes were implemented.

2.5 Sandwell PCT has a higher than often usual Consultant in Dental Public Health establishment. Many other local PCTs have reduced establishment following retirements and reorganisation. This PCT considers this specialist input is required in order to realise the benefits of the contract.

2.6 Sandwell PCT considers the enhanced information flows from the Dental Practice Board (DPB) are instrumental in identifying performance issues both in terms of reduced activity and poor performance by dentists.

2.7 Dentists are concerned that contracts are renegotiated at practice sale. Although PCTs are able to review the contract value at this stage, their contract value and required activity have remained the same for new owners in the case of the two practices sales since April 2006 in this PCT.

3. FINANCE PATIENT CHARGE RISK

3.1 Sandwell has a General Dental Service budget in 2007–08 of £18 million of which £3 and a half million are expected patient charges. In 2006–07 date forecast from month six data there will be a patient's charge shortfall of £92K. Some PCTs have found large shortfalls in patient charge shortfall, but in Sandwell the shortfall has reduced now activity levels have gone up to those commissioned.

3.2 Dentists have a concern that dental funding will be reduced in 2009 when the ring fence of dental monies is removed. The PCT welcomes the 9% uplift in 2008–09 which will give the opportunity for additional dental provision. There are no PCT plans to cut dental funding in 2009.

4. NUMBERS OF NHS DENTISTS AND DENTAL PATIENTS AND ACCESS TO CARE

4.1 Sandwell is a relatively deprived Borough with a limited potential for development of private dental practice. Only one practice which was only providing limited NHS care ceased to provide NHS care in April 2006.

4.2 The numbers of patients seen in Sandwell increased from March 06 to March 07 by 10,664.

4.3 Sandwell has relatively good dental access with 73% of the population seeing a dentist in the last 24 months. Compared to West Midland average of 58% and England 55% as at June 2007.

5. PROFESSIONALS COMPLIMENTARY TO DENTISTRY

5.1 The Oldbury training suite provides an outreach service for training of hygienist/therapist trainees. This should encourage a trained, local pool of staff for recruitment to enhance skill mix in the dental team.

5.2 It is hoped that Sandwell practices will participate in a Local West Midlands Workforce Deanery foundation training pilot for Dental Therapists post qualification. The reforms mean that the PCT has local funding to facilitate this.

6. QUALITY OF CARE

6.1 Reforms have led to local ability to terminate contracts and issue remedial breach notices on the basis of quality.

6.2 New data available to PCTs since the 2006 contract and the ability to request records has allowed investigation of quality concerns about individual dentists. This has allowed identification of remedial action and improved public protection.

6.3 With regards to quality in Orthodontics Sandwell has been relatively unique in having a good quality Orthodontic service provided in primary care by the salaried service. The orthodontists are all on the GDC Specialist List following a period of formal training. Under the old GDS contract dentists who were not on the Specialist List and who had no formal training in Orthodontics were able to limit their practice to orthodontics. These individuals were entitled to a contract under the transfer to the new contract. It is less likely in future that non specialists will win tenders for provision of Orthodontic activity. It is Sandwell PCT's intention to work with existing Orthodontic providers to reach the standards developed for recognition of Dentists with a Specialist Interest in Orthodontics.

6.4 The new Orthodontic contract requires dentists to provide information about outcomes of treatment to enable the PCT to monitor quality of Orthodontic care. The new data available to PCTs has enabled them to investigate quality concerns such as a high rate of termination of treatments before treatment is complete.

6.5 There is potential to develop enhanced Clinical Governance systems to improve quality including audits required by the PCT. For example now contracts require NICE guidelines to be followed, so commissioned audits are now possible. Previously audit results were confidential to dentists and were not shared in the majority of cases with the PCT.

6.6 The reforms have changed the system for entry to a Performers List. Dentists only have to be on a single list nationally so Sandwell PCT relies heavily on other PCTs to check out dentists who work in more than one place. Local procedures for advising the PCT of new performers in a practice picked up an issue of previous poor performance by a dentist who had left their post in the previous PCT. This additional check would be recommended to all PCTs in addition to the checks required to be undertaken by practices.

6.7 Sandwell PCT considers that provision of a quality service is a core part of contract provision and not something which is usually provided as an additional extra in exchange for the under provisions of UDAs.

6.8 Sandwell PCT has offered additional funding for dental practices participating in the Local Smoking Locally Enhanced Scheme. Unfortunately only one practice has chosen to join the scheme.

6.9 The comparison of quantity of different types of treatments provided identifies outliers, of whom enquiries can be made about quality of care. Quality markers of access, equity of provision according to need, appropriateness, efficiency and effectiveness are all available using data now available to PCTs.

7. PREVENTIVE CARE AND ADVICE

7.1 Sandwell residents have benefited from water fluoridation since 1986. Consequently oral health is better there than in other areas of equivalent deprivation. This is an effective population measure.

7.2 There is no evidence that the new contract has encouraged prevention but, there are possibilities in new schemes such as encouraging access to smoking cessation services although uptake by local dentists for their patients has been low.

7.3 The PCT welcomes the oral health promotion initiatives developed by the Department of Health including Delivering Oral Health, Smoke free and Smiling which are assisting the PCTs in facilitating the development of health promotion initiatives within dental practice.

8. DENTISTS WORKLOADS AND INCOMES

8.1 Dentists complain that they have to work harder under the new contract in order to maintain the same income. Required activity under the new contract is high as NHS activity was high under the old contract.

8.2 56% contracts produced less than the contracted activity in the first year 2006–07. Most have plans in place to make that up in the second year.

8.3 The PCT is as concerned by the numbers of extra patients to be cared for in Commissioning extra activity as well as the number of Units of Dental Activity (UDAs).

8.4 Dentists were planning to rely on Vocational Trainees providing some of the contracted activity within their contracted volume despite the issue of guidance in December 2005 that PCTs would require an agreed level of additional activity when additional funding was provided for Vocational Trainees in a practice. They were then upset when this activity was required.

9. RECRUITMENT AND RETENTION OF NHS DENTAL PRACTITIONERS

9.1 There is evidence that there is slower turnover in dentists on Sandwell Performers List since April 2006. In 2005–06 24 dentists joined Sandwell practices. In 2006–07 under the new contract 15 dentists joined Sandwell practices. This has led to a more stable local workforce.

Karen Elley
Consultant in Dental Public Health
Sandwell PCT

February 2008

Memorandum by Melvyn Smith (DS 39)

DENTAL PUBLIC HEALTH IMPACTS OF NHS DENTAL REFORMS

Major concerns of Dental Public Health include:

- maintenance and improvement of oral health;
- reduction of health inequalities;
- development of the availability of effective, safe dental services, sensitive to the needs of the individual; and
- collection and interpretation of data reflecting need, demand and service utilisation.

1) *The continuing need for action at national level*

Not all oral health improvement or reduction in health inequalities stems from treatment services. National policy decisions (such as those on banning smoking in public places and food labelling) remain paramount.

2) *A necessary shift to locally-commissioned services*

Previously, NHS dental services were shaped by dentists; a “supply-led” rather than a “needs-led” service, with open-ended, national funding and regulation. Dentists were not commissioned, but free to set up practice anywhere and offer NHS care to whatever part of the population they might select.

The 2006 NHS Dental Contract created the necessary opportunity for PCTs to commission services (not just from established practices) to address local needs, although this benefit has not been realised.

3) *Problems with transitional financial arrangements for the April 2006 contract*

The miscalculation, centrally, of the patient charges likely to be generated under the new contract system left many PCTs with shortfalls within their global “ringfenced” dental budgets.

- Any unallocated money/contract value has therefore been vulnerable to being held back in PCTs to meet this financial shortfall, rather than being reallocated to practices to address, say, access problems.
- Growing practices, particularly newly-established specialist orthodontic practices (which are slow to climb to steady state earnings) could often not be adequately funded, even where PCTs had supported their development to address a clear, local unmet need. Conversely, PCTs could not escape continuing to pay for orthodontic treatment being done in general practice by non-specialists.

4) *Adverse dental public health impacts—UDAs*

- Initially, the new contract was promoted as giving more opportunities to spend time on preventive interventions. Early pilot schemes followed this approach, but the late imposition of Units of Dental Activity (UDAs), as a measure of dentists' clinical output in the substantive contract, was not seen as recognising dentists' time being invested in prevention.
- As a measure of clinical output, the UDA is a blunt instrument. There are inherent incentives in Bands 2 and 3 for dentists to undertreat, or to split complicated, but necessary, treatment plans into separate courses of treatment.
- People identified as having a higher than average level of treatment need within these Bands (usually these are people in lower socioeconomic groups) may find greater difficulty in securing NHS dentistry.
- As a measure of activity for the more specialised services (such as referral practices providing sedation) the UDA is an entirely inappropriate basis for commissioning or contract monitoring. There is a risk that practices offering this important specialised work will be unable to achieve a realistic level of remuneration under GDS/PDS contractual arrangements, and therefore not remain viable.
- The salaried Primary Care Trust Dental Services (PCTDS) were historically established to provide care for people with special dental needs, which is generally more time consuming to provide, and so more costly. Such services also have a higher proportion of non-charge paying patients. Not understanding this, in some places PCT commissioners have made no distinction between the (relative) financial efficiency of such priority services, and the average cost of local general dental practices. This financially-driven approach to commissioning puts services for vulnerable people at risk.
- Similarly, service developments in economically deprived areas will cost the PCT more than those elsewhere. The higher proportion of charge exempt adult patients found in a deprived area means a greater proportion of the total service cost being borne by the PCT, increasing the cost per UDA being delivered.

5) *Adverse dental public health impacts—Patient charges and charge bands*

There is no sensible reason why people should have to pay for treatment of disease occurring in the mouth, but not pay for treatment of disease affecting the rest of the body. If there is a charging policy, the charging regime should be fair. The complex fee scale under the old contract needed to be reformed. It was hard to understand, and its complexity was a source of dissatisfaction and complaint.

- Current charge bands were designed to average out at the same overall amount as under the previous system. Band 2 and Band 3 cover very broad ranges of treatment, so within this averaging system the costs of, say, a single filling or a denture are higher than before. This generates perverse financial incentives for patients:
 - to seek or be offered such treatment outside of the NHS; and
 - to delay attendance until a greater amount of treatment is needed, to give them better value for money.

6) *Lack of information for planning purposes*

- NHS dental data are inadequate for strategic planning of dental services and preventive programmes. Nationally, too great an emphasis is paid to the collection and analysis of data relating to dental disease in five year old children, at the expense of any systematic approach to understanding the oral health status and treatment needs of the whole population.

The decennial Adult Dental Health Surveys (undertaken since 1968) were a valuable measure of trends, but the expected 2008 survey is not being done.
- The old fee-for-item contract gave, as a by product of the payment system, detailed information about all GDS treatment provided and the number of patients registered with practices. Since April 2006 data relate more broadly to courses of treatment and Units of Dental Activity. The purpose or value of one key headline measure adopted; “number of patients seen, as a percentage of the population in the previous 24 months” is not clear.
- Information about the patient experience could have been collected as a requirement of the new contract. The important opportunity for adoption of a requirement for such monitoring, using a national approach, consistent with validated survey methodology used in other primary care settings, was lost.

Melvyn Smith was an NHS consultant in dental public health between 1991 and 2007. He had extensive experience of working with the 13 Essex PCTs during the run up to the introduction of the 2006 contract, and during the first year of its implementation.

Currently he is employed as a senior lecturer in dental public health, involved in “outreach” dental undergraduate training.

February 2008

Memorandum by Teethwhite (DS 40)

DENTAL SERVICES INQUIRY

ABOUT TEETHWHITE

Teethwhite is a brand and trading name of Victoria Dental Products Limited, a company formed in 2003. Victoria Dental Products Limited also trades as the brand named Dentalwhite which is exclusively supplied to dentists. The company has emerged as a specialist supplier of cosmetic teeth whitening products, materials and equipment to the dental and beauty industries. Dentalwhite products are endorsed by a professor of dentistry and leading authority on the subject of teeth whitening.

EXECUTIVE SUMMARY

Teethwhite welcomes the Health Select Committee’s inquiry into NHS dental and orthodontic services. In particular, Teethwhite are interested to see that the inquiry aims to address areas relevant to patients’ access to NHS dental care; the work of allied professions; the quality of care provided to patients; and Dentists’ workloads.

Currently, teeth whitening is a non-surgical, cosmetic treatment offered both by dentists and non-dentist practitioners. However, some dentists have been quick to realise the financial benefits to be gained from the growing popularity of un-regulated, non-surgical cosmetic treatments, such as Botox, skin peels, dermal fillers and lip enhancements, which we are seeing being offered at entrepreneurial dental surgeries up and down the country. At the same time, the General Dental Council (GDC) has launched a highly aggressive PR campaign in recent months, which is causing concern amongst consumers that teeth whitening should only be performed by qualified dentists. If the General Dental Council is successful in restricting the procedure of teeth whitening and other non-surgical cosmetic areas to dentists, access to basic dental provision will only diminish further.

INTRODUCTION

1. Teeth whitening is a non-surgical, cosmetic treatment currently offered by both dental and non-dentist practitioners in the UK. The lack of clarity and ambiguous nature of regulation concerning teeth whitening has led to a situation which is now putting customers in danger and creating a distorted and fragmented market place for reputable and responsible non-dentist practitioners.

THE ISSUE—THE GDC’S ATTACK ON THE LEGALITY OF NON-DENTISTS PERFORMING TEETH WHITENING

2. Based upon weak legal grounds the General Dental Council (GDC) has launched a highly aggressive PR campaign in recent months which is causing concern amongst consumers that teeth whitening should only be performed by qualified dentists. The campaign could be perceived as being driven by financial interests. It appears to be aimed at eradicating competition by discrediting the credibility of those practitioners offering responsible teeth whitening procedures, outside a traditional dental setting. The products used for teeth whitening are legally classed as cosmetic (hydrogen peroxide) and were confirmed as being so on 28 June 2001 in the House of Lords in the case of Optident Limited and another v The Secretary of State for Trade and Industry. Teeth whitening is only one in a number of commercially lucrative non- surgical cosmetic treatment areas (such as Botox) into which dentists are trying to branch out in and take advantage of the absence of specific professional regulation.

3. The GDC has sought to exploit the vagueness of the legal definition, outlining the practice of dentistry, in the Dental Act of 1984. Because this has never been challenged, the Department of Health, based on a hollow, non-evidence based, one-sided argument, has chosen to take a passive position and agree with the opinion of the GDC, that tooth whitening constitutes the practice of dentistry. Despite the GDC claiming that they will prosecute anyone found to be performing teeth whitening without a dental qualification, they have yet to actively prosecute any individual, presumably because they realise the weakness of their own legal position. Up to this point, the GDC have been relying on the aggression of their well executed PR campaign to act as a powerful enough deterrent to prevent customers seeking these treatments outside a dentist surgery.

4. On the back of the GDCs campaign, Teethwhite has obtained independent legal opinion which supports the position that the way our whitening treatments are performed, does not constitute the practice of dentistry. As such, we are confident that Teethwhite would be able to successfully defend any legal action mounted against the company.

SAFEGUARDING CUSTOMERS AND RAISING PROFESSIONAL STANDARDS

5. As responsible and credible operators, Teethwhite are particularly concerned that the absence of clarity in existing regulation has meant that many rogue operators have entered this market place, which are ill equipped, both in practical training and knowledge to carry out treatments safely. This is putting customers in danger and it is because of this that we are calling for clarity and joint efforts, both by the dental profession and responsible and credible non-dentist practitioners to establish suitable and sufficient training criteria and codes of conduct, which would raise professional standards, weed out rogue operators and therefore safeguard the public.

6. Teethwhite spends considerable time, money and effort on ensuring that all technicians offering teeth whitening have had high quality training to do so. All of our technicians undergo high quality training and are assessed by dentists on their ability, both academically and technically, to perform procedures before they are signed off as competent. In addition, they sign a declaration so that we can ensure that they accept the Teethwhite code of conduct and never at any time say anything or act in a way that can be considered to be the practice of dentistry.

7. All Teethwhite customers are required to declare that they have consulted a dentist and that they are a suitable candidate for teeth whitening. Teethwhite's trainees are well aware of any hazards involving teeth whitening products and will not perform a procedure if they are in any doubt as to a customer's oral health or their suitability. Few dentists attend such rigorous training in teeth whitening and some unscrupulous operators do not attend any training at all, as there is currently no set of standards outlining how much and what kind of training is needed. Whilst Teethwhite is proud of its training curriculum and confident that it suitably equips its technicians to safely perform the procedure, we are keen for adequate industry training standards to be determined, with which we would happily comply.

THE CASE FOR TEETH WHITENING OUTSIDE TRADITIONAL DENTAL SETTINGS

8. The safety of Teethwhite customers is of paramount importance to us, however we do not agree that only dentists are suitably qualified to administer this procedure, and there are dentists who support our view on this matter.

9. The teeth whitening market is growing considerably and is currently estimated to be worth £88 million to the UK economy. It is predicted by industry analysts that this value will rise to £310 million by 2012. Some dentists have been quick to realise the financial benefits to be gained from the growing popularity of un-regulated, non-surgical cosmetic treatments, such as botox, skin peels, dermal fillers and lip enhancements, which we are seeing being offered at entrepreneurial dental surgeries up and down the country. Dentists also charge much higher prices for teeth whitening procedures than their non-dentist counterparts, which are often not reflective of the cost of the products used or the time taken to administer.

10. Access to basic NHS dental provision in the UK is already at a crisis point. If the General Dental Council is successful in restricting the procedure of teeth whitening and other non-surgical cosmetic areas to dentists, we will only see this access to basic dental provision, diminish further. Across the country we are already witnessing Dentists choosing to spend more and more of their time on lucrative, private and cosmetic dental areas, such as dental implants and smile correction, which stand to provide them with much greater financial returns.

11. Non-dentist professionals are well capable (with suitable theoretical and practical training) to perform teeth whitening procedures. In many cases, beauty therapists are performing much more dangerous and invasive cosmetic treatments, such as laser hair removal, eyelash tinting and electrolysis, in a non-regulated environment.

RECOMMENDATIONS

12. Teethwhite welcomes the intention behind reforming the old system of NHS dentistry, as set out in the Department of Health's report "NHS Dental Reforms: One year on" where it is stated that the department aimed to address the significant gaps in access to dental provisions that have developed in some parts of the country. However, Teethwhite recommends that the government should undertake further work to investigate the expanding area of services, outside of more traditional services, provided by dentists and how this affects access to NHS dental provisions.

13. As a responsible operator and supplier, Teethwhite urges the government to take forward an initiative to establish acceptable professional training standards, which would safeguard customers; enable a greater access to dentists for patients in need of NHS dental provisions; and allow for the continuation of healthy competition within the market place.

CONCLUSION

It is clear that a dangerous regulatory grey area exists where the fusion of beauty/cosmetic and medical/dental treatments meet, which needs further examination and clarity by the Department of Health, and industry, in the interest of practitioners and the safety of customers. Professional training standards would not only ensure that customers are safeguarded; it will ensure a level playing field free from market distortions; as well as ensuring that dentists time is freed up to guarantee that NHS dental provisions is always accessible.

February 2008

Memorandum by the Greater London Branch of the Socialist Health Association (DS 41)

EFFECTS OF THE NEW DENTAL CONTRACT IN LONDON

This short paper examines how the new dental contract has operated in London and comments on some of its effects. It highlights concerns over the robustness of data for measuring effects of contract, concerns over patients presenting with complex oral health needs and concerns over the impact on preventive care and community dental services. It recognizes that the effects vary from district to district depending on the make-up of the population and the availability of NHS dentists. Appended to this paper is a commentary on the November 2007 recommendations of the London Assembly's Health and Public Services Committee report "Teething problems—A review of NHS dental care in London." This paper does not replace the earlier submission by the Socialist Health Association but is an attempt by its London Branch to focus on those issues of particular concern to Londoners.

1. One concern is for patients who are poor but above the exempt level for payment, particularly those with high treatment needs. They find it particularly hard to get access to a dentist and, even if they do, may not get the full treatment necessary. On the other hand, the contract may have been a positive benefit for those patients who are already in good dental health.

2. A parallel concern is for those patients who are exempt from paying dental charges. Budgets for dentists are set by Primary Care Trusts but set minus patient charges. As a result there is an incentive for Primary Care Trusts to encourage dentists to take on paying patients and a disincentive for dentists to take on non-paying or part-paying patients. So, even patients exempt from paying dental charges have difficulty accessing a dentist and obtaining all treatment needed. Furthermore, it is understood that the Department of Health (DoH) is discouraging dentists from providing NHS care solely for children and adult exempt patients. This would considerably disadvantage such people from receiving NHS dental care. The system of setting budgets minus patient charge revenue disadvantages both the exempt patient and the dentist prepared to treat exempt patients. Dentists who under-perform might have to return funding to the Primary Care Trust and dentists who over-perform might not get any additional income for the extra work done over the year. There is a need for more flexibility between dentists and Primary Care Trusts to allow occasions where performance varies from that laid down to carry over into the next financial year.

3. Under the new dental contract the system of patients registering with a given dentist has been abandoned. This can result in a loss of continuity of care. Indeed, dentists are encouraged to take on new patients, particularly those who have to pay the patient charges. But this has been made more difficult by the new contract as dentists, understandably, do not wish to take on work if this does not improve their remuneration which is already set for the full year.

4. Many dentists, as a result, have long waiting times for their patients, particularly towards the end of the financial year. This is bad for patients, with many of the better off seeking private treatment rather than wait whilst those who are poor and have other pressing priorities may well be lost to the dental service. Hence the importance of keeping a regular tally of the waiting times for each dental practice and making it available to the public in updated form.

5. The measurement of numbers of dentists carrying out NHS work is deeply flawed as there is no mechanism for measuring the number of whole time equivalents (WTEs) providing treatment by PCT area, regionally or nationally. We doubt, therefore, the accuracy of what are claimed to be measures of available NHS dentists which have been made public. A very rough measure might be taken from using the number of Units of Dental Activity (UDAs) delivered by General Dental Practitioners (GDP) but this would be a very blunt instrument as the range of dental work done varies so much in each band. In summary, it is not really known whether the number of NHS dentists has increased or decreased under the new contract. Most likely it has decreased. The information on actual work carried out by GDPs has been hugely limited compared with that available under the old contract. It is understood that this is being put to rights, at least in part, by the DoH with a requirement to provide fuller information. The danger is that whilst, under the old "drill and fill" contract there was an incentive to over-prescribe, under the new the incentive is to under-prescribe.

6. There is evidence that the Community Dental Service has been run down to the extent that it cannot be utilized to improve access to NHS dentistry for poor people, ethnic minorities or those who live more of a nomadic existence. The work in schools has been considerably curtailed at serious risk to children's oral health, particularly those living in deprived areas. PCTs, not GDPs as in the past, are now responsible for out of hours and urgent treatments. The evidence is that across London this service is inadequate.

7. The most serious aspect with the new dental contract is the lack of any genuine requirement to ensure proper oral health for patients and through that for local populations. It is essential that the contract is adjusted to provide for this. This could be assisted by using the oral health measures of diseased, missing and filled teeth (DMF) for dental practices and PCTs.

8. We are also concerned that, since the government passed legislation to stop water companies being the obstacle to the fluoridation of water supplies, there has still been no progress made in London by Local Authorities and PCTs. The government should take action to encourage fluoridation schemes, particularly in deprived urban areas as part of its overall public health approach.

9. The Health and Public Services Committee of the Greater London Assembly recently carried out a review of the state of NHS dental care in the capital. The committee made a number of practical and sensible recommendations which are attached as an appendix. We have added comment on each which we believe strengthens what the assembly committee proposes.

John Lipetz

Greater London Branch of the Socialist Health Association

February 2008

Appendix

GREATER LONDON BRANCH OF THE SOCIALIST HEALTH ASSOCIATION PAPER ON NHS DENTISTRY

SUMMARY OF RECOMMENDATIONS BY THE GLA HEALTH AND PUBLIC SERVICES COMMITTEE

SUPPORTED BY GREATER LONDON BRANCH OF THE SOCIALIST HEALTH ASSOCIATION COMMENTS

1. NHS London should revise the Healthcare for London Framework to include proposals to improve access to dental care, through for example, the increased availability of home-based and outreach dental services, and by assessing whether proposals for new polyclinics, when developed, could include NHS dental surgeries in areas where access is limited.

Support. The current provision by PCTs for emergency treatments and out of hour provision is extremely limited. We would propose that existing dental practices are used for much of this need and resourced accordingly.

2. A London PCT dental network should be set up to enable PCTs to share and discuss good practice in commissioning services that better meet local needs. Representatives of Tower Hamlets PCT should be invited to the first network meeting to outline how their mobile outreach dental surgery model has improved access to and uptake of NHS dental care.

Support. We are surprised that it has been necessary to recommend a PCT dental network as this is an obvious requirement to enable PCTs to learn from each others activities and apply best practice. Would also encourage expansion of Community Dental Service to support outreach work as the Tower Hamlets outreach project is probably expensive related to actual treatments provided.

3. PCTs need to publicise local NHS dental services, NHS patient charges and low-income scheme, and ensure relevant information is accessible to different local communities. PCTs should consider (jointly or individually) setting up local helplines to assist people to find an NHS dentist.

Support. Information should be on web sites although this would not generally help the poorest and those from ethnic minorities. Information should include up to date details of waiting times for individual dental practices.

4. PCTs need to ensure that all NHS dental practices display information about the costs of treatment and who is exempt from charges, and that all NHS practices keep copies of HC1 forms and promote the NHS low-income scheme to patients who may be eligible.

Support.

5. The Department of Health needs to revise the dental charge banding structure to ensure that it is equitable and encourages regular attendance. The Department should consider adding extra charging bands between bands one and two, and between bands two and three.

Support. The current contract makes it uneconomic for dentists to carry out more complex treatments such as root canal therapy. This should be addressed so that patients with high treatment needs can be seen by dentists without detriment to the practice. It is therefore essential that the banding structure is refined in the way proposed as it would both encourage patient attendance and avoid much of the under-prescribing.

6. After April 2009, the Department of Health should base PCTs' dental funding allocations on local needs assessments, rather than historical provision.

Support. The ringfencing of dental care should be continued beyond this date to ensure that PCTs do not reduce the dental funding because of cost pressures and competing priorities. Because of the need to ensure proper care for children and exempt adults in areas of deprivation some method of attracting NHS dentists to these areas should be encouraged.

7. The Department of Health should consider how it could revise the current NHS dental contract so that preventive care is built into the way PCTs manage and monitor dental contracts and should consider whether dentists should be financially rewarded for providing preventive advice.

Support. It is suggested that the DoH examine the Scandinavian systems for preventive activity in this area. There is a need for a new payment band within the dental contract to provide for specified oral health advice and treatment. Use of Health Visitors and School Nurses to provide part of this service should be considered.

8. The Department of Health should ensure that performance ratings from dentists' balanced scorecards are made available to the public to help them choose a good quality dentist.

Support.

Memorandum by John Green (DS 42)

DENTAL AND ORTHODONTIC SERVICES

1.0 GENERAL COMMENTS

1.1 The opportunity is welcomed to provide evidence from a public health perspective. The new dental contract has the potential to allow dentists to take a preventive based population approach to providing care but this is being inhibited by the current contract currency—Units of Dental Activity (UDAs).

1.2 The PDS pilots, which preceded the 2006 changes, had an agreed patient turnover as the currency. Local evidence indicated an improvement in access but a reduction in activity resulting in a 50% fall in patient charge revenues.

1.3 Practitioners in the pilots experimented with increasing recall intervals and minimising clinical intervention, with a consequent lowering in the number of chargeable treatments for patients.

1.4 This allowed more time for talking to patients, which was welcomed by them and had the potential to allow a preventive approach to be effective.

1.5 However all systems have risks and incentives which influence patients as well as dentists. The PDS pilot approach carried the risk of under attendance and or under treatment. The UDA approach has incentives for activity and intervention but not necessarily for access.

1.6 A key feature of any of these changes has been the relative strength or weakness of the connection between clinical decisions and payment or reaching a contract target. This is at the heart of the “treadmill”—the incentive to treat in order to succeed. PDS pilots broke the connection but dentists perceive it has been at least partially re-made through the UDA targets.

1.7 PCTs have the opportunity in 2009 to weaken this link through a new approach to promoting access with a focus on patient outcomes using a key indicator framework.

2.0 THE ROLE OF PCTs IN COMMISSIONING DENTAL SERVICES

2.1 PCTs now have a positive role in re-aligning dental services with patient needs through local commissioning. However there have been capacity issues over the last two years because of PCT restructuring and funding pressures.

2.2 Evidence submitted by other parties has highlighted the variable levels of Dental Public Health support available to the PCTs. This is unfortunate at a time when the input of the Speciality to needs assessment, planning and strategic leadership is critical to the success of the new contracting and commissioning arrangements.

2.3 The changes brought an opportunity to streamline and improve out of hours services as well as providing PCT patient helplines for accessing urgent care or to find a dentist. This is a significant improvement and has been one of the key benefits of the new arrangements.

3.0 NUMBERS OF NHS DENTISTS AND THE NUMBERS OF PATIENTS REGISTERED WITH THEM

3.1 Work in Sheffield on a Health Equity Audit has shown that the numbers of dentists, expressed either as whole time equivalent (WTE) or as NHS hours are of little relevance to planning and investment. The Health Equity Audit showed that the contract volume expressed as a weighted course of treatment or UDA was a better indicator of service provision.

3.2 Local evidence from pilots in a relatively high NHS area such as Sheffield showed that many practices had quite high turnovers of NHS patients in the past. Many patients only attended at two-year intervals and a typical practice patient turnover was approximately 15% each year.

3.3 Registration with a dentist was only for 15 months, which meant that patients who chose to attend infrequently found it difficult to re-access care, as they were not registered. The problem is being perpetuated because of the disincentive to see new patients who may have high treatment needs.

4.0 NUMBERS OF PRIVATE SECTOR DENTISTS AND THE NUMBERS OF PATIENTS REGISTERED WITH THEM

4.1 The private sector is very difficult to assess as many dentists provide a mixture of NHS and private care, either in terms of the patients seen or individual treatments. However many patients seek private care because they perceive they don't have a choice and reluctantly have to accept what is on offer. This may be as much to do with media influence than the local reality of available NHS care.

4.2 Gaining information about the scale of this sector would be one benefit of maintaining the 10-yearly national survey of adult dental health. This series of studies, extending over the last 40 years, seems likely to be discontinued in the current review being carried out by the NHS Information Centre. The clinical, dental and social information it provides for PCTs is invaluable and not available from any other source.

5.0 THE WORK OF ALLIED PROFESSIONS

5.1 The planned increase in the numbers of hygiene and therapy students in training is producing more graduates at the same time as the new contract is being introduced.

5.2 Dentists report that the new contract acts as a disincentive to employing dental therapists because they will gain UDAs at a lower rate than a dentist, in the same surgery. Therefore it is likely that dentists are doing more simple work, which could be delegated to therapists. There is evidence that a considerable proportion of work in general dental practice could be delegated to dental hygienists and therapists.

5.3 Inequalities in the orthodontic workforce across the country could be partially offset by the advent of orthodontic therapists who are now beginning to enter training.

6.0 PATIENTS' ACCESS TO NHS DENTAL CARE

6.1 Access problems are likely to be greatest for those patients who are either new to the area or attend relatively infrequently. There is less incentive at the moment to take on a new patient who may have high needs so PCTs are having to provide local incentives and will increasingly do so, when they have the opportunity to recast contracts from 2009 onwards.

6.2 Some patients carry out a risk management strategy to balance the risk of pain or loss of teeth against the cost in time and earnings in order to attend. Patients on low income but not exempt from charges may have to settle for irregular attendance as a way to manage the risk.

6.3 Attendance prompted by symptoms carries a risk of more extensive treatment or even tooth loss, as more tooth tissue will have been destroyed at the point where pain is experienced. Asymptomatic attendance (regular checkups) allows for earlier intervention with less loss of tooth tissue and simpler treatment.

6.4 However, there is no evidence for the any particular recall interval other than for those at risk of Oral Cancer. Current NICE Guidance is for a recall interval agreed with the patient based on their level of disease risk, which could be anywhere from three months to 18 months or two years and considerably longer for those with no natural teeth and full dentures.

6.5 There are also concerns about patient charges, which may be acting as a disincentive to seeking treatment. Anecdotal information from patient help-lines has indicated that some patients find the gap between the present three bands unfair and they consider them as not supporting self-care and regular attendance.

6.6 There is a risk that patients will delay seeking care if they perceive the charges as being too high or poor value for money and may wait until there is more work to be done. Patients needing full dentures report that the cost of the full dentures is now almost twice what it would have been when their previous dentures were made.

6.7 Whilst the old charge regime based on 400 items of service was very complex it was highly sensitive to the volume of treatment provided and could be perceived by patients as being more equitable than the present system.

6.8 There have been reports from patients that they are finding it difficult to understand the variability in recommended recall intervals. This is often from patients who, for most of their lives, have attended every six to eight months but are now being discouraged from attending more than once a year. However, patients who do look after their mouths and attend regularly have less need to attend so there is a very real issue of education and support for patients and dentists.

6.9 Orthodontic waiting lists have proved very difficult for some PCTs in South Yorkshire in the last two years. The chosen way of determining contract values meant that recent growth in the provision of orthodontics was not reflected in contract values. PCTs that encouraged orthodontists to set up in areas of low provision then found that the dental budgets only covered a small proportion of the caseload. Work is going on in South Yorkshire to try and ensure that the historical cross PCT boundary provision of orthodontics is maintained. Some PCTs have found it possible to put more funding into orthodontics where growth was not matched by the budget.

7.0 THE QUALITY OF CARE PROVIDED TO PATIENTS

7.1 There is no real evidence yet, either way on the quality of care, at least in what's available routinely to PCTs.

7.2 PCTs have worked with the Dental Service Division to increase the value of Dental Reference Officer examinations of patients by relocating them to a dental practice where they have access to patient records. This has proved popular with both dentists and patients. There is the potential for it to become more sophisticated with the development of PCT governance arrangements.

7.3 However, there is a potential impact on quality if the contract currency encourages activity more than quality and outcomes.

8.0 THE EXTENT TO WHICH DENTISTS ARE ENCOURAGED TO PROVIDE PREVENTATIVE CARE AND ADVICE

8.1 PDS pilots did give dentists the opportunity to spend more time with patients, which they generally devoted to promoting prevention through self-care and in some practices, public health interventions such as smoking cessation. Unfortunately this mostly came to an end with the new contract because of the focus on activity targets. The new joint BASCD/ DH toolkit—"Delivering Better Oral Health" will help so that evidence based prevention can be encouraged through new revised contract values.

8.2 The biggest impact on the workloads of dentists, particularly in high need groups and areas would be the introduction of Water Fluoridation. In fluoridated areas the benefits are very clear to dentists in their surgery day by day as well as in the epidemiological evidence gathered in surveys of children.

9.0 DENTISTS' WORKLOADS AND INCOMES

9.1 There is anecdotal evidence from local dentists that they are working harder, although many in South Yorkshire had worked in PDS pilots, which took a quite different approach to activity and intervention rates.

9.2 One other effect is changing the business focus from practice income to the time and costs of providing care. The most obvious impact of this is the reduction in more complex care under the new arrangements.

10.0 THE RECRUITMENT AND RETENTION OF NHS DENTAL PRACTITIONERS

10.1 Retention is the more important challenge in the next round of changes in 2009. PCTs will need to make new local contracts more attractive by re-balancing the incentives to give increased time for prevention and improving health outcomes and reducing the influence of UDAs.

10.2 PCTs are developing a key indicators approach aimed at improving access and increasing the preventive approach, whilst ensuring a broad range of patients needs are properly addressed.

10.3 Treating UDAs more as indicators rather than targets would help a great deal in such an approach. Specific targets for access are appropriate and this will be helped by the new enhanced data sets that will be available from April. They will enable practices to demonstrate the amount of effort needed to maintain their particular case mix and measure work-load for new patients with high need.

10.4 One other medium to long -term issue is that of demographic changes. Age groups that have had very high levels of NHS intervention in the past are more likely to retain their teeth into advanced old age and so there needs to be recognition of the problems of caring for such ageing “dentitions”.

11.0 SUMMARY

11.1 From a public health perspective the ideal contract would have the following features.

- Access and attendance to suit patient’s needs and preferences.
- Patients receive an holistic preventive model of care.
- Clinical decisions are free from financial incentives for the dentists and (ideally) for the patient.
- The practice adopts a public health approach to managing the practice population, assessing risk and allocating the resources to those with greater risk or higher levels of disease, whilst promoting self-care and prevention.

11.2 The dental contract has the potential for such an approach if the contract currency and targets can be focussed on access and health outcomes. PCTs have an opportunity over the coming year to work with the profession to achieve these goals from 2009 onwards.

John Green

Consultant in Dental Public Health

18 February 2008

Memorandum by Margaret R Naylor (DS 43)

DENTAL SERVICES

SUMMARY

I have been committed to NHS dentistry for the last twelve years and have invested heavily in the future of NHS dentistry during this period.

In common with many NHS dentists I have serious misgivings about the new contract:

- An unproven system has been implemented which places dentists back on a treadmill of drilling and filling.
- The tendering process that favours the cheapest tender may provide low quality NHS treatment.
- PCTs may not commission in areas of greatest dental need due to financial considerations.
- There are no guarantees of the level of funding available for NHS dentistry post 2009.
- The variability of UDA values penalises some dentists by not taking account of a dentist working in:
 - Deprived areas with high dental need.
 - Non-fluoridated areas.
 - A practice taking on new patients.
- The charging system is unfair to patients in that it financially penalises those who care for their teeth and so require minimal treatment within a charge band.
- Patients are not discouraged from missing appointments and hence wasting surgery time.

Outreach training is a cost effective innovation that should be properly supported.

BACKGROUND

1.1 I graduated from Sheffield University as a dentist in 1996 and I have spent the last 12 years working in South Yorkshire in two dental practices, within two PCTs, providing predominantly NHS treatment. I have been an active member of the Local Dental Committee in Rotherham and I am also a BDA “Good Practice” assessor and so I am in close contact with many of my fellow professionals.

1.2 With my husband I am the joint principal of both practices and we have 12 dentists (including ourselves), some working part-time and others full-time. We have also become involved in "Outreach", a training programme in partnership with Sheffield University Dental School, whereby undergraduate dentists do part of their training in a dental practice. We have many years of experience of training Vocational Dental Practitioners.

THE ROLE OF PCTs IN COMMISSIONING DENTAL SERVICES

The PCT is now expected to assess need and develop services. This has a number of problems.

Implementation of the new contract

1.3 The new contract had no trial period prior to implementation. The original PDS pilot scheme bore little resemblance to the current contract. That scheme had no targets and the dentist was partially freed from the treadmill of "drill and fill" allowing time for preventive approaches including oral health promotion, smoking cessation and so on. The current contract places dentists back on the treadmill.

1.4 When PCTs have gone to tender for additional UDA provision they have often had multiple bids and had to select a preferred provider. This has been usually been at the lowest price; no account has been taken of the quality of the service offered. Locally, corporate bodies have tendered with a low price. They have staffed the practices with non-UK personnel who may not provide the same standard of care as a UK trained dentist, their training is not monitored by the GDC.

1.5 If a PCT has a fixed budget, ring fenced until 2009, and which is dependant on patients contributions, then there is an incentive for the PCT to commission in areas where patient contributions are higher. This risks under commissioning in areas of greater needs where patients are probably exempt from charges on account of their lower socioeconomic status.

1.6 In 2009 will there still be monies for dentistry? When the money is no longer ring-fenced there is a risk it will be diverted to other areas of need.

THE VALUE OF THE UNIT OF DENTAL ACTIVITY

1.7 There is a huge disparity of dental need in different areas affecting the cost of achieving a UDA. A band 2 (3 UDAs) course could include 1 filling, taking 20 minutes, yet another band 2 course could include 10 fillings several root treatments and extractions, taking several hours, but the number of UDAs relating to each course is still three. This anomaly has been dismissed as "swings and roundabouts" in that sometimes a dentist will do less than the average for his UDAs and sometimes more, but areas of high disease will have proportionally larger numbers of high need patients.

1.8 While recent legislation has encouraged water fluoridation we will still be left with the legacy of a higher caries rate in areas such as South Yorkshire. Patients in such areas will still have more complex needs.

1.9 There is a disincentive for dentists to accept new patients. It is more cost effective for a dental practice to see patients whose dental health has been maintained over several years than to take on new patients who are an unknown quantity and who may require complicated, time consuming and expensive treatment. We personally have continued to take on new patients but our associates are increasingly unhappy about providing treatment for new patients where the cost to them may be high, and the UDA banding system does not recognise these increased costs.

Dentists are paid different UDA values but these appear to be totally arbitrary depending on the history of the practice rather than the dental need.

WASTED SURGERY TIME

1.10 NHS dentists are one of the few health care professionals whose finances are totally dependent upon meeting targets. If we do not meet our targets then money is clawed back. In order to bring us into line with the rest of the NHS it was decided that we could no longer charge for failed appointments or late cancellations. An audit of our practice in 2004, when we could charge for failed appointments, showed wasted time was 5.5% of total hours worked, Shortly after the introduction of the new contract was introduced in 2006 this rose to 9.6%. We expect that this will have risen again in 2007. This wasted time means we are finding it harder to meet our target and reduces service delivery to patients.

CHARGING SYSTEM

1.11 Allegedly, the new banded charging system is easier for patients to understand. However, our experience is that it is more confusing for patients than the old system of paying for each item of treatment. The new system requires them to pay for charges that equate roughly to the complexity of treatment but not to the quantity.

1.12 The system rewards patients who do not look after their teeth; a regular motivated patient who needs a small filling will pay the same as a patient who needs twenty fillings and several root treatments.

1.13 It is interesting to note that despite both our practices being in relatively low income areas few of our patients have complained about the cost.

THE OUTREACH PROGRAMME

1.14 We are involved in the “Outreach Programme” in Sheffield. In the past nearly 90% of dental graduates provide primary care NHS services at some stage in their career. The Outreach Programme is an exciting initiative by Sheffield University placing students in their final years to work in primary care settings. The advantages of this are:

- Undergraduates gain experience of working within an NHS practice and see how valuable and interesting their work can be in this environment and hopefully they will wish to provide NHS services after graduation.
- Undergraduates are given the opportunity to deal with all the types of patient and treatment they will come across in their future career.
- The scheme provides experience, which is not possible within the confines of normal hospital-based training demonstrably improving their competence in providing everyday treatments.

1.15 The Programme is in its early stages in Sheffield. I am concerned that it is expected that four students will achieve the UDAs of one experienced dentist. That is likely to be an underestimate. Until April 2009 we are reliant upon the PCT absorbing any shortfall in achievement by students. We have not been given that firm assurance. After April 2009 the students may be taken out of the UDA equation but as of yet we have not had a detailed discussions. Strong support should be given to the practice owners who have taken a leap of faith with Sheffield University, and who are committed to raising standards in both dentistry and the NHS. Firm arrangements within the UDA system for accommodating undergraduate training would secure the future of this and other promising outreach programmes.

February 2008

Memorandum by the Faculty of General Dental Practice (UK), The Royal College of Surgeons of England (DS 44)

DENTAL SERVICES

I would be very grateful if the following comments can be drawn to the attention of the Health Select Committee, and be considered for inclusion in the publication of written evidence at the end of the inquiry.

The Faculty of General Dental Practice (UK) is a part of the Royal College of Surgeons of England. Our President Bernard Ribeiro has recently provided oral evidence to you on another issue and as a Faculty we would be very happy to assist with the inquiry now underway in any way we can.

As a Faculty our interest is in standard setting and quality. We have been very cautious about entering the debate about the new dental contract and issues of remuneration. These are more appropriately the interest of the British Dental Association. However, with our interest in ensuring quality of care for patients, our main concern has been the absence of independently validated evidence.

The Personal Dental Service (PDS) pilot schemes run from 1999–2005 were all externally assessed by a group from Birmingham University. When the new contract was introduced this quality assurance process should have been continued to provide an externally validated assessment of the effects of the new contract on the quality of patient care.

Any aspect of healthcare delivery should be evidence based and this is a major omission which we hope the Select Committee can help to rectify.

The basic question that needs to be answered is “are patients better off?”

Anecdotally, there is evidence that the contract is having an impact on the type of care delivered. For example, it appears that less work is being undertaken by dental laboratories and that less endodontic work is being carried out. The implication is that dentists are not undertaking the more time consuming and complex work that patients need because the payment structure mitigates against this. If so it is a serious concern that should be addressed, but we require the independently validated evidence which is so lacking at the moment in order to be able to make sound judgements.

I see the Committee’s inquiry extends to orthodontic services and I would like to make one final point in this area. A shortage of trained specialists in this field has for many years led to difficulty in young patients receiving the care and attention that they need. The Faculty has been very pleased to work with the British

Orthodontic Society to develop a training programme for general dental practitioners to develop competencies in this area. Many orthodontic treatments are well within the remit of general dental practitioners with additional training and we hope that PCTs will be encouraged to make use of contracting arrangements for commissioning suitable services for their populations, particularly with the Dentists with a Special Interest Scheme available. This latter initiative has been jointly managed and delivered by the Faculty and the Department of Health, and we would be very pleased to provide further information if helpful.

Richard Hayward
Dean

February 2008

Memorandum by Jane Davies-Slowik (DS 45)

SALARIED PRIMARY DENTAL CARE SERVICES IN ENGLAND

1. THE BACKGROUND TO AND ROLE OF SALARIED PRIMARY DENTAL CARE SERVICES

1.1 Background

Salaried Primary Dental Care Services (SPDCS) were formally known as the Community Dental Services and before that, the School Dental Service. The Services evolved from being a child only service established in response to high dental needs to a service complementary to the General Dental Services.

Creating the Future, (DoH, 2004) outlined proposals for modernising careers for salaried dentists in Primary Care. The document stated that:

“These NHS dentists, employed in the main by Primary Care Trusts (PCTs), represent about ten per cent of the primary dental care workforce.

The salaried primary dental care services have developed over a number of decades, predominantly in response to the need for services which could complement the independent contractor General Dental Service (GDS). Salaried dentists are thus a very important part of primary care dentistry, providing generalist and specialist care largely for vulnerable groups, and carrying out dental public health programmes for PCTs.

They often provide the most specialised care outside the hospital setting, to many who might not otherwise receive NHS dental care.”

1.2 Role of SPDCS

Each SPDCS service has developed in response to local need resulting in services of differing sizes and structure: their make up has differing skills-mix, providing care to different patient groups. In addition, SPDCS services carry out several public health functions, for example oral health promotion programmes, epidemiology and screening.

Some services have provision split between patients with special needs, vulnerable groups and Dental Access Centre (safety net) services.

Examples of the types of patients seen include:

Vulnerable groups

- Children from low socio-economic groups whose parents are not regular attendees at a family dentists and are more likely to have high disease rates.
- Adults and children with disabilities including learning disabilities.
- Medically compromised patients.
- Looked after children.
- Long stay hospital patients eg Mental Health Patients and Rehabilitation.
- Patients in Nursing and Residential Homes.
- Anxious and phobic patients.
- Drug and Alcohol dependant patients.
- Asylum seekers.

Safety net services

- Emergency patients who do not have regular dental care.
- Out of hours services.
- Treatment services in locations with access problems.

The majority of services are led by a Clinical Director and, as mentioned previously, they have a range of dental staff in the team. These include: senior dentists with specific skills in key areas, other specialists, generalist dentists, dental therapists, hygienists, oral health promotion staff, dental nurses and receptionists.

1.3 Current status of SPDCS services

One of the few studies to assess the views of Clinical Directors was that undertaken by the BDA in England between May and September 2007. It included questions about service provision since April 2006 when the new contract was implemented.

2. THE EFFECTS OF THE MODIFIED DENTAL CONTRACT INTRODUCED IN APRIL 2006

The effects are examined in four sections: those on patients, those on management including the commissioning process, workload and on staff.

2.1 Effects on patients

Changes to dental care provided by SPDCS

There have been no substantial changes in terms of prevention or treatment provided for individual patients as a result of the contract except in cases where different services have been commissioned. Some commissioners use other indicators besides Units of Dental Activity (UDAs) to monitor salaried services contracts. In some services the balance between patient groups has changed with more safety net patients seen in preference to special needs patients (see below). However now that comparisons are possible between the GDS and SPDCS, using a cost efficiency argument with the UDA as the only common currency, the temptation must exist to reduce the time spent on prevention and other activities with a poor UDA value, which add to the quality of care provided to individuals.

Waiting lists

Waiting lists for services for the priority groups traditionally seen in the salaried services appeared to have increased as reported in the BDA survey due to an increase in referrals (see section below).

Patient charges

Before the introduction of the new contract, Community Dental Services levied charges for patients only for treatment that included laboratory work ie dentures, crowns and bridges. This has been difficult to put into practice for patients and staff who have been used to a different arrangement for a number of years. Changes in the charge regime have had to be explained to patients, sometimes with great difficulty and it has been time consuming for staff.

Quotes from BDA survey:

- Carers do not know what benefits their clients are receiving.
- Establishing patients exemption status especially for those with special needs living in group homes can be very time consuming and ultimately delays.
- Problem charging elderly and confused patients in hospitals, as carers not available and ward staff do not know circumstances.
- Problem with nursing care homes, particularly with people with dementia.
- Very difficult to determine eligibility for adults with special needs—especially older people—huge amounts of time taken up with this and we do not have receptionists.

2.2 Commissioning

The positive effects of commissioning dental care services should enable the provision of a comprehensive service to populations. It has raised the profile of the salaried services and GDPs are more aware of the service we provide and are referring more patients, however, not always appropriately.

Relationships with commissioners vary around the country. With good relationships and mutual understanding, SPDCS can develop to improve services but with poorer relationships energy can be wasted in battles rather than service delivery for the most vulnerable groups.

Comments from BDA survey:

- Good working relationship with commissioners at the moment.
- No discussion with commissioners to date.
- There is no lead within the PCT commissioners for dental services—most of PCT time regarding dental has been spent resolving contract disputes with GDPs.

UDA targets for all?

The patients seen by the SPDCS include patients referred into the service. Patients seen by SPDCS generally require more time to be spent on them for a number of reasons. These include: patient management; a greater number of appointments because of anxiety; a higher than average amount of dental disease, and a reduced amount of treatment at each appointment because of reduced co-operation. They are also more likely to fail appointments.

In addition to the extra time taken to treat patients, services incur greater on-costs of working in a large organisation, and other requirements such as decontamination in PCT salaried services.

2.3 Workload

Increased referrals

Services have had increased number of referrals for special needs patients, children and other patients since the new contract was introduced. There has been a reported increased number of referrals of patients with high disease levels or those needing complex restorative care from some GDPs.

79% of Clinical Directors reported that referrals for children into their services had increased.

Comments from BDA survey:

General Anaesthetic:

- GA/IV.
- Inappropriate referrals.
- Complaints re access.
- Referrals that could be treated in GDS eg high caries in children.
- RA referrals.
- Referrals for endodontic, crown & bridge and general treatment.

70% of Clinical Directors said that they had received increased referrals for special needs patients and 78% for other groups of patients. These included the following quotes from the survey of Clinical Directors:

Increased:

- Inappropriate adult referrals.
- Domiciliary visits.
- GA/sedation.
- Numbers of routine patients who need high volume of care and are unacceptable to GDS.
- Rejected referrals if outside criteria.
- Staff stress.

The effects of increased referrals has been in some cases to increase the waiting times for the traditional group of SPDCS patients from priority groups particularly those who are less able to speak out for themselves.

Referrals back to GDP

In some areas where few GDPs are taking on NHS patients, for children who have been anxious but who are ready to be treated in practice it can sometimes be difficult to refer back to the originating practice because parents' dentist is independent or private.

Emergency treatment

Dental Access Centres can be overrun with emergencies especially in areas where there are problems with access to NHS dentistry.

In some of these areas the time for treating vulnerable groups is reduced by the service having to take on a greater volume of "safety net" work to the detriment of the special needs side of the service.

Some practices rely on their local Dental Access Centres to provide emergency cover when they are closed.

3. EFFECTS ON STAFF

Changes to any system results in additional stresses for some staff. 65% of Clinical Directors said that they had difficulties recruiting although a small number commented that recruiting had become easier with the new contract. This may be due to the reduction of available jobs in practice and the increased availability of dentists from overseas who have come onto the dental register.

Comments from BDA survey:

- Changing role of salaried service is resulting in shrinkage of service.
- Difficult to recruit experienced special care dentists from newly qualified practitioners, but they need the support.
- For last available post used both NHS e-recruitment and BDJ—brought a great number of applicants.
- Impossible to recruit in CDO posts—SDO post difficult due to changes to nGDS.
- One clinician left access/GDP service that we provided as they felt overwhelmed by patients with high need being sent to the service by GDP.
- Previously had problems recruiting—recently lots of applicants from GDS who view PCTDS as safer option—increasing numbers of overseas candidates make process of recruitment more complex and time consuming—getting work permits etc.
- Recruitment has improved over last six months.
- Recruitment has improved since nGDS.
- The introduction of FP17—based reporting has sapped the energy of many senior clinicians in Special Care Dentistry—new day spine will be awaited with keen interest by their staff.
- We are having to disestablish our vacancy savings.

More worrying comments are those about the service becoming smaller and vacancies in salaried services being disestablished in some areas. 30% of Clinical Directors reported that posts were frozen and this has contributed to increasing uncertainties about the primary dental care services post 2009.

4. SUMMARY

In summary the new contract has potential to enable the SPDCS to become better understood and play a more complimentary role to GDP services, providing dental care for the most vulnerable sections of the community with higher dental needs. In reality this has not been the case everywhere because of increased referrals of patients who do not strictly meet the criteria for treatment and who would have previously been successfully treated in practice. This has had knock on effects for the traditional service users in terms of increased waiting lists for services and inhibited service developments.

The wholesale use of UDAs as a universal monitoring tool has masked the pattern of treatment provision in the SPDCS. This can only be addressed if different or additional indicators are used.

There is a degree of uncertainty about primary care dental service provision post 2009 which is having a negative impact on individuals.

Jane Davies-Slowik

February 2008

Memorandum by Andrew Sadler (DS 46)

1.1 I have been invited to submit written evidence to the Committee on the impact of the new dental contract on the Secondary Care Hospital Service within which I work. I would also like to comment on two other areas within the terms and reference of the Committee; that is quality of care provided to the patient and the role of the Primary Care Trusts in commissioning dental services.

1.2 I am a registered medical and dental practitioner. I work as a Consultant in Oral and Maxillofacial Surgery for the United Lincolnshire Hospitals NHS Trust. I have worked in this capacity in Lincolnshire since 1994.

1.3 My work in Oral and Maxillofacial Surgery is concerned with treating patients with conditions of the mouth, face and jaws. A large part of the work of our service involves minor oral surgery such as the removal of impacted and buried teeth such as impacted third molars (wisdom teeth) and some simple dental extractions for patients with co-existing medical problems. Most of this minor work is referred by General Dental Practitioners.

IMPACT OF THE NEW DENTAL CONTRACT ON SECONDARY CARE SERVICES

2.1 Since the introduction of the new contract there has been a significant increase in referrals for dental extractions to the Hospital service. The reason is that it does not pay the Dentist to do this dental extraction work under the new contract. This has overloaded the work on our Department meaning that it is very difficult for us to meet the targets for treatment times. 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.

2.2 This has also disadvantaged patients who have been unnecessarily pushed into the Hospital system causing them delay, sometimes in pain, for extractions which should be done by a Primary Care Dentist. It has also inconvenienced patients in that they have had to travel to the Hospital for treatment rather than having it carried out locally at the dentist. Patients who have been referred for dental extractions are more frequently those who are socially disadvantaged and have a high level of dental disease.

QUALITY OF CARE

3.1 I am particularly concerned that the new contract has encouraged the unnecessary and inappropriate prescription of antibiotics to patients with dental pain before they are referred to the Hospital for the extractions. Patients presenting to a Dentist with dental pain should be treated by having the painful tooth dressed or the inflamed pulp removed where necessary or if the tooth is beyond restoration extracted. The new contract pays three quarters of a unit of dental activity (UDA) to the Dentist for issuing a prescription for antibiotics with the patient paying no charge for this. This policy is encouraging over prescription of antibiotics which is further encouraging the development of antibiotic resistant organisms within the community.

3.2 The UDA system does not reward Dentists for treating patients with anything other than a minor amount of dental disease. This disadvantages those patients who the NHS should be helping the most ie the poor disadvantaged patients with a lot of dental disease who attend the Dentist in pain. Consequent upon this system Dentists have been using the Hospital to dispose of patients who need much dental work who would be unprofitable for them to treat.

3.3 Dentists have routinely not been telling patients about the dental disease that they have in order to avoid having to undertake unprofitable treatment for them.

3.4 In the last couple of years the Lincolnshire Primary Care Trust has recruited a large number of Dentists from overseas to Lincolnshire to help with the problem of access to dental care. Dentists from outside the European Economic Community have to pass the Overseas Registration Examination before being able to practice in the United Kingdom. This examination proves their competence up to the standard of a UK graduate. However those new Dentists from within the EEC do not have to take this examination and it is clear from seeing patients referred by them that many of them have been trained to a different standard and are not competent to the same standard.

ROLE OF THE PRIMARY CARE TRUST IN COMMISSIONING SERVICES

4.1 The Primary Care Trust does not appear to have any system of induction for overseas trained dentists into working in the UK nor any effective system of monitoring quality of care received.

4.2 On 30 November 2007 I visited the Lincolnshire Primary Care Trust with two of the colleagues to discuss the problems that were being caused by the new contact. At the meeting I gave a presentation to them about the quality issues which I have outlined above. At the end of the meeting it was left that they would contact me to advise what further information they would need concerning the Dentists over whom I had particular concern.

4.3 On 5 December I saw the Dental Adviser to the Primary Care Trust who told me that they would probably deal with my concerns about the individual Dentists through the Dental Practices internal complaints procedures. I regard this as being unsatisfactory.

4.4 On 21 February I telephoned the Primary Care Trust to speak to the dental advisor. I was subsequently told that no action was to be taken about my concerns and that none could be taken without complaints from patients. I believe that there should be a pro active system of monitoring quality of care and of dealing with my concerns as most patients have little idea what has been done in their mouths and more particularly what has not been done but should have been.

EXAMPLES

I have X-rays for each of these cases but I have been advised by the Medical Director of the United Lincolnshire Hospitals NHS Trust that these cannot be shown without specific permission from each of the patients.

Case 1

A 48 year old lady was referred for removal of an upper third molar tooth. The removal of the tooth was a simple matter which could have been carried out very easily in the dental surgery. The x ray shows that the patient had decay in the upper left second molar tooth and the lower right second molar tooth neither of which she had been informed about.

Case 2

A 19 year old lady was referred for removal of the upper right, lower right and lower left second molar teeth. The upper right second molar tooth needed removal which could have easily been carried out in the primary care service. The other two teeth that she had been referred for could have been restored. She had not been offered restoration of these teeth by the Dentist. Removal of these teeth would have mutilated her otherwise intact dentition.

Furthermore clinical examination revealed that she had cavities in three other teeth which was confirmed on x ray. The Dentist had not told her about the dental disease in these other teeth.

Case 3

A 46 year old lady was referred for the extraction of the lower right second molar tooth. This tooth was very decayed but was not impacted and could have been removed in primary care. Clinical examination showed that she had a soft filling in the lower right first pre molar tooth, a cavity all around the filling in the lower left second pre molar tooth and early dental decay in the two left molar teeth. The findings were confirmed on the x ray which also showed that she had a shadow beneath the right pre molar tooth indicating chronic infection of which she was unaware.

Case 4

A 50 year old gentleman was referred for removal of the upper right second molar tooth. Clinical examination revealed that he did need removal of this tooth but he also had a broken incisor tooth and a cavity in the upper left second molar tooth which was confirmed on the x ray. He was unaware of this other disease. He reported that he had a check up six or seven weeks before and there had been no mention of any other treatment needing to be done.

Case 5

A 52 year old gentleman was referred for removal of two teeth. Clinical examination revealed a large cavity in a third tooth which was confirmed on the x ray. This had not been mentioned by the Dentist.

Case 6

A 40 year old gentleman had been referred for removal of four decayed tooth roots. Examination revealed that he had obvious decay in three other teeth which was confirmed on the x ray. No mention had been made to him about this by the Dentist.

Case 7

A 46 year gentleman was referred for removal of one decayed molar tooth, the lower left first molar. Clinical and x ray examination revealed cavities in the upper left second molar and the lower right first molar. No mention had been made by the Dentist about this to the patient.

Case 8

A 43 year old gentleman was referred concerning soreness in the mouth and white patches. The Dentist had provided antibiotics unnecessarily on four occasions. X rays were provided by the Dentist but these were of such poor quality that they had to be repeated leading to unnecessary radiation exposure. The x rays clearly showed dental caries in the upper second molar teeth on both sides.

Case 9

A 46 year old lady was referred by the Dentist who reported repeated episodes of pain from the area where a wisdom tooth had been removed at the Hospital in 2001. The patient denied that the pain had been coming from this area but that it had been coming from the upper left first molar tooth. Clinical and x ray examination revealed no problem where the original tooth had been removed at the Hospital but there was a shadow on the x ray around the upper left first molar tooth from where the patient had reported pain. The patient was referred back to the Dentist with the suggestion that he carried out the appropriate restorative treatment.

Case 10

A 59 year old gentleman was referred regarding a third molar tooth for removal. Clinical and x ray examination showed that he had a cavity in this tooth and also one in the opposing tooth. The teeth were functional and he had not been offered restoration of them. He indicated to me that he would like the teeth restored if possible rather than removed and so he was sent back to the Dentist.

Case 11

A 43 year old gentleman was referred for removal of five teeth. The gentleman had several teeth which were restorable so he was referred back to the Dentist to carry out this work and was seen on a second occasion at the Hospital to arrange the extractions. He had been told by the Dentist that the restorative treatment had been completed but the x ray revealed that he still had cavities in two of his molar teeth on the left hand side and he had cavities that were clinically obvious in the upper right canine and first premolar tooth.

Case 12

A 17 year old lady was referred by the Dentist for removal of a third wisdom tooth which was allegedly causing pain. Clinical examination revealed that all her third molars were completely unerupted and not in a position to be causing the pain but there was decay in the second molar tooth which was very obvious. There was also decay in the upper left first molar, the lower left first and second molars and the upper right first molar. The x ray that had been taken by the Dentist contravened radiology protection guidelines in that it was of completely undiagnostic quality and had to be repeated at the Hospital. The patient had not been told about any of her other dental disease.

Andrew Sadler
Consultant Oral & Maxillofacial Surgeon
United Lincolnshire NHS Trust

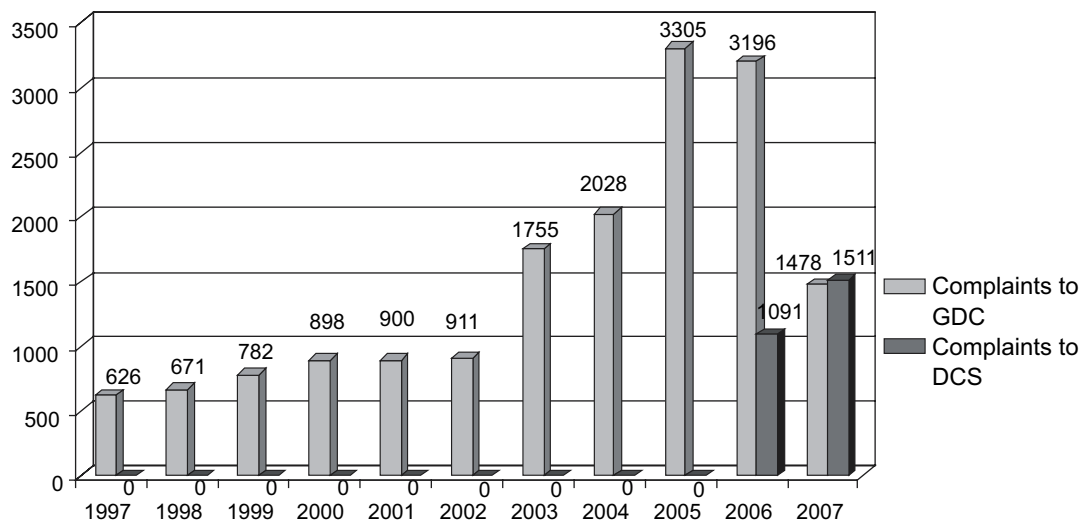
March 2008

Memorandum by the General Dental Council (DS 47)

DENTAL SERVICES

1. How has the number of complaints made against dentists changed over the last 10 years?

The following bar chart shows the number of complaints about dental professionals raised with our fitness to practise team each year, from 1997–2007.



Please note that the figures for 2003 onwards are not directly comparable with the figures from previous years. In 2003 we introduced a new database and began recording a wider range of queries, including those which were resolved without recourse to our fitness to practise procedures.

Two possible factors contributing to the drop-off in the number of complaints logged by our Fitness to Practise Team in 2007 are:

- The launch of the Dental Complaints Service (DCS) in May 2006, which we set up to deal specifically with those private patient complaints which are not about fitness to practise issues.
- The introduction of our own in-house Customer Advice and Information Team which is able to provide callers with information on their different options and signpost to other relevant organisations, such as the NHS complaints procedure, where appropriate.

2. Has the new contract had any discernable impact on the type of complaints received?

We have seen an increase in the number of complaints logged with us over the ten year period. This fact could be attributed to many different factors.

We classify fitness to practise cases by type, according to the main issues they raise. The table below shows how we classify cases. However, from the data we currently capture, we would be unable to draw any conclusions about the impact or otherwise of the contract on the type of complaints received.

- Behaviour or conduct
- Clinical standards/treatment
- Consent (inc. explanation of treatment)
- Facilities or equipment
- Fees charged
- Fraud
- Sexual assault or abuse
- Service provided
- Health problem
- Other

3. To what extent has any change in the number of complaints arisen from the introduction of a complaints system covering private dentistry?

The bar chart above shows the number of complaints logged by the Dental Complaints Service, the private patient complaints scheme set up by the GDC in May 2006.

We would not necessarily expect the advent of the Dental Complaints Service to have an impact on the number of cases taken forward under our fitness to practise procedures, since the two systems exist to meet different needs. The Dental Complaints Service provides a service which was not previously available anywhere else. It is possible that the GDC now receives fewer general enquires about making a complaint as a result of the new Service.

March 2008

Memorandum by Professor Martin Tickle (DS 48)

ACCESS TO DENTAL SERVICES IN THE NORTH WEST

In articles published on pages 285 and 288 in the Dental News section of the British Dental Journal Volume 24 No. 6 Teresa Perchard, policy Director of the Citizens Advice Bureau is reported as saying in her evidence to the Health Select Committee that that the South West and North West were “dental deserts” where access is particularly poor.

The North West does not have a significant dental access problem. In fact using the Department of Health’s measure of access which is the number of individuals who have attended during the last 24 months, access in the North West is better than the national average. Latest figures available from the Information Centre (June 2007) show that 60% of the population in the North West had visited the dentist in the last two years compared to 55% for England as a whole. Access in the North West has been remarkably constant over the last two years or so, even though we lost about 5% of dentists when the new dental contract was introduced in April 2006. So I am puzzled why the CAB has identified the North West as having a severe problem.

The North West Strategic Health Authority recognises that improvements are needed and there are a small number of areas where access to NHS dental services is a problem. In March 2007 the SHA asked all of the PCTs in the North West to produce a local oral health strategy to set out how they will improve the dental health of their population and increase access to dental services. These plans are now being implemented and many PCTs have made significant investments in dental services from their general allocations over and above the recently announced 11% uplift in ring-fenced funding from the Department of Health.

I think there is a large gap between public and media perceptions of obtaining access to NHS dental services and the real situation. The efforts made by the NHS to shrink this gap and help members of the public to access dental services is not helped by the inaccurate and misleading statements attributed to Ms Perchard.

I should be grateful if you could relay these facts to the Health Select Committee.

Professor Martin Tickle

Consultant in Dental Public Health and Dental lead for the North West Strategic Health Authority
NHS North West

4 April 2008

Memorandum by Robin Pope (DS 49)

I am a practicing NHS dentist of 20 years experience and the real problem with the contract is the UDA. We have been given no guidance as to how the individual UDA values were calculated. In Shropshire the values range from £15.00 to £25.00. The PCT says these values are not negotiable and so a Dentist providing a crown with a UDA value of £15.00 will receive 12 units x £15.00 = £180.00 which with a patient charge of £196 is a subsidy to the PCT of £16.00 whereas the Dentist with a UDA value of £25.00 would receive 12 x £25.00 = £300 – 196.00, in effect the PCT is subsidising the cost of a crown by £104.00. How can this be correct in the same county with similar overheads. I also do not see how UDA values can be fairly altered in the future if the PCT refuse to discuss changing the value except by indexation. The Dentist may retire and so the new Dentist inherits the contract and its UDA value.

PCT are inadequate to deal with these issues locally and so will adhere rigidly to government guidelines which may not be appropriate.

I must declare my own interest in that our three man practice have a very low UDA value and are facing clawbacks for underperformance even though we have treated the same patients in the same way for 20 yrs. The total clawback for the contract is of the order of £80,000. This, if applied will bankrupt the practice.

The MP for Shrewsbury and Atcham, Mr Daniel Kawczynski is aware of this case but I have contacted you to highlight the real concerns of the profession with the new contract and why many Dentists are still leaving or are contemplating leaving the NHS.

Robin Pope
Monkmoor Dental Practice

27 March 2008

Memorandum by the National Audit Office DS 50)¹⁰

SUMMARY

In November 2004, the National Audit Office published its report “Reforming NHS Dentistry—ensuring effective management of risks”. This was followed by the Committee of Public Account’s report published in April 2005. Both reports made a series of recommendations to support the management of risks in implementing the new contract. In this informal briefing we set out our analysis of what progress been made against the recommendations.

Our main methodology was a telephone survey of Strategic Health Authorities (SHA) to better understand their role in securing good dental health for a health economy and their role in performance managing the implementation of the nGDS contracts by Primary Care Trusts. This work was underpinned by a review of published information and data.

We found that:

- there is a variance in the role that the SHAs play in performance managing their PCTs and involvement in promoting dental health;
- the 2006 reorganisation of PCTs and SHAs has meant that only now are trusts finding their feet;
- information on oral health, demand for dentistry and access remains limited; and
- SHAs and PCTs lack the capacity (numbers and skills) to commission dental services effectively.

NATIONAL AUDIT OFFICE AND COMMITTEE OF PUBLIC ACCOUNTS REPORTS ON REFORMING NHS DENTISTRY

Recommendations and progress in implementation to date

PAC conclusion and recommendation

1

The Department has set itself an ambitious programme for reforming NHS dentistry. Some key milestones have been missed, and the planned introduction of the new base contract was deferred by six months, to October 2005. . . . Primary Care Trusts will need to give high priority to developing sufficient expertise in dentistry if the Department is to meet its new target of April 2006.

Progress made in implementing recommendation

Partly as a result of the NAO’s report the Department delayed the implementation of the new contract from October 2005 to April 2006. However, the implementation of the contract was still rushed. The Department did not issue Primary Care Trusts with budgets until 2 December 2005, giving them less than four months before formal introduction of the new contract. With such little notice to carry out financial and business planning it was difficult for PCTs to plan the use of the contract or understand the levers available to them in the contract. PCTs concentrated on implementing the contract and getting dentists to sign up to the new contract. In the run up to 1 April 2006 1,050 contracts rejected their new contract.

The Department provided support and training for PCT staff involved in the contract negotiations and the management of dental services, prior to the introduction of the new contract. However whilst take up was good, there has been significant turnover in staff and the team providing the training has moved on.

The implementation of the contracts was made more difficult by the reorganisation of PCT in October 2006. So not only were PCTs in a position where they already had limited expertise in commissioning dental services, they also had to deal with reorganisation of responsibilities and/or personnel. Based on the SHA survey, SHA dental leads still believe that PCTs lack the skills and numbers to manage the commissioning of dental services.

PCTs are supported by the NHS Primary Care Contracting team who provide national guidance on commissioning issues.

¹⁰ Includes a response from the Department of Health

DH Response—the introduction of the new contract system was bound to be challenging, as it extended the remit of PCTs into a new (for them) field. We acknowledge that the PCT reorganisation added to the challenge PCTs faced in 2006–07.

We continue to contract with Primary Care Contracting (PCC), and almost all PCTs also subscribe to PCC for support. Having concentrated on providing general advice and guidance, this year, PCC will be offering targeted support at PCCs who appear to have furthest to travel in terms of improving their dental services commissioning.

PAC conclusion and recommendation

2

The Department is proposing to move from patient charges for 400 different items of treatment, to a small number of price bands. This radical upheaval to the historical system of charging may have unintended consequences both for dentists' willingness to provide treatment and for patients' willingness to pay. . . . The Department will need to pay close attention to the results of their consultation on dental charging if they are to emerge with a system which commands the assent of all parties. . . . [It] will also need to avoid creating incentives to offer private treatment to registered NHS patients at a lower cost than the NHS charge. . . . The Committee is concerned that the time needed for the consultation and ministerial debate will leave little time for convincing dentists to agree to the new charges by April 2006.

Progress made in implementing recommendation

The Department consulted at a national level on the new patient charging system (DoH 2006, Gateway number 5931). Respondents did think that the current system was bureaucratic and needed an overhaul but the majority thought the disadvantages of the new banding system outweighed the advantages. The Department nonetheless were committed to the three band system. Details of proposed system were announced in July 2005 and were implemented from April 2006. Whilst the three band system has indeed simplified patient charging, commentators have raised a number of issues with the system. Patients are unsure of the system, there is a lack of clarity on what treatments can be included in each band and dentists consider that the charges do not reflect the cost of provision of services. Bands are too broad which means that dentists are not incentivised to provide dental care at the top end of the range.

DH Response—The new charging system was developed by a working group chaired by Harry Cayton, which included representatives of the dental profession as well as patients' groups. There was unanimous support on the group for the changes, and while many respondents to consultation may have opposed the banding system, it drew strong support from Which? and Citizen's Advice, who speak for consumers of dentistry, who know how confusing the previous system of over 400 different charges for items of service were for the public.

The Department remains firmly convinced that this change was both necessary and beneficial to the public, at the same time as being fair for dentists by reflecting their previous earnings.

PAC conclusion and recommendation

3

Dentists will no longer have a financial incentive to try and collect debts from patients who fail to pay the correct NHS charges for the treatments they receive because, under the new system, dentists' income is guaranteed for three years and is not dependent on the level of charge income. Primary Care Trusts will need to monitor outstanding debt to see whether dental practices are as rigorous in collecting payments. . . . as they were under the old system. . . .

Progress made in implementing recommendation

The Department did not fully accept PAC's conclusion that Patient Charge Revenue would decrease. Dentists' contract values are calculated in gross terms, ie before taking into account charges collected from patients. The monies due to be collected as patient charges are then netted off the monthly payments that dentists receive from the NHS. Failure to collect patient charges has a direct impact on the dentist's net income. This was not clear when the PAC wrote their conclusion.

In the first year of the contract there was a shortfall in charges collected by Dentists. The reasons for this are not certain, but dentists believe they are treating different mixes of patients. However, PCTs are anxious to recover the shortfall, either by asking for a refund from dentists or by adjusting the following year's contract. Dentists are arguing that they have little control of this and that the new system is not flexible enough. In the first year of the contract there is a perception (evidence unclear on this point) that PCTs held back some funding expecting lower levels of patient income and overestimated the number of UDAs that some dentists could deliver which meant money needed to be recovered from dentists; this may have contributed to underpays on dentistry by the PCT.

DH Response—It is true that patient charge revenue fell in the first year of the new system. However the indications are that in 2007–08, this will show a marked increase. Although there were many cases where dentists either over- or under-performed against their contracted UDA values, in many cases the quantum

was small. The BDA's own survey showed that many PCTs were willing to write off under-performance beyond the 4% tolerance in the first year. And in fact PCTs spent 96.7% of the ring-fenced gross dental budget.

We have issued further guidance on handling over- and under-performance against contract.

PAC conclusion and recommendation

4

PAC conclusion (iv): The move away from a system where dentists are paid per item of treatment will mean that the Dental Practice Board will no longer be able to monitor dentists' performance by collating information on treatments carried out. . . . The new arrangements being introduced by the Dental Reference Service will need to provide effective accountability arrangements, including clinical audit and evidence based quality assurance arrangements. . .

Progress made in implementing recommendation

In its Minute to the Treasury in response to the PAC's report, the Department did not agree that there would be less information for managing dentists. It is, however, clear that the new system of charging and data collection does not provide sufficient information to enable PCTs to understand specifically what units of dental activity are being commissioned.

The Information Centre (for Health and Social Care) published a comparison of activities between 2003 and 2007. The main concern here was that, for 2003 the Dental Practice Board collected complete activity statistic as a result of the fee per item of service system. The new system collects data by units of dental activity (UDAs) does not provide specific details. Data was collected through a request from BSA for 10 record cards for each NHS dentist and extrapolated from there. Also the data published was not a direct comparison as it compared activity over two years. This approach was thought to be flawed. Additional concern, from academics is the potential loss of data for research and longitudinal studies.

The DRS provided the quality assurance check on dentists. Since the introduction of the new contract and the loss of the DPB database, their review have been paper based and less targeted.

The Department has informed us they will be introducing new data collection systems later this year, but we have not reviewed them or their content.

DH Response—we have indeed introduced a new data collection system, in the form of the FP17 form, which will collect data on the type of treatment given. This will answer the underlying concern in this point.

The complete activity statistic measured work carried out, and payments made. It was not a measure of oral health.

The DRS has adopted a risk-based approach to quality assurance and monitoring; this is a standard audit approach.

PAC conclusion and recommendation

5 and 6

Indicators of oral health, which have tended to focus on children, show that children in England average lower levels of decay than their European neighbours, but with strong regional variations in the extent of dental decay in adults and children. . . .

Poor oral health tends to be associated with social deprivation, and some deprived areas have relatively few dentists as it can be difficult to attract them to set up practices in these areas. . . . The Department should consider whether initiatives such as using access centres and mobile dental units. . . have been given a sufficiently high priority under the new system. Primary Care Trusts will need to use their new commissioning responsibilities. . . to influence dentists to provide NHS dental services in areas of greatest oral health need.

Progress made in implementing recommendations

The Health and Social Care (Community Health and Standards) Act 2003 gives PCTs new functions in relation to dental public health in their area. One of the aims of the new contractual arrangements is to support PCTs in promoting oral health by enabling them to commission a wider range of services than those provided for in the current system of dental remuneration based on items of treatment. The lack of good quality information on oral health and capacity and capability and PCT level hinders PCT's ability to make the most out of the new contract. The Department believes that fluoridation of water offers the best prospect of reducing inequalities in oral health. Strategic Health Authorities (SHAs) now have the power under the Water Act 2003 to fluoridate the water supply, where the SHA can demonstrate a local consensus. The Department issued guidance on fluoridation to the NHS on 8 September 2005. They have also developed an oral health plan, encompassing best practice guidance for PCTs. This gives advice to PCTs on how to reflect oral health needs in their commissioning of dental services and how to develop preventive programmes (working with partners across regional and local government and the voluntary sector). It is also aimed at helping people adopt healthy choices, thereby keeping more of their teeth for life.

The lack of information on oral health and the lack of capacity at PCT level means that commissioning of services in the areas of greatest oral health is more difficult. There is no evidence that PCTs have commissioned more mobile dental services or access centres. In general PCTs can only commission fixed NHS services where dentists are already based as the ability to attract new dentists into the NHS is limited. The main concern is that PCTs still do not have sufficient data to identify where dentists are needed. The SHAs we contacted said that they were not in a position to target resources or intervention for specific needs.

DH Response—the Government announced in February the allocation of £14 million capital funding to support fluoridation schemes, and we understand that a number of SHAs are actively planning to consult on fluoridation proposals. Water fluoridation is demonstrably effective in reducing tooth decay, and is particularly effective in improving the dental health of deprived communities, who tend to have less rigorous dental hygiene and less healthy diets. Children in relatively poor areas, such as Birmingham and Sandwell, enjoy significantly better oral health than those in equivalent areas whose water is not fluoridated.

The NHS Operating Framework, published in December 2007 identifies dentistry as a national priority and requires that “PCTs also need to ensure robust commissioning strategies for primary dental services, based on assessments of local needs, and with the objective of ensuring year-on-year improvements in the number of patients accessing NHS services. . . .”

We already have evidence of good and innovative commissioning in some PCTs, for example Tower Hamlets, which has commissioned outreach services to widen access among its many deprived communities. As stated above (in response to recommendation 1), Primary Care Contracting will begin to target those PCTs that appear to require most support in commissioning dental services.

We have also started to address the uneven distribution of funds. Because the old system saw funds allocated on the basis of where NHS dentists were located, there is a very uneven pattern of funding. The funds for improving dental access this year were distributed mainly on a straight population basis, which starts to address this anomaly, and we will be working to develop a fairer allocations policy for dental funding.

PAC conclusion and recommendation

7

The Department has not attempted to assess demand for NHS dentistry, although it estimates that currently there are about two million people who would like to register with an NHS dentist but are unable to do so. . . Strategic Health Authorities and Primary Care Trusts need to improve their understanding of both need and demand for local NHS dental services through modelling the requirements of their local health economies.

Progress made in implementing recommendations

SHAs report that there has been some progress on assessing demand for local NHS dental services. Some SHAs report that at PCT or SHA level some attempts have been made to understand access through surveys although there has been no systematic attempt to understand need and demand for dental services. Without modelling and a clear understanding of demand it is unclear how PCTs can commission on the basis of need. There have been some interventions by PCTs using the corporate dental providers.

DH Response—as above, we are seeing evidence of good practice in commissioning in some places, and will be targeting support on those with furthest to travel.

We are seeing an increase in the size and activity of the dental corporate sector. This, together with the increased funding for NHS dentistry (11% increase this year) represents a challenge for existing dentists, especially those who have been able to increase their private practice because of shortages of access to local NHS dental services.

PAC conclusion and recommendation

8

Matching demand and supply of NHS dentists over the long term is dependent on the Department and Primary Care Trusts developing a clear understanding of dentists’ reasons for switching to PDS contracts in advance of the new contracting arrangements. The Department should undertake a survey . . . to understand more fully their reasons and determine whether the expected increase in commitment is being realised.

Progress made in implementing recommendations

In its response to the Treasury the Department supported this conclusion in principle but considered that PCTs are best placed to review the experience of PDS pilots with local dentists. This response failed to take into account that many PCT areas did not have experience of the PDS pilots so therefore relied on a small number of PCTs disseminating their experience. Understanding the attitudes of dentists remains important to assess future demands for NHS dentistry without a good understanding of commitment to NHS dentistry it will be difficult to plan locally to meet demand. On a SHA level and national level it is important to enable effective workforce planning ie assessing the number of dental training places in Universities. The Department have not produced an evaluation of the PDS pilots. Our commissioned review was the nearest.

DH Response—accepting that workforce planning tends to be an inexact science, given fluctuations in demand and skill mix, we need to ensure that there are enough dentists to meet the demand for NHS services. The Government opened two new dental schools last year, in Plymouth and Preston, and the number of dental graduates is set to increase by 25%.

As PCTs look to invest the extra funding they have received this year, they are tendering new services and/ or seeking to extend existing contracts. We understand that they are finding no lack of applicants.

PAC conclusion and recommendation

9

England has one of the highest ratios of people to dentists of all the European Union and G7 countries, and in 2002 the Department estimated that in 2003 there would be a shortage of 1,850 dentists. The shortfall in dentists is being met in the short term by international recruitment initiatives. In the long term the Department is increasing the number of dental training places by 25% and is quadrupling the number of dental therapist places. The Department needs to explore options for incentivising these additional dentists to commit to the NHS.

Progress made in implementing recommendations

We are not aware of any specific incentives for attracting new dentists to work in the NHS. There was a concerted drive to recruit dentist from Poland and India with mixed success. Whilst a number of dentists were recruited, there are stories that many have returned and that expected the influx from India did not materialise.

DH Response—In July 2004 the Government launched Project 1000, with a commitment to recruit the equivalent of 1,000 more dentists. In fact it exceeded this target. By October 2005 it had recruited the equivalent of 1,453 new whole time dentists, including dentists returning from employment breaks in England, and 743 overseas dentists, mainly from Europe and India.

As stated above, we have increased the number of dentists in training, and PCTs are experiencing little difficulty in identifying potential suppliers of new and expanded services.

PAC conclusion and recommendation

10

The Prime Minister's pledge that everyone should be able to see a NHS dentist by phoning NHS Direct requires up to date information on dentists' capacity, but the data provided to NHS Direct by Primary Care Trusts is often out of date . . . Primary Care Trusts need to . . . develop a more accurate system of providing the necessary data. NHS Direct should introduce a feedback system so that it can track the accuracy and effectiveness of its advice.

Progress made in implementing recommendations

The new contract places responsibility on Primary Care Trusts to have an accurate system of recording requests for an NHS dentist, this is not collected nationally. As a result there is no national data or information on the demand for NHS dentistry. SHA report that they do not collect this information and they are not aware if there is any mechanism for collecting the data collected by NHS Direct. We do not know how effectively data has been collected by PCTs. Role of NHS Direct has changed and they now do not provide this service in many areas.

DH Response—it is true that there is not a firm definition of the demand for NHS dentistry. The CAB's survey, published in January suggested that 2.7 million people who wanted to access dentistry had been unable to do so. Figures from the Information Centre show that in the past 24 months, some 54% of the population had seen an NHS dentist. Access has not ever exceeded 60%. With more people keeping their teeth for longer, it might be assumed that demand will grow in the future.

However patterns of demand may vary locally. In more prosperous areas, for example, there is widespread private provision, and many people may choose to use (or continue to use) private dentistry. Local commissioners need to make their own assessments of local need and gaps in access.

PAC conclusion and recommendation

11

The National Institute of Clinical Excellence's 2004 advice on changing the dental recall period, from the six months used by most dentists to between three to 18 months depending on clinical need, should also help free up capacity. There is however a risk that the existing incentive for dentists to see their patients too often will be replaced by an incentive to reduce patient visits to below the optimum frequency for oral health. The Department should provide posters and leaflets... so that patients understand any proposed variation in their recall period.

Progress made in implementing recommendations

There is no evidence that dentists have changed the routine recall and there is no evidence that patients are not being seen with NICE guidelines. The lack of data makes this very difficult to monitor. Dentists have always claimed that recall based upon clinical needs, but the new charging system does not appear to support this.

DH Response—the new clinical dataset, derived from the FP17 form, will give us more information on this. The Dental Services Division is also able to identify the intervals in which patients are seen.

PAC conclusion and recommendation

12

There is a lack of consensus on suitable measures of oral health . . . The National Audit Office used an Oral Health Index devised by the University of Birmingham . . . The Department should consider adopting this index, or agree on a more suitable oral health measure.

Progress made in implementing recommendations

There is still no consistent measure of recording oral health. The Department accepts the need to improve the range of oral health measures and proposes using existing oral health measures and rejects the one suggested in the Committee's recommendation. The Treasury Minute response does not say if these measures will be used consistently. There is a need to re-emphasise the importance of using consistent oral health measures as it facilitates monitoring of oral health over time and helps identify health inequalities. This could be a key tool in determining and assessing need and targeting interventions.

DH Response—It is important to recognise that a good deal of needs assessment is going on. PCTs are required to provide a local public health function. As indicated above, the NHS Operating Framework requires PCTs to have robust commissioning strategies, based on assessments of local needs.

The Adult Dental Health Survey will take place in 2009, and the British Association for the Study of Community Dentistry provides a forum for dentists with an interest in public health and oral health studies to network and share their research and expertise.

As to measures of recording oral health, although for orthodontics, the Index of Orthodontic Treatment Need (IOTN) has gained acceptance, there is no such generally accepted index for general oral health and dental treatment need.

SURVEY OF STRATEGIC HEALTH AUTHORITIES (SHAs)

Summary of findings

1. *Methodology*

We carried out a telephone survey of seven of the 10 SHAs in England to understand their role in providing strategic direction and management of PCTs in relation to NHS Dentistry. The contact list for the Strategic Health Authority leads was provided by the Department of Health. We found it difficult to contact the appropriate person at the Strategic Health Authority with responsibility for dental health. We also spoke briefly and informally to the Chief Dental Officer to understand his perspective on the role of the Strategic Health Authorities.

2. *Findings*

Role of SHA in NHS Dentistry

The role of the SHA, with regard to dentistry, is primarily to performance manage and support PCTs in commissioning NHS dentistry. They distribute funding to PCTs and monitor their expenditure on dentistry against allocation. They also support PCTs in developing their wider strategic approach to improving public oral health, often leading on issues such as fluoridation. Data on dental activity, (such as no. of Units of Dental Activity, patients seen, no. of practices with lists, contracts in dispute patient charges) provided on a monthly basis to PCTs from the BSA. Many perceive that the role of SHAs is limited and while these functions are carried out there is scope for greater involvement.

Strategy and Policy

The involvement of the SHAs in developing a regional approach on dentistry varied across the country. One SHA had developed a formal strategy for dentistry where other SHAs had relied on reviewing individual PCT strategies on dentistry. Others are in the process of developing a strategy and are consulting the public at present.

Information on Dental Need and Access

Most SHAs did not collect information on dental need or access over and above what is supplied by the Business Services Authority. Most simply passed the data back to the PCTs and did not know how it was used and whether it was good quality data. One SHA had carried out a survey to understand access and satisfaction with NHS dentistry. SHAs acknowledged that they had left the responsibility for understanding patient need on dentistry to PCTs. There was not a consistent approach to assessing oral health in the strategic health authority area. The SHA leads acknowledged that understanding and carrying out oral

health surveys in children was easier than adults because of their access to cohorts through schools. We contacted the Information Centre (for Health and Social Care) to ask when they would carry out their planned adult health survey. They said that they were currently consulting on their involvement in carrying out this survey.

Performance Management and Monitoring

The extent to which SHA performance manage the commissioning of dental contract by PCTs varies. Most SHAs performance monitors commissioning in association with other aspects of primary care, and dentistry is a lower priority than GP services. All SHAs monitor expenditure of dental budgets against allocation. Many SHA we spoke to noted that in the first year PCT had problems of spending their budgets against allocation because of uncertainties about contract volumes and income from patient charge revenue.

Expertise at SHA Level

The majority of SHAs acknowledged that expertise and capacity on dental issues could be improved at SHA level. We found it difficult to contact the designated dental lead at SHA level and in general dental expertise was bought in from individual PCTs to work at SHA level. Many SHAs acknowledged that they had been affected by SHA reorganisation in October 2006 and roles and responsibilities were only now “bedding-in”. Many dental leads are new in post and are building up the quality of staff and acquired knowledge.

Commissioning by PCTs

We asked the SHAs for their view on the expertise of PCTs in commissioning dental services. All SHAs highlighted that the capacity to commission dental services could be improved. Many PCTs did not have sufficient good-quality data to be able to make effective commissioning decisions. They also did not have enough staff with the right skills to be able to commission effectively. This was applicable across primary care and was not limited to dentistry. The NAO will publish a report on GP Contracts on 28 February which highlights similar issues with commissioning by PCTs. The tools are available for PCTs to improve access but there is a lack of accurate information to match demand with supply.

Supplementary memorandum by the Department of Health (DS 01A)

1) *A breakdown of how many patients are currently on PCT waiting lists for dental services*

The decision on whether or not to hold details of patients seeking NHS dental treatment is a local one to be made by PCTs. Dental services are commissioned and provided locally and access levels vary widely- not all PCTs by any means have patients currently unable to find an NHS dentist.

However, the Department strongly encourages PCTs to develop robust local arrangements to ensure that finding a dentist is as simple a process as possible for patients. Virtually all PCTs now run dental access help lines which patients seeking care can call for advice.

The Department has also been working with NHS Choices to help publicise the existence of these help lines to the public. Now when a patient uses the website to search for a dentist in their area, the relevant PCT help line is automatically displayed.

2) *Figures over the last five years, for which the information is available, for the number of contacts with NHS Direct from patients experiencing symptoms relating to tooth pain*

The following tables set out the number of calls which ended with the caller being advised to seek some form of dental treatment, by year, going back to 2003. These are presented as a proportion of all calls where the caller rings up seeking advice on their symptoms (rather than just for general health information)—known as symptomatic calls, and of all calls answered. It should be noted that this data does not include any dental calls where the caller was not advised by NHS Direct to visit a dentist, for example patients given self care advice only.¹¹

¹¹ See Ev 156

	<i>Callers advised to seek dental treatment, as a % of Symptomatic Calls</i>	<i>Caller advised to seek dental treatment as a % of all Calls Answered by NHS Direct</i>
2003	5%	3%
2004	6%	3%
2005	6%	4%
2006	9%	6%
2007	11%	8%

	<i>Callers advised to seek dental treatment</i>	<i>Symptomatic Calls</i>	<i>All Calls Answered by NHS Direct</i>
2003	166,539	3,640,172	6,443,091
2004	220,681	3,993,805	6,431,102
2005	275,367	4,374,303	6,804,759
2006	381,371	4,112,785	6,359,898
2007	421,825	3,821,570	5,496,089

3) *The number of dentists employed on community salaried dentist contracts in England*

As at 31 March 2007, there were 1,588 exclusively salaried dentists in England reported centrally. A further 2,665 were reported as working simultaneously in the salaried service and as independent contractors. (A dentist working as an independent contractor might for example also be employed directly by the PCT on a salary to deliver additional sessions in the PCT out of hours service).

Note: “Exclusively salaried” means in this context that the dentist holds a Trust Dental Services (TDS) contract and is not recorded as holding either a General Dental Services (GDS) and/or Personal Dental Services (PDS) contract. The dentist concerned may or may not be working full time in the salaried service—this is headcount rather than whole time equivalent data.

Data source: NHS Dental Statistics for England: 2006–07, The Information Centre for Health and Social Care.

February 2008

Supplementary memorandum by the Department of Health (DS 01B)

FURTHER INFORMATION PROMISED BY OFFICIALS WHEN THEY GAVE EVIDENCE TO THE COMMITTEE ON 4 FEBRUARY

HARD TO REACH GROUPS: INNOVATIVE SERVICE DELIVERY

We are currently working with ASDA to explore whether, working with local commissioners, topical fluoride varnishes could be delivered to children through services based in their supermarkets. We are happy to talk to other commercial organisation about similar approaches.

Taking targeted preventative services to the patient in this way addresses the long standing difficulty of reaching those most in need of regular dental care but who tend to only visit the dentist irregularly if at all. Generally speaking the higher the deprivation score for an area the less likely residents are to be regular dental attenders—often this is not because services are unavailable but because there has been no tradition of regular dental attendance in that community.

The problem of improving the oral health of so called “hard to reach groups” is long standing. What the new system does is enable the NHS to be more proactive in developing innovative services in this way.

PCT CASE STUDIES

	<i>Developments and New Activity</i>	<i>Location</i>
NORTH WEST SHA	<p>The North West Fluoridation Evaluation Group made up of reps from all 24 PCTs and the SHA, is working up proposals for consultation on a scheme to fluoridate Greater Manchester and the surrounding area and will examine the feasibility and affordability of potential schemes across the N. West</p> <p>Expansion of dental education programme. The expansion programme includes 32 training places to be located at outreach training practices in Lancashire and Cumbria, ie at Preston, Blackpool, Morecombe Bay and Carlisle. It is a 4 year graduate entrant programme with the first cohort of students starting in September and qualifying in July 2011. The location of dental students in the area should help to address the longstanding access problems which Lancashire and the far NW have faced in the past</p>	Preston, Blackpool, Morecombe Bay and Carlisle
Ashton Leigh & Wigan PCT	<p>New Domiciliary Dental Service A new domiciliary dental service has recently been commissioned and started seeing patients in August 2007</p> <p>Minor Oral Surgery Service A new service to provide minor oral surgery within a primary care setting has also been commissioned. It began accepting referrals in September 2007. This will contribute to providing more convenient care for patients, to meeting the 18 week target for waiting times and to providing care out of hospital.</p> <p>Multi-surgery Dental “Centres of Excellence” 2 multi-surgery dental “centres of excellence” are planned within LIFT developments. The first, a three surgery dental suite, is currently being developed at Pemberton clinic. The second is planned at Leigh clinic. This will enable the PCT to offer a range of primary and specialist dental services alongside other primary care services.</p>	Pemberton and Leigh
Central and Eastern Cheshire PCT	<p>The CDO opened a new practice in Crewe 11 January 2008. It is an enhanced training practice which takes outreach students from Liverpool University, and is also a vocational training practice with dedicated dental helpline. The practice is accepting new NHS patients and is growing considerably.</p>	Crewe
Bolton PCT	<p>Tender and procurement process April 2007 and 2 successful bidders chosen June 2007. 2 new practices near to Bolton town centre (one open January, one open February/March). Delivery of 31,680 UDAs pa 2008–09 expanding to deliver 39,600 UDAs pa from 2009–10 onwards. Estimated 10,000 new patients will be seen. Complementary in model and target population covering a) new dental access service and b) new practice to serve targeted area of deprivation.</p>	Bolton town centre

	<i>Developments and New Activity</i>	<i>Location</i>
NORTH EAST SHA		
Co Durham PCT	<p>A number of new dental practices have been set up in County Durham. Some of these developments are the result of re-commissioning services, whereas others have been funded by the PCT from outside its specific dental allocation. The new practices are in Easington Village, South Hetton, Chester le Street and Willington. The number of patients served by these practices will depend partly on the needs of patients coming forward for treatment, but they could potentially provide NHS dentistry for some 22,000 patients.</p> <p>A specialist orthodontist has been recruited in recent weeks to provide orthodontics to Durham and the communities in the north of County Durham where there was previously a four-year wait for orthodontics. Work with youngsters in the area indicated where the need was greatest. The service will treat approximately 200 children over each 18 month period—that is the average time it takes to treat an orthodontic case. Work on this project has been reported on the PCC website as good practice guidance.</p>	Easington Village, South Hetton, Chester le Street and Willington
YORKS AND HUMBER SHA		
Hull PCT	<p>New contract commenced April 07 to provide 17,083 UDAs annually, 2. new contract commenced June 07 for 12,500 UDAs annually, 3. new contract due to comence Feb 08 for 18,750 UDAs, 4. new specialist orthodontic contract jointly commissioned with ERYPCT to provide 3,060 UOAs (1,530 for each PCT), 5. growth to existing contract for the provision of additional 17,083 UDAs, 6. growth to existng specialist orthodontic contract for provision of additional 1,020 UOAs annually, 7. growth for the joint specialist orthodontic practice to provide an additional 2,041 UOAs (Hull only). Both specialist orthodontic practices on target to deliver annual contracted activity incl the pro rata growth element. Contract which commenced April is on target but June contract has been slow to pick up but this would reflect locality and patient base.</p>	
EAST MIDLANDS SHA		
Lincolnshire PCT	8 new contracts (part replacement due to retirement and part new service; new provision after review of area.). Includes Specialist Service Orthodontics in east of county where lack identified	Mablethorpe, Louth, Market Raison, Gainsborough, Sleaford, Boston, Holbeach, Spalding.
Northamptonshire PCT	Tendered for minor oral surgery service which has been operational since May 2007. Contract awarded to Oasis, operating from 3 sites across county and planned activity is approx 2,000 cases this year. Performing well, expect additional activity next year. Scheme developed as invest to save scheme and each case represents saving on what would have been spent as a secondary care day case of approx £500.	
WEST MIDLANDS SHA		
	NB West Midlands have carried out a public consultation which identified access to NHS dentistry as the biggest concern among local residents. Accordingly they have published a dental services strategy for the region which addresses access and improving oral health.	

	<i>Developments and New Activity</i>	<i>Location</i>
Walsall PCT	Re-commissioning to address health inequalities. Four new contracts have been awarded for a 12-month fixed period with the option to extend for a further period subject to satisfactory performance.	Darlaston, Willenhall, Bloxwich and Walsall
Hereford PCT	New NHS dental facility at Pool Farm in Hereford opened on 1 November 2007. The 5 surgery centre will be owned and operated by Oasis Dental Care Ltd under contract to HPCT and will provide general dental services for Herefordshire patients under NHS terms and conditions. When it reaches its full operating capacity in about 18 months' time, the new dental facility will be able to treat more than 10,000 patients annually	Poole Farm, Hereford
Birmingham East and North PCT	awarded additional UDA activity June 2007. 4 successful bidders (3 existing contract holders started immediately and the other was Oasis Dental Corporate who opened 27 December 2007)	
Worcestershire PCT	Newly commissioned capacity in Wyre Forest constituency	Wyre Forest Constituency
Shropshire PCT	Additional capacity has been commissioned in South Shropshire whilst other new provision is in process of being commissioned	Ludlow Much Wenlock Bishops Castle
North Staffordshire PCT	In addition 9 practices are available to take on additional patients New service in Biddulph—£350k currently out to tender (19 expressions of interest and submission of 5 tenders), due to open in April 2008. 3 practices offering additional services in Staffordshire Moorlands.	Biddulph and Staffordshire Moorlands (Werrington, Cheadle and Leek)
EAST OF ENGLAND SHA	East of England carried out a regional consultation that identified access to dentistry as a top priority. As a result they have now written to every PCT requiring them to define local access needs, based on distance and travel times people have to experience to access an NHS dentist, and develop a clear improvement plan to meet all gaps. The Chief Executive of Suffolk PCT has been appointed by the SHA to lead the management of this process, and will carry out a further patient survey.	
Suffolk PCT	Recently invested further in capital grant funding for dental practices, to develop and improve services for patients, including disabled access. A large number of practices have already successfully bid for money and we are now seeing the improvements being carried out. A new dental practice in Stowmarket was officially opened in April 2007. It took 15 months work between the district council, which backed the project, the PCT, which provides the contract, and Peter Barter of Starburst Treatment Centres Ltd. who undertook the refurbishment of the property and oversaw the project to completion	Stowmarket
Norfolk PCT	Has established new services in rural areas, creating access for some 10,000 patients. West Norfolk have already benefited with the opening of a new six chair dental surgery, providing better access both in and out of hours.	
Bedfordshire PCT	New practice in Leighton Buzzard.	

	<i>Developments and New Activity</i>	<i>Location</i>
SOUTH WEST SHA		
Gloucestershire PCT	Two further new dental practices have been commissioned in Cheltenham and Tewkesbury. Both will be able to provide treatment for over 10,000 patients. The Cheltenham new practice opened in August, now full and with a waiting list! The Tewkesbury practice was then scheduled to open in December following delays of about a month due to the floods—Tewkesbury planning committee was delayed in making decisions.	Cheltenham and Tewkesbury
South Gloucestershire PCT	The PCT plans to establish a new dental practice in Bradley Stoke where dentistry is poorly served. Bradley Stoke to be available 1st quarter of 2009–10 and will cover as many patients as want to register and will provide equivalent of 2 wt dentists Special community dental services are available in Kingswood and Yate for people who need special services.	Bradley Stoke
Cornwall and the Isles of Scilly PCT	New practice opened in Penzance to accommodate 7,500 patients from the area.	Penzance
Bath and North East Somerset PCT	Additional services commissioned	Bath City, Oldfield, Twerton (Bath)
Bristol PCT	New services: localised dental pain provision—25 sessions across the city in variety of locations in North, South and Central Bristol. Dentists in targeted wards doing fluoride varnish/fissure sealants New Practices: Due to be accepting NHS patients in Autumn in Hartcliffe Autumn 2008 and around December in Southmead plus new pain provision in Arnos Vale from 1 April on a sessional basis. Tooth brushing and fluoride varnishes already available. Additional continuing care of 16 sessions in Southmead 4 sessions in the city centre 20 sessions in Hartcliffe 2 sessions in Fishponds PCT will have invested £600,000 as of 1 April 2008. The PCT has increased funding for preventative work in targeted wards where there is an indication of poor oral health in five-year olds. This includes the twice yearly application of fluoride varnish and fissure sealants to targeted children. Also opening on 1 April Single Point of Access telephone line which should allow more streamlined access to NHS services and new pain provision targeted on a local level throughout the city. Single Point of Access will streamline the process for patients making it easier. See earlier comment re: tooth brushing scheme and fluoride varnish etc.	Keynsham, Paulton, Radstock, Hartcliffe Southmead Arnos Vale

	<i>Developments and New Activity</i>	<i>Location</i>
New dental school	<p>Within Bristol the number of people who have access to NHS dentistry in the previous 24 months has increased between March 2006 and December 2007 by approx 10,000 patients. Out of Hours Service means patients in severe pain can access dental care during weekends and Bank holidays and evenings until 9pm.</p> <p>Plans for the new dental school building in Truro have been submitted for planning approval. By 2010 there will be a total of 20,000 new NHS appointments per year possible in the new-build Truro facility. This should enable around 10,000 new patients to be seen there. The new Truro School is expected to open in September 2009 and will have 32 Chairs for the training of students. In its first year 9,200 appointments will be possible in Truro. The School opened last month with Exeter being the first part of the School to open. It has 16 Chairs and will by Year 4 have capacity for 8,320 appointments per year. Plymouth will have 2 new builds and should open next September. Both buildings will have 40 chairs and so by Year 4 a total of 50,000 new appointments will be available in Plymouth. Student dentists will see 4 patients per day.</p>	
SOUTH CENTRAL SHA		
Bucks PCT	New practice opened in Jan by CDO	Thame
Oxford PCT	Seeing improvement in access. PCT have carried out a review. Now surveying practices to establish spare capacity, including a dental equity audit. PALS information has informed review. New practice in Banbury opened in July 2007 includes 5 surgeries—no of patients = approx 7–8,000 and capacity for premises expansion too	Banbury
Berkshire East PCT	Recommissioned the Dental Access Centre Service via a tendering process in spring. The commissioning intention was to align the service more closely across the PCT with service demand peaks. New sessions commenced in July 2007 under PDS contracts. Reports on activity from DSD show that number of UDA completed by Dental Access centres has increased significantly. Also reallocated small number UDAs that were returned to PCT following end of year reviews 2006–07.	
Hampshire PCT	New practices opened since November 2007 PCT aware of shortfall in provision in Waterlooville, Petersfield, Horndean, Romsey, Eastleigh southern parishes, Chandlers Ford and Alton. A list of approved providers has been set up through tender process. PCT is starting to allocate contracts from February 2008	Gosport Basingstoke
SOUTH EAST COAST SHA		
Medway PCT	Smokefree and Smiling, bringing prevention into practice. Dentists in Medway PCT are being encouraged to refer patients to local smoking cessation specialists. This is a good initiative which fits in well with bringing dentists into broader public health initiatives within the PCT.	
West Sussex PCT	New services commissioned for access and domiciliary services	Worthing Horsham Chichester

	<i>Developments and New Activity</i>	<i>Location</i>
LONDON SHA		
Tower Hamlets PCT	Tower Hamlets PCT has a dental access project which uses mobile dental surgeries staffed by the salaried service which provide both screening and, for people living in an area with low dentist provision, dental treatment. This service is very popular with the public. Link workers (some of whom are refugee dentists) hold workshops before the mobile unit is due to visit in order to explain about the screening and about NHS dentistry generally (costs, pain relief etc). They also attend the screening sessions.	
Barking and Dagenham PCT	Extended opening hours pilot scheme. 5 additional practices closing later and opening earlier (8 am–8 pm). This is in addition to normal opening hours and does not replace existing opening.	
Croydon PCT	<p>New oral surgery scheme, out to tender in summer 2007 and now up and running. A new additional service for minor oral surgery no longer from Mayday hospital but from specialist practices running a triage system.</p> <p>December 2006 tender issued for 3 dental contracts; received 34 tenders from existing and new bidders. February 2007 let 2 new contracts and added to 2 existing contracts as follows: 1) 15,000 UDAs, £300,000 (new contractor), 2) 3,500 UDAs, £70,000 (new contractor), 3) 7,500 UDAs, £150,000 (existing contractor), 4) 4,000 UDAs, £80,000 (existing contractor).</p> <p>Contract 1 was new activity, contracts 2–4 to replace capacity lost as a result of a resignation November 06. Activity provided by the 2 existing contractors came on stream from 1 April 2007 and the 2 new contractors both in July 2007. Contract values shown are at 2006–07 prices and would have been uplifted for 2007–08.</p>	
Kingston PCT	<p>Dec 06 tender issued for 3 dental contracts; received 34 tenders from existing and new bidders.</p> <p>February 2007 let 2 new contracts and added to 2 existing contracts</p> <p>One contract was new activity, others replace capacity lost as a result of a resignation November 2006.</p>	
Lewisham PCT	<p>Access in Lewisham is not presenting a problem. Recent adverts for dentists received 200 applicants.</p> <p>Minor oral surgery is available from one site with plans to extend the scheme to operate from within dental practices. Emergency out of hours scheme in use, using nurse triage.</p>	

Supplementary memorandum by the Department of Health (DS 01C)

CAPITAL FUNDING FOR PRIMARY CARE NHS DENTISTRY

The Government announced in May 2006 that the Department was making available £100 million capital funding to take forward infrastructure improvements for NHS primary dental services over the two years 2006–07 and 2007–08. This is intended to support dentists in modernising premises and equipment for patients and allow PCTs to give greater financial support to help dentists establish new practices or expand existing surgeries to improve access to services.

The Department has allocated £40 million in 2006–07 and £60 million in 2007–08. These funds have been allocated to SHAs on a simple capitation basis (ie pro rata to the size of their local populations). SHAs are responsible for deciding the allocation of resources to their individual PCTs, based on the SHA's assessment of the most suitable basis for distribution or where investment will secure maximum benefits for NHS dental services and the relative needs of the PCTs in their area.

The funds can be invested in grants to independent dental contractors or in facilities for Trust led salaried dental services at local discretion. PCTs also have discretion to use any of their general NHS capital funds to assist primary care dentistry if they consider this an appropriate local priority.

Capital Allocations for Primary Care NHS Dentistry in 2006–07 and 2007–08

The distribution of the 2006–07 and 2007–08 capital funds nominated by SHAs is listed in the table below. The 2006–07 allocations have been reclassified to match the new PCT structures.

		<i>Capital Allocation 2006–07 £000's</i>	<i>Capital Allocation 2007–08 £000's</i>
<i>Q30</i>	<i>North East SHA⁽¹⁾</i>		
	County Durham PCT	482	710
	Darlington PCT	0	0
	Gateshead PCT	0	0
	Hartlepool PCT	0	0
	Middlesbrough PCT	439	646
	Newcastle PCT	590	869
	North Tees PCT	0	0
	North Tyneside PCT	0	0
	Northumberland Care Trust	0	0
	Redcar & Cleveland PCT	0	0
	South Tyneside PCT	0	0
	Sunderland Teaching PCT	521	766
<i>Q31</i>	<i>North West SHA</i>		
	Ashton, Leigh and Wigan PCT	240	360
	Blackburn with Darwen PCT	123	150
	Blackpool PCT	121	570
	Bolton PCT	207	300
	Bury PCT	132	164
	Central & Eastern Cheshire PCT	294	500
	Central Lancashire PCT	316	150
	Cumbria PCT	361	570
	East Lancashire PCT	290	570
	Halton & St. Helens PCT	253	400
	Heywood, Middleton & Rochdale PCT	168	176
	Knowsley PCT	146	219
	Liverpool PCT	435	544
	Manchester PCT	440	520
	North Lancashire PCT	239	570
	Oldham PCT	179	450
	Salford PCT	195	292
	Sefton PCT	217	69
	Stockport PCT	197	252
	Tameside with Glossop PCT	177	265
	Trafford PCT	153	228
	Warrington PCT	135	128
	Western Cheshire PCT	173	300
	Wirral PCT	261	395

		<i>Capital Allocation 2006–07 £000's</i>	<i>Capital Allocation 2007–08 £000's</i>
<i>Q32</i>	<i>Yorkshire and The Humber SHA</i>		
	Barnsley PCT	207	309
	Bradford & Airedale PCT	407	609
	Calderdale PCT	152	227
	Doncaster PCT	253	378
	East Riding of Yorkshire PCT	216	327
	Hull PCT	228	337
	Kirklees PCT	296	442
	Leeds PCT	567	844
	North East Lincolnshire PCT	130	193
	North Lincolnshire PCT	120	179
	North Yorkshire & York PCT	532	797
	Rotherham PCT	206	308
	Sheffield PCT	428	635
	Wakefield District PCT	282	421
<i>Q33</i>	<i>East Midlands SHA</i>		
	Bassetlaw PCT	91	134
	Derby City PCT	225	332
	Derbyshire County PCT	563	833
	Leicester City PCT	267	391
	Leicestershire County & Rutland PCT	450	667
	Lincolnshire PCT	570	849
	Northamptonshire PCT	479	728
	Nottingham City PCT	262	384
	Nottinghamshire County Teaching PCT	510	754
<i>Q34</i>	<i>West Midlands SHA</i>		
	Birmingham East & North PCT	350	522
	Coventry PCT	275	409
	Dudley PCT	231	344
	Heart of Birmingham PCT	265	396
	Herefordshire PCT	131	197
	North Staffordshire PCT	156	233
	Sandwell PCT	270	401
	Shropshire County PCT	206	308
	Solihull Care Trust	147	219
	South Birmingham PCT	288	430
	South Staffordshire PCT	409	612
	Stoke on Trent PCT	223	332
	Telford and Wrekin PCT	122	182
	Walsall PCT	213	317
	Warwickshire PCT	374	560
	Wolverhampton City PCT	211	314
	Worcestershire PCT	388	582
<i>Q35</i>	<i>East of England SHA</i>		
	Bedfordshire PCT	319	483
	Cambridgeshire PCT	429	700
	East & North Hertfordshire PCT	431	648
	Great Yarmouth & Waveney PCT	174	263
	Luton PCT	144	216
	Mid Essex PCT	234	418
	Norfolk PCT	558	852
	North East Essex PCT	201	365
	Peterborough PCT	158	179
	South East Essex PCT	424	392
	South West Essex PCT	271	465
	Suffolk PCT	455	701
	West Essex PCT	162	306
	West Hertfordshire PCT	425	640

		<i>Capital Allocation 2006–07 £000's</i>	<i>Capital Allocation 2007–08 £000's</i>
<i>Q36</i>	<i>London SHA</i>		
	Barking and Dagenham PCT	133	206
	Barnet PCT	236	359
	Bexley Care Trust	143	215
	Brent PCT	226	341
	Bromley PCT	207	314
	Camden PCT	204	305
	City and Hackney PCT	211	323
	Croydon PCT	235	350
	Ealing PCT	247	368
	Enfield PCT	195	296
	Greenwich PCT	191	287
	Hammersmith and Fulham PCT	147	224
	Haringey PCT	192	287
	Harrow PCT	141	215
	Havering PCT	168	260
	Hillingdon PCT	171	260
	Hounslow PCT	165	251
	Islington PCT	187	278
	Kensington and Chelsea PCT	152	233
	Kingston PCT	112	171
	Lambeth PCT	259	395
	Lewisham PCT	220	332
	Newham PCT	230	350
	Redbridge PCT	162	242
	Richmond and Twickenham PCT	124	188
	Southwark PCT	223	332
	Sutton and Merton PCT	255	386
	Tower Hamlets PCT	200	305
	Waltham Forest PCT	178	269
	Wandsworth PCT	215	323
	Westminster PCT	203	305
<i>Q37</i>	<i>South East Coast SHA⁽²⁾</i>	<i>3,344</i>	
	Brighton and Hove City PCT	0	346
	East Sussex Downs & Weald PCT	0	405
	Eastern & Coastal Kent Teaching PCT	0	922
	Hastings & Rother PCT	0	240
	Medway PCT	0	309
	Surrey PCT	0	1,154
	West Kent PCT	0	735
	West Sussex PCT	0	917
<i>Q38</i>	<i>South Central SHA</i>		
	Berkshire East PCT	318	480
	Berkshire West PCT	337	509
	Buckinghamshire PCT	354	535
	Hampshire PCT	775	1,171
	Isle of Wight PCT	179	271
	Milton Keynes PCT	261	396
	Oxfordshire PCT	386	584
	Portsmouth City PCT	260	393
	Southampton City PCT	262	396
<i>Q39</i>	<i>South West SHA</i>		
	Bath and North East Somerset PCT	137	207
	Bournemouth & Poole PCT	240	362
	Bristol Teaching PCT	314	474
	Cornwall & Isles of Scilly PCT	412	622
	Devon PCT	578	872
	Dorset PCT	319	481
	Gloucestershire PCT	457	690
	North Somerset PCT	154	232
	Plymouth PCT	195	293

	<i>Capital Allocation 2006–07 £000's</i>	<i>Capital Allocation 2007–08 £000's</i>
Somerset PCT	408	616
South Gloucestershire PCT	198	298
Swindon PCT	150	226
Torbay Care Trust	107	160
Wiltshire PCT	354	535
England Total	40,000	59,996

Notes

1. The North East SHA proposed that their allocation should be directed to a lead PCT in each of four management clusters of PCTs on a weighted capitation basis. We understand that each cluster would then decide locally how the funding should be distributed among the relevant PCTs to respond to local access issues.
2. Details of the 2006–07 distribution within the South East Coast SHA area are not available centrally.

Capital Allocations for 2008–09

In some areas there has been slippage in finalising distribution of the previous years' funding. This is not unusual when dealing with capital projects, and particularly with a scheme which requires local co-ordination with a number of independent dental practices.

All year end underspends within the NHS are handled at overall Department of Health level under HM Treasury End Year Flexibility (EYF) arrangements. Individual Primary Care Trusts (PCTs) do not have any automatic or locally administered carry forward of prior year underspends. However the recently published NHS Operating Framework confirmed that in 2008–09, £400 million would be made available to PCTs to fund local capital schemes with an additional £250 million for national initiatives. PCTs have been asked to develop robust capital plans for 2008–09 to be signed off by their Strategic Health Authority (SHA) in due course. The Operating Framework also states that slippage in programmes in the SHA and PCT sector from previous years should be included in these capital plans and phased in the years the expenditure will be incurred, to ensure existing commitments are recognised. The opportunity to deliver assistance to dental practices will not therefore be automatically forfeited at the 2007–08 year end.

COST OF OVERSEAS RECRUITMENT OF DENTAL PERSONNEL

The cost of the Department's centrally funded initiatives to attract overseas dentists with the high quality skills necessary to work in the NHS in England, and to assist the General Dental Council to provide additional places in the International Qualifying Examination taken by dentists from outside the EEA to enable them to practise in the UK, are summarised in the following table.

<i>Financial Year</i>	<i>Cost (£ million)</i>
2004–05	2.6
2005–06	0.3

No further central initiatives have been undertaken since 2005–06. However some SHAs, PCTs, dental corporate bodies or individual dental practices have co-operated in undertaking additional overseas recruitment activities at their own initiative, but information on the scale and duration of these activities is not available centrally.

Supplementary memorandum by CHALLENGE (DS 06A)
DENTAL SERVICES

In the oral evidence we gave to the Health Committee on 7 February one or two points that were raised did not figure in our written submission. We were asked, and we were happy to agree, to provide the Committee with further comment and any evidence we had to back up some of those points.

The assertion made by the Chief Dental Officer that the oral health of 12 year olds in the UK was the best in Europe was described as “fanciful” and “a devious use of dodgy statistics”. It falls to me to explain the difference of opinion.

12 YEAR OLDS' ORAL HEALTH IN THE UK COMPARED WITH THE REST OF EUROPE

The data that provided the CDO with the "evidence" to make his statement about 12 year olds in the UK came from a data collection exercise carried out by the World Health Organisation (WHO). The published data he apparently used can be found at the following internet address: www.whocollab.od.mah.se/euro.html

A little careful analysis and some further digging reveals substantial weaknesses in this data. As usual the data varies greatly in its quality. Some is old, for example the Armenian data relates to a study carried out in 1990 and the data from Kyrgyzstan goes back all the way to 1973.

The Belgian data apparently relates to a study carried out in the city of Brussels alone in 1998.

The Greek data for 12 year olds was obtained from the city of Attica alone.

The sample size is also an issue with some of the data, for example the data from Poland was gathered as recently as 2003 but the numbers of children involved was only 180.

The data for Russian children (data collected between 1996 and 1998) was gathered from only 108 subjects, hardly a representative sample of all the 12 year olds in Russia.

Another small sample was the data from Austria where only 550 children were examined.

CONCLUSION

There is no doubt that the 12 year olds in the UK have comparatively good oral health.

There is no doubt we have good evidence to support that statement but to claim it is the best in Europe on the basis of the data identified above is questionable and to use the data as a reason for downgrading the dental service in the way the Department of Health has is an abuse of statistics. The CDO's statement is not based on sound figures and cannot withstand even superficial scrutiny.

John Renshaw

CHALLENGE

February 2008

Supplementary memorandum by Sandwell Local Dental Committee (DS 10A)

DENTAL SERVICES

I am aware that representatives of various PCTs were giving evidence to the Health Committee on 21 February on the way the new contract for the delivery of dental services in the NHS has been working since its introduction in April 2006.

I am the secretary of Sandwell LDC and I have detailed knowledge of one of the areas represented, namely Sandwell. Colleagues and I have watched the evidence session carefully and we would wish to make the following points.

Although we would agree with much that was said, there were areas where we have difficulty with the evidence given.

It was said that Sandwell PCT was accommodating in allowing GDPs to make up a deficit of more than 4% on their UDA target during the second year of the contract. However it should be pointed out that it was not accommodating in allowing only a 2% leeway for overproduction when all neighbouring PCTs allowed 4% to be carried over.

The suggestion was made that dentists did not object to money being clawed back if they did not have a "robust plan" to recover underproduction. We do not know of any dentists who willingly handed back funding. They had no option, they had either to get on a faster treadmill or have the money clawed back. The fact that 56% of contracts failed to deliver UDA targets suggests that those targets were set too high.

There was a contradiction in the information given regarding the dental suite in the Oldbury Health Centre. It was implied that this service was set up because of the local commissioning allowed by the new contract. However the funding and planning of this facility was pre new contract, and a GDP was installed only because she had an atypical test year and a ridiculously small contract value and needed to work somewhere.

We would take issue with the statistic that 73% of the population accessed NHS dentistry. In the days of patient registration there were never more than around 50% of the population who saw an NHS dentist. We suggest that these statistical statements should be further explained. Similarly the claim that 10,664 more patients were seen in the first year of the new contract is hard to believe and should be further substantiated.

It was stated that Sandwell PCT was not just commissioning on UDAs. As far as we aware there is no commissioning taking place and no indication that any future commissioning will be on anything other than UDAs.

One Practice in Sandwell refused the new contract, which left 1,000 patients to be accommodated. We are not aware that these patients were re-distributed by the PCT nor that any other dentists received any additional funding to take them on.

The mention of “waiting lists” in the Sandwell LDC written submission alluded to the increase in secondary care waiting list as a result of more referrals from primary care under the new contract eg Orthodontics and Oral Surgery.

We agree that Vocational Training is very important and an excellent introduction to General Dental Practice. It is an educational and developmental process and the Trainee should not be driven hard but properly supported. It is worth noting that having Trainees is financially advantageous to the PCT, as any patient charge revenue the Trainee generates goes to the PCT although the UDAs do not go to the Practice.

David Cooper (Hon Sec)

29 February 2008

Supplementary memorandum by the British Dental Association (DS 19A)

The Clerk of the Committee asked that the British Dental Association respond to the following:

1. The quote by the Chief Dental Officer on 6 March concerning the introduction of UDAs

Q 755 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.

There was a small working group constituted of three representatives from the Department and three from the BDA. The CDO was not one of the three Department representatives. This group held informal discussions over a six month period and at these discussions the concept of weighted courses of treatment was considered.

2. Comment on how UDAs were derived and whether they were piloted before implementation

No serious objections were raised around the concept of weighted courses of treatment at the time. It is important to note that the discussions were around the concept of weighted courses of treatment and patient-centred measures generally, not UDAs, which only emerged later. It should also be noted that although informally discussed by the working group, the concept of weighted courses of treatment was never formally endorsed by the relevant committee of the BDA; the General Dental Practice Committee.

Pressure from the Department of Health on the BDA to endorse the new contract to the profession, something the BDA was not prepared to do, meant discussions were suspended for a period of approximately nine months. It was during this period that the discussions on weighted courses of treatment were disregarded and UDAs were created. The BDA was not, therefore, involved in, or consulted on, that development.

Units of Dental Activity were never piloted.

March 2008

Further memorandum by Citizens Advice (DS 25A)

DENTAL SERVICES

In December 2007 Citizens Advice commissioned Ipsos MORI to undertake research into access to NHS dentistry, in order to clarify the size and nature of the problem.

Questions were placed on the Ipsos MORI Omnibus. A nationally representative quota sample of 1,813 adults aged 15 and over was interviewed throughout England and Wales by Ipsos MORI in 169 sampling points. Interviews were conducted face-to-face in people’s homes, using CAPI (Computer Assisted Personal Interviewing) between 7 and 13 December 2007. Data were weighted to the known population profile of England and Wales. Extrapolated population figures quoted in this report were calculated using ONS 2006 Mid-Year Population estimates, taking the total adult (15+) population of England and Wales as the total.

Respondents were asked whether they had been to a dentist since April 2006. Sixty-five percent had done so, and of these, 64% had had NHS treatment on their last visit and 31% had had private treatment. There were income differences between those who had had NHS and private treatment, with people with annual household incomes of less than £30,000 being more likely to have had NHS treatment. Young people aged under 25 were also significantly more likely than those aged 65 or over to have had NHS rather than private treatment on their last visit.

DIFFICULTIES IN FINDING AN NHS DENTIST

Approximately 54% of the adult population had not had NHS treatment since April 2006—either because they had had no treatment or because they had gone privately. These respondents were asked for the main reasons why they had not been to an NHS dentist. Two reasons dominated the replies. Firstly 31% of respondents who had not had NHS treatment since April 2006 said that the reason for this was that they could not find a dentist to provide NHS treatment. This equates to approximately 7.4 million people. Of these, the equivalent of approximately 4.7 million people had sought private treatment instead, and around 2.7 million had gone without any dental treatment.

There is evidence that problems finding an NHS dentist are not uniformly spread across England and Wales. In the south west, 53% of those who had not had NHS treatment since April 2006 cited this as a main reason for not having been to an NHS dentist, and the percentage was also well above average in the North West (39%). In contrast, this reason was given by only 19% of respondents in Greater London and 21% in the West Midlands.

PERCEIVED NEED FOR DENTAL TREATMENT

Problems with accessing NHS dentistry are not however the only reason why people have not had dental treatment since April 2006. The other common reason, given by 30% of all those who had not been to an NHS dentist, was that they considered they had not needed treatment. This reason was disproportionately given by people in typically disadvantaged groups. Thirty-nine percent of people in social grades DE stated that they had not needed treatment, a significantly higher proportion than the 25% and 27% of people in social grades AB and C1 respectively who stated the same. This reason was also given by 35% of those with annual household incomes of less than £17,500 per year (a significantly higher proportion than the 22% of people with annual household incomes of £17,500 or more who stated the same). Not feeling a need to see the dentist was also stated by 57% of non-white respondents, compared to just 26% of white respondents.

Although not an issue covered in this research, it seems unlikely that these groups had better oral health than the rest of the population. Rather their response may indicate a difference in perception about the importance of regular visits to a dentist in order to receive preventive dental care, as opposed to waiting for a problem to occur before making an appointment.

These responses were not evenly spread geographically either, with respondents in Yorks/Humberside (46%) and the West Midlands (40%) being particularly likely to say they had no need for dental treatment.

NHS DENTAL CHARGES

Only 4% of respondents mentioned the cost of NHS treatment as one of the main reasons why they had not been to an NHS dentist¹² There was some indication that younger people (aged under 35) were more likely to give the cost of NHS treatment as a reason for not going to the dentist, but the numbers giving this as a reason were too small to make further analysis possible.

February 2008

Supplementary memorandum by Citizens Advice (DS 25B)

DENTAL SERVICES

Q 683 Dr Naysmith asked Citizens Advice what reasons were given by patients in their on-line survey who had received Band 2 treatment, for not being satisfied with their treatment

1. Between August and November 2007 Citizens Advice carried out an online survey of people who have had NHS treatment since the reforms came into effect. 341 people responded. 32% said they were very satisfied and a further 36% said they were fairly satisfied. However 32% said they were not satisfied with the treatment they received. Patients who had had Band 2 treatment were most likely to say they were dissatisfied (41%). This percentage consisted of 43 respondents, all of whom gave reasons for their answer.

2. There was a general feeling that their treatment had been rushed and in some cases of a poor quality. This was seen in some cases to be due to a lack of time. One respondent described being “treated like cattle”. A couple of respondents reported fillings falling out soon after treatment. A couple more said they had had roots left in and a few reported not receiving anaesthetic before fillings were put in.

¹² However the 2007 CAB online survey showed that many people do find the NHS charges difficult to afford.

3. Some respondents reported having to return to their dentist for follow up treatment, when they felt this could have been done all in one go. Another respondent attended an emergency appointment at which they had a tooth removed for £15.90, but had to pay a further £28.40 later due to the fact it had been a difficult extraction. The respondent was told to make another appointment to get a filling and after a six week wait paid £43.60 for a coating which later came off. This was recoated for a further £15.90. There were some other cases of dentists missing fillings and patients having to return to get these done and having to pay again.

4. A lack of clarity about the NHS/private charging interface was reported by a small number of respondents. One said they were not told about the costs upfront and were not sure what were NHS costs and what were private costs. One respondent was told at her first appointment to come back for a second check up and cleaning for which she paid £40 (clearly a private charge). Bridges were an area of confusion; some people had been given the impression that this treatment was not available on the NHS and one reported being asked for £850 for a bridge when it should cost £194.

5. A few respondents commented that NHS dentistry was too expensive. One commented that £15.90 for a two minute check up was wrong. A check up and filling for £43.60 was described by one respondent as too expensive and by another as “ridiculously overpriced”—especially as the treatment took only ten minutes for the latter patient. Another described NHS charges as “exorbitant”.

March 2008

Memorandum by the Dental Laboratories Association (DS 26A)¹³

NHS DENTAL SERVICES

EXECUTIVE SUMMARY

The primary driver of the NHS Dental Reforms was to devolve the service to make it responsive to local need and address problems of accessing NHS care. Also, as stressed in the Department of Health’s report on the reforms, One year on, they were intended to “shift the service away from the old system, which operated on a piecework basis (often described as ‘drill and fill’ treadmill). . .”

In doing this we have seen a significant reduction of at least 44% in Band 3 treatments, treatments that repair the consequences of the “drill and fill treadmill”. Moreover, the cohort of the population that need these treatments, who benefited from NHS dentistry, are going to make the greatest demand on dental care during the next 20 to 30 years but are in danger of being abandoned by the service.

1. *The Problem*

1.1 We begin our evidence by looking at what has gone wrong following the most fundamental change to NHS primary care dentistry in England and Wales since its inception, with the introduction of personal dental services (PDS), before considering the implications, if not addressed, and a possible way forward.

1.2 Our concerns are not only about the significant fall in the provision of Band 3 treatments (treatments requiring laboratory work like crowns, bridges and dentures) but also the quality of what is provided. Of the 480 or so fees under the old fee per item, general dental services (GDS), just over 40% involved laboratory work. Significantly, these accounted for around 8% of courses of treatment (CoTs), Band 1 (checkups, scaling and diagnostic procedures) 52% and Band 2 (fillings, root canal treatment and extractions) 40%.

1.3 However, NHS Dental Statistics for 2006–07, published by the NHS Information Centre (IC), show Band 3 treatments during the first year of PDS 50% lower than under the GDS, at 4% of CoTs. These treatments have probably settled at around 56% of what they were or 4.5% of CoTs. This was the level in quarters three and four of 2006–07, following a recovery from 2.2% at the beginning of the first quarter, rising to 3.7% by the end of it and 4% in the second quarter.

1.4 The reason for very low Band 3 CoTs during the early months of the PDS was that these courses of treatment generally take longer than others to complete. Also, and more significantly, there was a lot of activity, particularly in the provision of what were to become Band 3 treatments, during the final quarter of the GDS contract, as general dental practitioners (GDPs) attempted to provide these under fee per item of service, before the changeover to PDS.

1.5 The latter resulted in patients benefiting from lower patient charges for single treatments before the significant increases accompanying the PDS. The Department has exclusively focussed on the reduction in the maximum patient charge from £378 under the GDS to £189.00 during the first year of the PDS—the patient charge for Band 3 treatments. But for single treatments, like a porcelain jacket crown, the patient

¹³ This is a revised version of the Dental Laboratories Association’s original memorandum published in HC 289-II—<http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/289ii.pdf>

charge increased by 184%; a full or jacket crown in non-precious metal by 179%; a full upper or lower denture by 123%; and a full upper and lower set of dentures by 43%.¹⁴ Increases in price of these magnitudes will have significant effects on the demand for dental care.

1.6 This reduction in Band 3 treatments was identified in our surveys of dental laboratories, conducted at regular intervals following the introduction of the PDS and during the pilot schemes. In the first year, this showed an overall decline of 57% in units of Band 3 appliances supplied to GDPs in England and Wales, compared to increases of 15% in Scotland and 17% in Northern Ireland, both of which retained the GDS. For individual items, the decline ranged from 41% for non-precious metal crowns to 84% for chrome framed dentures. This was not matched by an increase in private work, which increased by just 18%.

1.7 Band 2 items also experienced a fall in demand, accounting for around 40% of CoTs under the GDS to 30% under the PDS, again reflecting increases in patient charges for individual treatments. The patient charge for a Band 2 CoT was introduced at £42.40, which compared, for example, to a price of £6.20 for a simple, amalgam filling under the GDS which, when combined with the charge for an examination of £5.84 (see footnote), meant a 252% increase in the patient charge.

1.8 One of the consequences of a reduction in demand for Band 3 and, to some extent, Band 2 CoTs has been a significant shortfall in patient charge revenue, with knock-on effects for primary care trusts (PCTs). In *NHS Dental Reforms: One Year On*, the Department stated that patient charges were expected to raise around £600 million, although warning that “a number of PCTs, though not all, have been projecting lower than expected income from patient charges during the first year. . . the Department has increased funding allocations for 2007–08 to allow for slightly lower levels of patient charge income as a proportion of gross expenditure.”

1.9 As it turned out, patient charge revenue was £475 million, a massive £125 million short of the £600 million assumed in the indicative gross allocations issued to PCTs. The Department had plenty of warning that this might happen from the PDS pilot schemes—we estimate that patient charge revenue from these were some £80 million short of the £190 expected, out of a total spend of £764 million in England and Wales.

1.10 As well as demand-side effects, there were also supply-side effects influencing the provision of band 3 treatments. If a patient needed multiple crowns, for example, and could afford the maximum charge, GDPs were quite willing to provide these under the GDS as their fee was not constrained—simply the number of crowns times the fee. Although the PDS contract value, target of units of dental activity (UDAs) and therefore value of UDAs were determined by a GDP’s previous activity under the GDS, GDPs have been reluctant to provide multiple treatments as they incur higher direct costs for the same fee (12 x £UDA). This will be compounded after April 2009 when the dental budget is no longer ring fenced and UDAs begin to float.

1.11 Partial dentures have bucked the trend, with the Dental Treatment Band Analysis for England, published by IC, showing that within Band 3, CoTs containing partial dentures rose from 27.4% to 34.7%. Our surveys show that during the first year of the PDS, there was a 76 per cent increase in the most basic partial denture—the single tooth denture.

2. Demand for Dental Care

2.1 The Department’s mantra accompanying the introduction of the PDS and repeated to PCT commissioners at every opportunity since, has been prevention, prevention, prevention. The move away from intervention to prevention is appropriate for children—according to the World Health Organisation, UK 12 year-olds have the lowest levels of tooth decay in Europe. It is also appropriate for adults brought up post 1960’s, who benefited from the introduction of fluoride toothpaste and a more preventative approach to dental caries. However, it is totally inappropriate for those born in the 1930’s, 1940’s and 1950’s.

2.2 This cohort of the population was at high risk of developing caries and increasingly enjoyed access to dentistry through the NHS. Techniques universally favoured cavity preparation based on the principle of “extension for prevention”. These patients had decayed teeth that entered into the “restorative cycle”—repeated placement and replacement of restorations, with progressive loss of tooth structure and weakening of the tooth. In short, those most likely to need Band 3 treatments under the PDS.

2.3 It is these patients, with their huge volume of restorations and expectations to maintain a natural dentition, who will have the biggest impact on the demand for dental care over the next 20–30 years but are in danger of being abandoned by the PDS. The question has to be asked can one fee, however it has been arrived at which, through time, will inevitably degrade, ensure that this cohort of the population receives the treatment it needs when it covers such a wide range of appliances and therefore costs?

¹⁴ Under the GDS, an examination was charged separately but is now included in the patient charge for band 2 and 3 courses of treatment. Therefore, to estimate the increase, the patient charge under the GDS for an examination was added to the patient charge for the individual item.

3. *The Solution*

3.1 We do not, however, see a return to more fees for band 3 treatments as the way forward. Dentistry is unlike medicine in that there are often a variety of ways of restoring/repairing/replacing the dentition that differ in quality and cost. The problem of having a different fee for a procedure to reflect the laboratory component is no different to a specific allowance built into the fee as under the GDS—it inevitably becomes the maximum and the GDP has no incentive to involve the patient in decisions about what is used.

3.2 The patient is unaware of this cost minimisation pressure, nor of its significance in limiting options, even though there may be considerable choice available—choice about the aesthetic and durability of something that will be present in their mouth for some considerable time. This complete lack of transparency and consumer sovereignty is at variance with market efficiency and is particularly difficult to accept in a health care system where patient charges have been a feature since 1951, introduced, ironically, for dentures.

3.3 However, if, as we propose, the patient pays for the laboratory component and the NHS subsidises treatment, we will see the emergence of an enfranchised patient, making real and informed choices about the dental care they receive.

February 2008

Supplementary memorandum by the Dental Laboratories Association (DS 26B)

NHS DENTAL SERVICES

EXECUTIVE SUMMARY

In this supplementary evidence we report on the lack of progress in establishing work-based training places for dental technicians. We examine the implications for the future of dental laboratories, including the possibility of sourcing appliances from abroad with recent experience in the US providing an example of what could happen here before addressing doubt cast by the Chief Dental Officer on the DLA's evidence on the impact of the new dental contract.

1. *Lack of Training Places*

1.1 The lack of work-based, vocational training places in dental technology is having a significant effect on the employment of dental technicians. The new foundation degree in dental technology provides a good, broad based education but the transition to the workplace requires a significant amount of vocational training, which is too expensive for laboratories to provide themselves.

1.2 A vocational training scheme for dental technicians has been successfully piloted and introduced in Scotland. We have asked the Department of Health (DoH) for help in setting up a similar scheme in England and Wales but they have refused. This is against a background of increasing the number dental undergraduates by 25% but with no provision for support services provided by dental technicians. The biggest factor affecting the future of dental laboratories will be the increasing scarcity of high quality dental technicians, putting further pressure on sourcing appliances from abroad.

2. *US experience of appliances sourced in China*

2.1 A patient in Columbus, Ohio was fitted with a bridge, which had an immediate allergic reaction. The bridge was removed and further surgery was required. The patient discovered that the bridge was manufactured in China and that the porcelain used for the teeth contained dangerously high levels of lead, 160 parts per million (ppm)—to put this in context Matel removed its toys from the market that contained levels of lead of just over 90 ppm. A local television station subsequently enlisted the help of dentists to send work to eight laboratories in China, which was then independently tested. One crown was found to have porcelain containing lead of 210 ppm!

2.2 Could the same thing happen here with the introduction of statutory registration of dental technicians and the updating of the Medical Devices Directive that regulates laboratory work? The answer is yes, although, as David Smith reported to the Committee, we believe that the number of units coming into the country from China is at present quite low, the risk to patients receiving these appliances is high. The General Dental Council will not stop the sourcing of laboratory work from countries that do not have a regulatory framework for dental technicians similar to the one to be introduced into the UK from August this year. Also, at the UK's insistence, the new Directive does not require disclosure to the dentist or patient of where the appliance was made or what it contains. When the DLA raised the lack of a disclosure requirement with the DoH just three weeks ago we were told that "patients didn't want to know where their restorations were made".

3. DLA evidence

3.1 In his second oral evidence session, the Chief Dental Officer, Barry Cockcroft, cast doubt on the authenticity of the results of the DLA survey into the effects of the new contract on what was being supplied to general dental practitioners by dental laboratories. This is the first time that this criticism been made despite having worked closely with the DoH in developing the survey. Indeed, the NHS Information Centre went as far as welcoming the work in providing the only source of information on what was being provided to patients within band 3 treatments. We would like to reassure the Committee that the survey was robust, using a sample of 440 laboratories of varying sizes, drawn from around the UK supplying GDPs in England and Wales.

March 2008

Supplementary memorandum by the Department of Health (DS 01D)

BREAKDOWN OF CALLS MADE TO NHS DIRECT (DATA SOURCE: NHS DIRECT)

HSC were particularly interested in the number of calls which NHS Direct receive as the contractor chosen by a PCT to deliver a front end dental service—eg an out of hours triage service. These calls are shown in the column headed “Callers to PCT contracted dental service”. The “Calls to 0845 service” column shows the dental calls to the general NHS Direct telephone number.

	Callers advised to seek dental treatment	Calls to 0845	% Calls to 0845	Calls to GP OOH Service	% Calls to GP OOH Service	Calls to PCT contracted Dental Service	% Calls to PCT contracted Dental Service	All Symptomatic Calls answered by NHS Direct	All Cal Answered by NHS Direct
2003	166,539	129,549	78%	5,279	3%	31,711	19%	3,640,172	6,443,091
2004	220,681	185,949	84%	6,107	3%	28,625	13%	3,993,805	6,431,102
2005	275,367	240,611	87%	6,672	2%	28,084	10%	4,374,303	6,804,759
2006	381,371	285,055	75%	7,540	2%	88,776	23%	4,112,785	6,359,898
2007	421,825	304,673	72%	2,493	1%	114,659	27%	3,821,570	5,496,089

TYPES OF CALLS NHS DIRECT PROCESS

0845 46 47—a single national telephone number that where the caller may be calling for any medical reason. The calls are triaged nationally and then may be categorised and dealt with by either nurses, health information advisers or dental nurses.

GP Out of Hours—an individual number ascribed to each local service. These are handled within NHS Direct at regional level and deal with only the calls relating to the advertised GP service.

Dental—individual number ascribed to each local service. These are handled within the NHS Direct at regional level and deal with only dental calls.

June 2008

Supplementary memorandum by the Department of Health (DS 01E)

The Clerk of the Committee asked the Department to provide further details of the increase in the Dental Services budget allocation from 2008–09. The Department’s response is as follows:

The total net allocation for primary care dental services in 2007–08 was £1.87 billion.

The 11% increase takes the net dental allocation for primary dental care services in England for 2008–09 to £2.081 billion, before taking account of income from dental charges. This represents an 11% increase over the equivalent 2007–08 allocation.

The 11% uplift works out at £209 million.

June 2008