

NHS dental services in England

An independent review led by
Professor Jimmy Steele

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The review team and introductory letter

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Introductory letter

Dear Andy,

I am delighted to enclose the review into NHS dentistry which I have been honoured to lead over the last six months. As a clinician, researcher and teacher in the NHS this was an exciting opportunity and a huge responsibility.

Your predecessor asked that this review was independently led. The independence of the process has been important and I have been supported by an outstanding team of colleagues. I expect all stakeholders to find things that they agree with as well as things that may make uncomfortable reading, but that is an essential part of an independent process. We have striven to provide an honest assessment of where we are and a set of recommendations to take NHS dentistry forward.

Oral health is for the long term and I believe in getting some simple things right. Putting these basics in place is more about co-ordination than money. If it can be done now we can build a national oral health service fit for the 21st century with an oral health legacy to match.

Over the last six months three particular issues struck me. The first was, as a clinician, the outstanding level of care that many dentists are providing to NHS patients. The second was the assault of comments, suggestions and exhortations to make things better. These came from the widest group imaginable: dentists, patients, NHS staff, politicians, charities and many others. My personal mailbox, never mind the review one, has been inundated. The third thing was the interconnected nature of the whole system. It is hard for a patient to get good care from a dentist who is poor at their job, for a good dentist to provide high-quality care without the backing of the primary care trust (PCT), and for a good PCT to operate without support and guidance from the strategic health authority and the Department of Health. The whole system works best when everybody is pointing in the same direction.

NHS dentistry has had a very difficult time over recent years. But sometimes difficult times serve a purpose; they can help to expose longstanding issues and help everybody to find that common direction. I believe we are at that point now and I trust that this review has captured this and offers a firm basis for a way forward.

Implementing the recommendations will need good communication and co-operation between all parties, but as the NHS builds on the *High Quality Care for All* review there is a real opportunity to realign NHS dentistry.

Yours

A handwritten signature in black ink, appearing to read 'Jimmy', with a stylized flourish underneath.

Jimmy

Executive summary and key recommendations

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

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

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

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

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

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

A better service for patients: accessible and high quality

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

However, perceptions of problems with access are compounded by simple problems of information. People are uncertain how to find a dentist and the information they require is often not available in the right places, is not co-ordinated or is not kept up to date. **PCTs and the NHS should communicate clearly how people might find a dentist through the most appropriate media and what to expect from a dentist when**

they get there. This is much more a matter of organisation than resource and would make a big difference to patients and their perceptions of access. People have a right to access an NHS dentist; the NHS now needs to work to make this a reality and to extend this to a meaningful oral health service.

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

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

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

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

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

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

Aligning the contract to improve access and quality

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

We therefore recommend that dental contracts are developed with much clearer incentives for improving health, improving access and improving quality. The basic structure of the existing contract is quite flexible and we suggest that much could be achieved within existing regulations or with relatively minor adjustments. **We recommend that the current contract is developed specifically to allow payments for continuing care responsibility, blended with rewards for both activity and quality. We further recommend that these are piloted and then nationally applied.**

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

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

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

What the NHS has to do

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

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

Technology can help to facilitate the collection and organisation of data. Software systems are available to record what happens chair-side and link it to national datasets. Around 25% of practices do not even have the very basic computer hardware that can

allow this to happen. **We recommend that PCs are used in all dental surgeries within three years and are, ultimately, centrally connected to allow clinical data to support shared information on quality and outcomes.**

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

Implementation challenges

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

The next chapters set out the above in more detail, giving further background and a suggested timetable for implementation.

- Chapter 1 sets out some of the background to NHS dentistry today.
- Chapter 2 examines the different perspectives of dentistry (patient, dentist and NHS).
- Chapter 3 looks at what we have a right to expect from NHS dentistry in the 21st century.
- Chapters 4, 5 and 6 cover the key findings and recommendations from the review and are grouped and organised according to what the patient should receive, what the dental team should deliver and what the supporting healthcare system needs to do to support this.
- Finally, Chapter 7 suggests how this review might be taken forward to make a difference to people.

1 Context: dentistry in England since 1948

The origins of NHS dentistry

This chapter sets out the recent history of NHS dentistry, an essential first step to put the rest of this review in context. The last 60 years have seen vast changes in oral health and dentistry. This chapter investigates where we are now and how NHS dentistry can develop to meet the new challenges of the 21st century.

In the first half of the 20th century oral health in England was very poor. Many people had no teeth, dental decay was almost universal and sepsis was common. Until the inception of the NHS, even fillings were expensive and out of the reach of many ordinary people; having teeth removed was seen by many as preferable.

The treatment options available to dentists at the time were also limited. Most dentists were highly skilled in removing teeth and in making false teeth. They were also skilled in placing fillings and inlays, but many techniques and materials that are now familiar were unknown or poorly developed.

It was against this background that dentistry was introduced as an important and popular component of the new NHS in 1948. Britain's dentists signed up to deliver treatment on a fee-for-service basis and retained their status as independent businesses.

With such a backlog of disease the initial demand was huge. In the very early years of the service millions of sets of complete dentures were made to take people out of pain and return them to function. Dentists worked hard to meet need but costs to the Government increased and, within three years, patient charges were introduced. Even with charges, the fee-for-service incentive worked well and dentists began to deal with the burden of disease by filling tens of millions of teeth to save them from extraction.

The NHS dental service was a success, with dentists and patients enjoying the benefits of a system that was well suited and aligned with the problem.

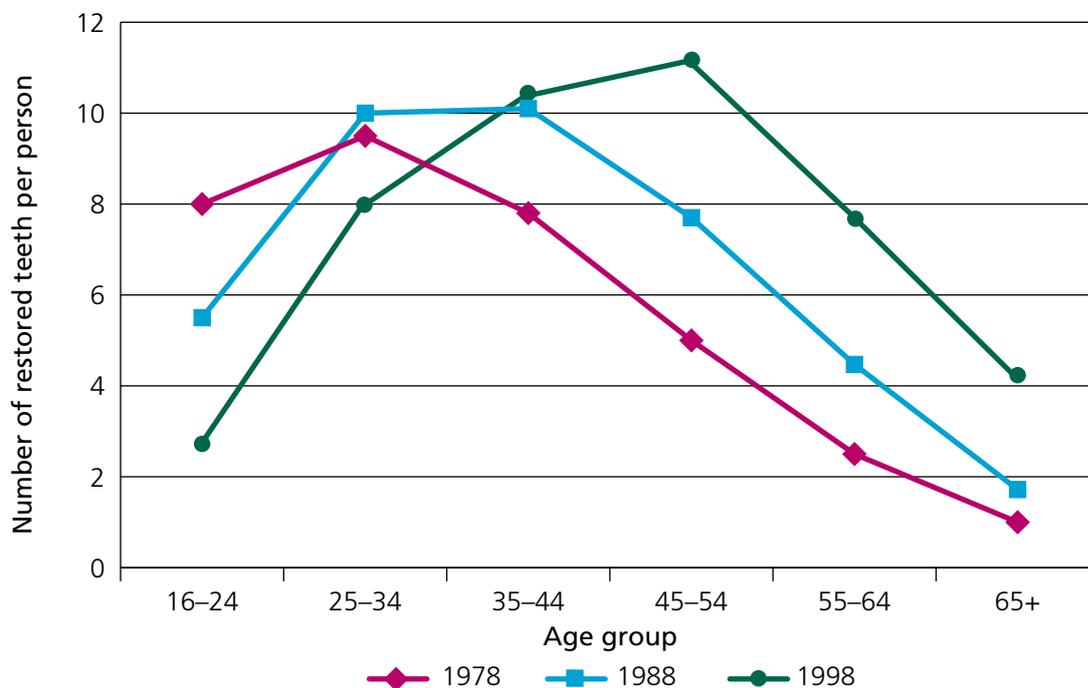
Improvements in oral health

By the time of the first survey of adult dental health in 1968 the legacy of disease and extraction were clearly visible.¹ Nearly half the population had no teeth at all and, even among the relatively young, there were many who wore complete dentures. However, by 1978 and the second national survey of adult oral health the pattern was beginning to change. Generations who had lost all their teeth were gradually being replaced by generations who had their natural teeth filled rather than extracted.² The achievements of NHS had been considerable, transforming the way the population felt, functioned, looked and behaved in just 30 years.

National surveys of children's oral health were also undertaken at 10-year intervals and in 1983 the first signs of a sustained reduction in dental decay in children were observed.³ This was probably largely the result of the widespread introduction and marketing of fluoride toothpaste in the early 1970s. By 1988 (the next adult dental health survey) this reduction was visible in young adults.⁴

Figure 1: The "heavy metal" wave

The younger generation of 1978 (16–34-year-olds) had high levels of decay and many fillings, mostly of dental amalgam. This wave of restorations can be traced as the cohort ages.



In 1998 three groups moving through the population could be clearly identified, each with very different needs.⁵ Older age groups (those past the age of retirement) were dominated by those with no teeth at all and a need for complete dentures. A young generation (under the age of about 30) had lower levels of decay than their parents. They had low restorative needs and will benefit from maintaining this state. Finally, and importantly, a group between 30 and 65 could be identified who had experienced high levels of disease which had been treated by fillings and other restorations (the "heavy metal generation") and who will have high maintenance needs as they age (see Figure 1).

The challenging variations in oral health are related not only to age and generation but also to socio-economic conditions, with an established relationship between poor oral health (particularly decay) and deprivation.

Reforming the system

Despite this changing world, the basics of the system in the late 1980s were still as they were in 1951. The focus for dentists was on delivering extractions and fillings and, despite the emerging group with better oral health, there was no financial incentive to keep patients disease free. Dentists were still rewarded according to how much they drilled and filled, not how well they did it or how appropriately they made their treatment decisions.

Patient demand, as opposed to need, was also increasing and changing in nature as new generations aspired to ever higher standards of care and appearance, but there was little emphasis and insufficient direction to help patients to take responsibility for their own oral health.

There was concern that the financial incentives could lead to over treatment and, following a review of these risks,⁶ a new contract was introduced in 1990 with an element of capitation (around 20%), which aimed to encourage registration of patients into continuing care. The new arrangement was very successful, demonstrating the importance of aligning financial incentives to objectives. Registration was popular with dentists and patients. However, expenditure and earnings were higher than expected and the fees paid to dentists were cut by 7% to bring expenditure back into line.

This upset the profession, who felt unfairly penalised and embarked on a progressive shift towards increasing provision of private dentistry and reducing their NHS commitment. This, combined with the changing dental demography, resulted in the first taste of the access problems that subsequently became prominent. Some 40 years on, NHS dentistry had become a victim of its own success.

In the wake of these events, Sir Kenneth Bloomfield reported in 1992⁷ on dental remuneration and made a number of recommendations for the short and long term, including greater local control, a blended contract with continuing care payments and payments for quality.

2006: local commissioning and the “new” contract

By the mid-1990s access to an NHS dentist was entering the public consciousness as a political issue. The profession and DH recognised that the system needed to be reformed to support changing oral health needs.

NHS Dentistry: Options for Change set out a vision for NHS dentistry with prevention at its heart and was widely supported by the profession.⁸ Personal Dental Services (PDS) pilots took place between 1998 and 2006. These schemes were broadly welcomed and supported by the profession. However, treatment interventions fell and there was little hard evidence of preventive activity or benefits. Because the system required the fee-for-item arrangements for patient charges to remain in place during these pilots, income from patient charges fell alongside the reduction in treatment interventions, leaving a problematic revenue shortfall.

The expectation in the profession was that whole-system change of General Dental Services (GDS) would be based on the PDS piloting work, but this proved difficult and the relationship between the British Dental Association (BDA) and DH broke down. A different methodology for the measurement of dentists' activity was introduced in the new contract which had not been piloted. The arrangements were governed by regulations,⁹ and a model GDS contract¹⁰ was produced by DH. PDS arrangements were similar. The new contract did not command the widespread support of the profession.

The 2006 reforms comprised three key issues:

- Responsibility for planning and securing NHS dental services was devolved to local PCTs.
- The system of patient charges was changed, resulting in a reduction in the possible number of charges from around 400 to just three.
- The mechanism by which dentists are paid to deliver NHS services was changed from one based on fees for items of service to one where providers are paid an annual sum in return for delivering an agreed number of “courses of treatment” weighted by complexity.

Some dentists were uncomfortable and insecure about the new arrangements and chose to convert to private care. While the lost capacity was fairly small (about 4% of provision) it exacerbated the access problems that had been growing since the early 1990s.

The NHS will spend approximately £2.25 billion on dentistry this year and NHS patients will fund a further £550 million of services through patient charges. Despite additional funding and programmes to increase the dental workforce through increasing the intake of student dentists and supporting overseas recruitment, the access problem remained in the public consciousness. New concerns about NHS dentistry and the delivery of NHS care continued to surface in the media and the profession. It was against this background that the House of Commons Health Select Committee undertook an investigation into NHS dentistry in 2008.¹¹ The report identified a number of important issues to be addressed.

This review

The present review picks up where the Health Select Committee left off. In line with our terms of reference it seeks to set out our advice to the Government on how the NHS dental system might become more accessible and efficient, be delivered to a higher quality and be more preventively focused, while also recognising the range of initiatives already in place. In undertaking this we have attempted to do the following:

- diagnose the problems in NHS dentistry from the standpoint of patients, professionals and the NHS
- review the underpinning principles of the NHS as they might apply to dentistry to help us clarify what NHS dentistry can and should do for patients
- build on that vision to try to identify contractual and organisational solutions and to clarify who is responsible for delivering them.

In doing so we are acutely aware of the issues facing the wider economy, in general and in public spending in particular. The responsibility to use our scarce resource more effectively falls on everybody and has never been greater.

Our approach has been to use the existing research to confirm some of the main issues highlighted in the Health Select Committee report – that too many people find it difficult to access services and that, when they do access services, there is unwarranted variation in the quality of the care they receive. We have then focused on developing a deeper understanding of why people find it difficult to access services and what kind of services they want and need from the NHS, as well as developing a deeper understanding of the supply side – what drives dentists’ behaviours and how the system could work better to support clinicians. The review has:

- used focus groups with the public and dentists
- used short, focused interviews with PCT commissioners
- researched the relationship between dentists and PCTs and how dentists actually respond to different incentives.

The review is grateful to many other organisations, including Which?, Citizens Advice and the Patients Association, for sharing their research, some of it as yet unpublished.

The review has also engaged extensively with the dental profession, the NHS and the wider public and their representatives. This engagement has included regional events to discuss the emerging findings and an online blog and mailbox. Podcasts of the engagement event discussions have also been made available online for those who could not attend. The review team has also sought, received and considered a substantial volume of written and oral submissions from a wide range of stakeholders and is grateful for their contributions.

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Current status of dentistry: different perspectives

This chapter looks at NHS dentistry today from the perspective of patients, dentists and the NHS.

It concludes that although some patients have only good things to say about NHS dentistry others are confused about how to access a dentist and what they will get when they get there. Many people place great value on a relationship of trust with a dentist. Dentists are seeking to have pride in the work they do, and want the system to support them in their effort. And commissioners are just beginning to use the tools available to them, but require further support and direction.

What the patient sees

Almost everyone is a dental patient at some stage in their life. Large sections of the healthy population will see a dentist much more frequently and regularly than they will see their GP. For others, a visit to the dentist is not seen as important or relevant, while for a few the prospect is terrifying.

No matter what kind of patient you are, some trepidation about a dental visit is understandable. Where treatment is required a dental patient is necessarily powerless and the experience necessarily intimate. Dentists are expert in the control of dental pain, in managing anxiety and in dealing with this intimacy in a highly professional way, but the prospect of imminent discomfort is still enough to provoke unease and tension in the most rational of people.

These experiences go with the territory, but there are other unique elements of the dentist–patient relationship that create additional tensions. In the NHS about half of all dental patients pay for treatment. Transmitting messages about cost and payment, NHS entitlements and private care are particularly challenging in an already difficult clinical environment.

Around 53.4% of people have visited an NHS dentist in the previous two years¹ but public satisfaction with NHS dentists has fallen fairly steadily over the last 25 years, from over 70% to just above 40%.²

This section sets out the breadth of those experiences and follows a patient journey, from attempting to find a dentist through to receiving and paying for care. The quotes and data reported here come from the review's own qualitative work with the public and from a recent survey conducted by Which?.

Finding a dentist

For those not returning to keep a scheduled appointment, the process of finding a dentist was not clear or easy. Patients told us that they tended to use word of mouth, *Yellow Pages* or a Google search to find a new dentist. Some reported driving around the local area looking for boards advertising availability and then visiting or telephoning "on spec". The near universal impression, reinforced by media and word of mouth, is that NHS dentists are hard to find. Dentists, as a group, sometimes do little to rectify this. In a recent Which? study 3 in 10 dentists not taking on NHS patients gave no more than minimal help to find another dentist.³

“I was told by a friend that this practice had spaces – they were taking on so many over-60s. I was lucky to get in.” (65+ patient, West Midlands)

Overall the large majority of those trying to get an NHS appointment managed to do so; the recent Which? survey showed that 68% of people had tried to get an NHS appointment in the last two years and 88% of these had been successful. There was also regional variation, with 65% of patients in urban areas able to make an NHS appointment with the first dentist they telephoned compared with only 44% in rural areas.

Research by Which? supported this – 29% of dentists in rural areas and 46% in urban ones were taking on new NHS patients. This varied by region, from 78% in the West Midlands down to just 12% in Yorkshire and the Humber. So while the vast majority of people were successful in finding an NHS dentist, for the 12% who were not the experience is of great concern.

All PCTs run dental helplines. Citizens Advice last year “mystery shopped” 55 of these with the aim of finding out how effective they were at putting patients in touch with dentists. The survey found a mixed picture. A total of 71% of callers were given details of local dentists taking on new patients and 84% of these were given a choice of two or more practices. But 18% of callers had to be put on a waiting list and in 2.5% of calls the callers were told that no local dentist was taking on new patients and were not offered a place on a waiting list. Those PCTs with the best access had the best helplines. PCTs in most need of an effective helpline were the least likely to have one.⁴

The dental experience

There are many very happy patients in the NHS. Some told us they feel “lucky” to have a good dentist and are very positive about both the dentist and the service they receive. This finding is not unique to one sector of the population or one geographical part of the country – it is widespread. Which? found that 86% of those receiving NHS treatment are very or fairly satisfied.

“I’m very pleased with my dentist. He’s very good and very kind and very polite. Half the battle is if they are kind and understanding and gentle.” (65+ patient, Leeds)

“I get a really good service – the dentist is very nice; he does his job perfectly. I’m never in pain and it’s not too expensive.” (20–35 patient, West Midlands)

There are some differences in behaviours and attitudes by age cohort. Many younger adults tend to have had good care in their formative years, with good habits and low disease experience, reinforcing what we know about long-term trends.

Some of those in middle age recounted negative experiences over the years, mentioning large numbers of fillings. They are most keen for regular care and to stick with a trusted dentist.

“I had a bad experience as a child and a difficult time when I was a teenager and it really put me off going to a dentist for years, but then I got an abscess and I had to go back.” (35–60 patient, London)

“He talks to me and is very reassuring but the best thing is he tells me what options I’ve got and we talk it through together.” (35–60 patient, London)

Those beyond retirement age have seen the biggest changes in dentistry. It is older people who probably express greatest concern. The review mailbox received many submissions from older patients worried about the costs of maintenance and many older people who we listened to also feel their teeth “require more care and attention”. They are keen to keep their teeth but are worried about the cost.

What makes a good or bad experience?

A good experience and relationship with a dentist is promoted by a number of factors. It is important for the patient to feel that they have time to ask for advice, for information and for an explanation of treatment options. The “bedside manner” is also important in putting people at ease. People also spoke favourably about being presented with options in terms of treatment, approach and costs, as well as convenient services – easy recalls, appointment reminders and flexible appointment times.

“I want a friendly dentist who doesn’t rush you, has a good manner and puts you at your ease.” (20–35 patient, West Midlands)

A lack of communication, especially regarding the options for care, makes people suspicious or likely to be concerned about whether the treatment offered is really necessary. People do not like feeling coerced into compliance, and some feel under pressure to attend regular six-month checkups.

At the heart of the patient experience is a feeling of trust and control. This could be built up over time and sit as part of a long-term relationship. Small things can damage the sense of trust though – including the fear of being given unnecessary or expensive treatment.

The cost of dentistry

Is the dentist a purveyor of goods or a mouth doctor? Patient charges have an immediate bearing on the relationship between the dentist, the patient and the NHS. While most other healthcare is free at the point of use, about half of NHS dental patients have to pay a substantial contribution to the cost of care. Patients often expect something tangible and physical for that.

Attitudes to cost are variable. People feel costs can be well handled – if they are a good fit with expectations or previous estimates, and particularly if there is no sense of being “ripped off” or “encouraged” to have unnecessary treatments.

However, people's knowledge of what the dental charges are is very limited. Few are familiar with the current banding system or with how this fits with a course of treatment. Significant numbers have not seen the current NHS leaflet⁵ displayed in their surgery and have not had a conversation about charges with their dentist. All those questioned thought that the leaflet should be universally available.

"These are very reasonable. You can have all this treatment under Band 2 and that includes the examination?" (65+ patient, West Midlands)

"It's got good information like what to expect from your dentist, what to do if you're not happy." (20–35 patient, West Midlands)

From the Which? survey only 46% of those who last paid for NHS treatment said they had the charges explained to them before treatment began, and only 33% said they had a treatment plan at all.

Patients generally like the simplicity of the banding structure but many are very sceptical about whether it really represents their own experiences. Perhaps the greatest surprise relates to the position of a scale and polish as part of a Band 1 charge. Many regular NHS patients told us they are paying privately for this treatment with a hygienist.

"You look at the list and think, well I've never had a scale and polish with my examination... he makes me go to the hygienist and it costs me £30." (20–35 patient, West Midlands)

However, the simplicity of three bands is also a problem. The current banded system can give rise to anomalies – some patients feel short changed if they are receiving only one relatively small item that falls within Band 2 or Band 3.

"I think that it's £40 something for an extraction and that's whether they take one tooth out or 10 – you pay for the course of treatment, which is good value if you have a lot done, but if you go a lot [to the dentist] and they are only doing one thing at a time, you might feel that you're paying over the odds." (65+ patient, Leeds)

The concept of NHS charges for dentistry is not new and seems to be accepted, but the knowledge and understanding of what these charges represent is not. There is an imbalance of knowledge between the dentist and the public, which leaves patients in a difficult and sometimes frustrating position when it comes to making choices about treatment.

What treatment is offered?

There is particular confusion about what the NHS offers to dental patients.

Dentists are currently allowed to provide both private and NHS care from the same practice – and even for the same patient. This is an important part of dentistry for many

dentists and many patients. Patients often told us it is impossible for them to distinguish between private and NHS care, leading to resentment.

“I think NHS and private should be separate, not one dentist doing both, because they are more interested in looking after the private patients and you feel rushed as NHS.” (20–35 patient, West Midlands)

There is no prescribed list of items of treatment that are offered by the NHS. This gives the dentist freedom, but leaves the options for care open to interpretation. This uncertainty presents a problem for dentists because, in business terms, not everything is seen as possible. Dentists can (and do) pick and choose what is provided and what is not. The result is that patients do not know what the NHS offers them.

Some patients see benefits in a mixed system, such as an increase in patient choice and allowing treatments to fit to personal values. It can create a “best of both worlds”, providing continuity of care with no need for a separate referral.

“I like the fact that the dentist does both. You get a choice of treatment that isn’t available on the NHS like cosmetic treatments, and you shouldn’t get cosmetic treatments on the NHS... I think that’s quite unacceptable.” (65+ patient, West Midlands)

The mixed system can cause confusion though and there is a need for much greater clarity about what the NHS does for patients.

Patients and prevention

Patients are keen on the idea of prevention but, other than the scale and polish, there is little feel for what it might include. Many feel that unless they have something actively “done” they are not getting value for money. There seems to be little value placed on discussion about treatment or lifestyle.

“You can’t help being a bit suspicious. When you sit in the chair they seem to have a quick look around and tell you everything is fine – they don’t seem to do very much.” (30–55 patient, Manchester)

“You want to feel they are really checking for mouth cancer, looking for any changes since last time and seeing if your gums are healthy, but sometimes it’s so quick you wonder what they do.” (20–35 patient, London)

The whole concept of prevention is critical in dentistry. However, the findings from patients suggest that a substantial readjustment of expectations and understanding among patients will be just as necessary as contractual and incentive changes for dentists.

People who do not attend a dentist regularly

A significant minority of the population choose not to go to a dentist on a regular basis. Some do not go for cost or accessibility reasons (either real or perceived). Some simply do not want to, citing a fear of dentists. Around a third say they go only when they have a problem. In some cases people have simply fallen out of the habit when moving around the country. Sometimes these fears and worries about costs can combine.

“I have not seen a dentist for more than two years. I can’t afford it. I’ve not been able to find an NHS dentist in my area. I’ve not really looked. I’m terrified of the dentist.” (Response to Which? research)

In addition to ensuring that oral health is looked after and promoted, the service and those who work in it have a responsibility to provide a positive experience for NHS dental patients. An improved experience would make for a better relationship with the dentist and better oral health. Clarity, information, communication and time would help to deliver this.

What the dentist sees

The dentist as a clinician

The communication and the technical challenges in diagnosing, preventing and treating oral disease are considerable. When undertaking treatment the dentist works in a confined and very intimate space, often on a patient who is fearful. The technical challenges of, for example, providing root treatment in a molar tooth involve preparation to tenths of millimetres of accuracy in a root canal narrower than a pin and in a place the dentist cannot see.

Technically demanding though this is, arguably more challenging for the dentist are the clinical decisions that need to be made in planning appropriate care. For every patient there is often a range of possible approaches to treatment. In making their clinical decisions dentists have to deal with uncertain concepts such as the likelihood of further pain, disease or mechanical failure. They also have to take into account short and long-term cost. Decisions are rarely supported by high-quality evidence. This is particularly important because, in the absence of high-quality evidence, decisions about “best practice” are subject to external incentives and the personal values of the dentist and the patient.

Patients’ visions of dental health are also often different from dentists’. The immediate priorities for the patient may not be compatible with a lifelong vision of oral health. In a patient-led service it is important to understand the patient’s demands, but when these diverge from good professional judgement the conflict can be difficult to manage.

“Under the system you are not able to prescribe the best treatment for the patient’s benefit.” (Dentist at engagement event, Newcastle)

The dentist as a business person

Many of the dentists in this country operate as part of independent businesses that hold contracts with the NHS. They receive an agreed amount of money in return for delivering an agreed number of weighted courses of treatment each year. The money comes from the taxpayer through local PCTs but this is offset by a significant contribution from patient charges (29% of the total).

This is not unusual. Almost all healthcare systems that provide dentistry involve some sort of payment by the patient (other than through direct taxation).⁶ Table 1 compares the method of funding of dental services in nine comparator countries and gives an indication of the huge variation in the way dental services are supported around the world.⁷ Private and social insurance schemes are common in equivalent countries, as are direct out-of-pocket payments. Nevertheless, the transaction that takes place between dentist and patient marks dentistry out as different from most other areas of the NHS.

“There is a professional conflict between being a dental professional, being a businessman and acting ethically.” (Dentist at engagement event, London)

Table 1: A comparison of public dental services for selected countries

Country	Covered population	User charges in publicly funded dental care
Australia	Targeted groups only: adults on low incomes, those with chronic conditions or complex care needs; children and adolescents	Some dental services provided to eligible groups attract user charges, including school dental services; user charges vary regionally/locally
Canada	Targeted groups only: indigenous people, Armed Forces, refugees, local and provincial programmes (e.g. for individuals on low incomes)	Dental services provided to eligible groups may attract user charges; these vary regionally/locally
England	Universal entitlement	Patients pay a user charge for each course of treatment based on three “bands”, broadly reflecting differences in the degree of service complexity
Finland	Universal entitlement	User charges are determined locally within limits set by the Government; patients contribute 20% of costs on average
France	Universal entitlement under social health insurance	Social health insurance covers 70% of the costs of healthcare, including dental services; the remaining 30% are covered by the patient

Country	Covered population	User charges in publicly funded dental care
Germany	Entitlement under social health insurance (covering about 88% of population)	Different services attract different contributions, as reimbursement levels are set in relation to diagnosis. A co-payment of 50% applies to crowns, bridges and dentures; the percentage can be lowered if a patient has participated in regular checkups; a practice fee of €10 is payable once every three months if a dentist is seen within this period, unless the visit involves a dental checkup
Netherlands	Universal entitlement to “basic package” of health services	Patients eligible for publicly funded dental treatment contribute 25% of the cost of prostheses and €125 per jaw for implants
New Zealand	Targeted groups only: individuals on low incomes or with complex care needs	Emergency dental care for adults on low incomes attracts a maximum user charge of NZ\$35. Dental outpatient services in public hospitals also involve charges
Spain	Universal entitlement (acute dental care only); more comprehensive treatment for children, pregnant women, disabled people and pensioners (in some regions)	Public dental services do not involve user charges
Sweden	Universal entitlement	Patients contribute 50% of the cost of treatment if the costs incurred are between SEK3,000 and SEK15,000 in a period of 12 months. The contribution is reduced to 15% if the costs are higher than SEK15,000

There is, and always has been, a viable private dental care market. Many NHS dentists provide private care for some patients. The private market is well established in dentistry and often provides an excellent service.

However, the presence of a viable alternative to NHS care is more than a distraction. Many dentists see it as preferable, which impacts on the way that NHS services are offered. Our work with dentists suggests that the common motivation for providing private care is often less about income and more about lifestyle, citing more time to see patients as a major incentive. The combination of private and NHS care provides the patient with choice, but patients are reliant on the dentist for advice, leading to an inherent risk, both in private and NHS practice, of that advice being self-interested.

In dental practices, the providers (contract holders) carry the financial risks. The provider buys or rents the practice and employs the staff and almost all the costs are recovered through payments for patient care.

What the introduction of the 2006 contract meant to the dentist

As our review team travelled the country we visited, heard about and met staff from outstanding practices led by exceptional people with a strong personal healthcare ethic. The services they provide are as good as you will find anywhere. The staff in such practices work together as a team, are well looked after and are very well supported to develop their careers. Such practices have systems voluntarily in place to prevent disease and improve oral health and the quality of care.

It would be good if this were the norm, but it is not. Since the 1960s dentists have complained about being on a “dental treadmill”, churning out dentistry to meet costs. In a recent study in Wales, following the introduction of the 2006 contract 86% of dentists said they felt they were still on a dental “treadmill”.⁸ We saw and heard from practices where dentists felt under financial pressures, where staff felt disenfranchised and, most concerning of all, where clinicians were interpreting NHS care in a way that was not intended and not necessarily conducive to improving health. Such interpretation represents a substantial waste of public resource.

Change is always difficult but the reaction to the new contract was particularly hostile. The anger from the profession is well documented elsewhere and could be largely summarised under the following headings:

- for some dentists, a sense of professional frustration about how they feel they are having to practise, and a perception that it adversely affects their patients
- for most dentists, the perceived uncertainty it creates, particularly in terms of business risk
- for many dentists, poor or inappropriate commissioning is frustrating
- a general suspicion of government motives and the lack of piloting
- growing bureaucracy.

“There are no clear rules in several areas so you have to do things your own way and make your own decisions.” (Dentist at engagement event, Newcastle)

What follows tries to summarise these major issues from the point of view of dentists, based on the many meetings, discussions, interviews and conversations the team has had with the profession as part of the review.

Professional frustration: the Unit of Dental Activity, bands and behaviour

The currency of the new contract is the Unit of Dental Activity (UDA). Depending on the complexity of a course of routine treatment delivered, the dentist is awarded either one,

three or 12 UDAs. Contracts are drawn up around an agreement to deliver a prescribed number of UDAs in a 12-month period for an agreed annual financial value.

Because of the way the transition from old contracts to new contracts was prescribed by regulations,⁹ UDA values vary from provider to provider. The current average is around £25 but the actual value varies from about £17 to nearly £40. This means that the value of a Band 3 course of treatment for which the dentist is rewarded with 12 UDAs can range from around £200 in one practice to well over double that in another.

The provider has a contractual duty to provide all necessary care for an unspecified number of patients for which the provider will be paid a certain number of UDAs. On the basis of both the verbal and written evidence submitted to the review, a consequence of the UDA “target” is that collecting UDAs to ensure that the contract is delivered can become the focus of practice at the expense of providing high-quality care.

We heard accounts from younger dentists that suggest that the single-minded pursuit of UDAs can, and has, become ingrained in young practitioners to a worrying degree. Behaviour may be adopted that maximises the rate at which the UDAs are achieved, often referred to as “gaming”. This does not maximise income in itself, but releases time for other activities. There has of course been “gaming” from the very beginning of the NHS; it is nothing new in dentistry or in any other area of work. However, the UDA-based system is associated with some specific “gaming” behaviours related to the UDA bands.

The quote below comes from one committed young dentist but probably represents the sentiment of many.

“There are two things you think: how can I do the best for the patient and how can I maximise the UDAs?” (Young dentist, north of England)

Another more experienced and totally committed NHS dentist working in a deprived area said:

“... [Under the new contract] I find it difficult to take pride in my work any more.” (Experienced NHS dentist, West Midlands)

There are some clinical procedures where the banding assigned to them is perceived as unrealistic when combined with a low UDA rate. These procedures are simply not offered on the NHS by some dentists. This is a breach of contract, but most patients are unsure about their entitlement.

The accounts that caused us the most concern relate to providers sanctioning approaches to care, treatments or techniques that appear to have no purpose but to increase the number of UDAs. These include recalling more frequently than would seem justified and provision of treatments that are clinically no better than a lower band alternative. In the case of the latter, the treatment can be clinically justified but, clinical

benefits being equal, the more profitable treatment is chosen. The worst cases relate to providing treatment that is less clinically appropriate but yields more UDAs, or even to accounts that imply the provision of treatments that are completely unnecessary but which pay well.

“Meeting your targets does not mean good dentistry and not meeting your targets does not mean bad dentistry.” (Participant at engagement event, Bristol)

The findings point to problems in the profession and the system. Where the incentives in the contract and the objectives of the system are not aligned there risks being poor use of the financial and human resources. Capturing that capacity in order to allow the same resources to deliver improved oral health for NHS patients should now be an absolute priority.

Uncertainty and business risk

Under the pre-2006 arrangements, the development growth and continuity of the NHS elements of a dental practice or business were largely in the control of the practice owner. Local commissioning changed that, shifting control to the local PCT. This was a new phenomenon and many dental practice owners felt uncertain about the security of their NHS business.

A major concern of practice owners has been the loss of the “goodwill” value of a practice, represented by the patient list. It would have been sold with the practice when a dentist retired or sold on. Now, when a provider changes, the PCT has to consider its responsibilities under the Public Contracts Regulations¹⁰ and may go to open tender. If the PCT goes to tender, traditional “goodwill” value is lost. There are ways of successfully managing a transfer which preserve “goodwill” value. The extent to which dentists have lost out is difficult to quantify, but they feel exposed.

The other side of this is that, as an independent business, there is no cap on the salary that a dentist can take out of the contract and there is also nothing to prevent the dentist from undertaking private practice. Some dentists and provider organisations seem to be doing very well indeed.¹¹

NHS dentists and commissioning

Dentists generally view the new contract with suspicion and their subsequent experience is heavily influenced by the way their local PCT approaches their new responsibility.

“PCTs did not have the skills and experience to interact with dentists – they had expertise with GPs but it did not transfer. This is still a problem.” (Dentist at engagement event, Bristol)

Some clinicians we heard from recognised excellent commissioning of services which, despite the inevitable strain of negotiating issues in the contract, has resulted in dentists who recognise the value of good commissioning.

However, others tell a different story where they feel bullied, or feel the PCT has been unreasonable in its approach to dealing with the new contract. The possible reasons for this are explored in the next section, which focuses on perceptions of PCTs and the NHS.

“Some dentists don’t see people from the PCT for a whole year, aside from the odd leaflet.” (Dentist at engagement event, Bristol)

Data and information, properly used, would have led to more informed commissioning and monitoring. The fear (and reality) of “clawback” (money being clawed back by the PCT where a provider’s activity falls below target) is also a concern for many. Reliance on the UDA as the sole currency by which contract performance is judged and a formulaic approach to “clawback” lie at the heart of much of the dissatisfaction with the new system.

Of the many dentists we met, it was often the seemingly hard-working and committed NHS dentists who had a low UDA value and who refused to cut corners who felt worst done by, particularly when subjected to clawback.

Suspicion of government motives and the lack of piloting

Dentists are suspicious of government motives towards NHS dentistry. The NHS has benefited from huge investment in recent years. Although dentistry has benefited, as the overall NHS expenditure has increased, dentistry’s share has reduced from 2.9% of net expenditure in 1997/98 to 2.1% in 2007/08. While dentists have rarely said specifically that they feel left out of this transformation, there has been a move towards the private sector in the last quarter of a century. This supports an analysis that some dentists have long seen NHS dentistry as a “second-rate” option.

Any underlying suspicion was not helped when some of the aspects of the reforms were introduced without piloting, particularly the use of the UDA as the prime contract currency. There was piloting of capitation-based PDS schemes prior to the 2006 contract but the final arrangements were fundamentally different from the PDS schemes.

Bureaucracy

Finally, there is a perception of a growing weight of bureaucracy. For a dentist paying for the premises, equipment and staffing, the costs of bureaucracy are particularly visible. Mostly this is not to do with the contract but with wider changes in regulation and governance. Dentists see regulation as important and will comply but, where there is needless duplication, they feel frustrated.

The process of tendering for NHS contracts is seen as bureaucratic too, and many dentists and some of the corporate providers would like to see a standardised and more streamlined approach to the process.

Providers, performers and the future

One other important theme that emerged from our work was the dynamic nature of dental services. The way dentistry is provided is now changing.

There is a trend towards big providers because of the economies of scale and the way in which contracts are awarded. Corporate organisations are now responsible for delivering care to millions of patients in England. The “corporates” are unpopular with many independent dentists who are quick to question the motives of the companies and the dentists who work within them. The many small providers are finding it difficult to operate in the way they have for many years.

Many young dentists are worried about their future, although they are generally well paid by any reasonable measure of income. Those who aspire to become a provider and hold a contract feel frustrated that this may become difficult with the trend towards larger contracts shared between fewer providers.

“The current remuneration system has destabilised the profession – it is having an impact on career development and choices.”
(Dentist at engagement event, Birmingham)

The increase in dental undergraduate intakes will make an impact. The first of these big years will soon enter the vocational training programme and this increased output will be sustained. The impact of this is difficult to predict in the context of an evolving service and an inward and outward flow of international graduates.

Changes to the Dentists Act and the regulatory framework¹² mean that there is increasing scope for the use of dental care professionals, including dental nurses, hygienists, therapists and clinical dental technicians, in the delivery of dental care. A frequently cited view is that the current contractual system does not support the use of an extended team business model. Dentists have mixed views about how or even whether to use this diverse workforce, but some are doing so imaginatively and successfully.

What the NHS sees

Although clearly seen as an important part of the NHS by patients, dentistry has existed on the edge of mainstream NHS development. This is perhaps understandable when one considers that the relationship between dentists and the NHS was for the most part one where the contract was a national one and where the funding came from a central pot, thus bypassing the local NHS.

The Health and Social Care Act 2003 defined more clearly PCTs’ responsibilities for dentistry and oral health.¹³ In 2006 a full transition to a new system combining the local responsibility for commissioning services and the introduction of a new contract with which to engage with dentists to deliver that responsibility meant that PCTs had a new role to play, for which many were unprepared.

“Each Primary Care Trust and Local Health Board must, to the extent that it considers necessary to meet all reasonable requirements, exercise its powers so as to provide primary dental services within its area, or secure their provision within its area.” (Health and Social Care Act 2003)

The views of NHS commissioners

As part of the review we have been able to engage with many commissioners and PCT employees at all levels. We have also heard from those who represent them, and specifically from the NHS Confederation, which provided a comprehensive assessment of the implementation of local commissioning in dentistry.

To PCTs the run-up to the change in 2006 felt rushed. The difficulty of commissioning with dentists for the first time was seen to be compounded by mergers and changes to PCT structures, efforts to achieve the 18 Weeks programme and developing Practice Based Commissioning for GPs. Dentistry, perhaps understandably, slipped down the priority list.

“NHS dentistry has always been a bit of a side show to the rest of the NHS.”
(Participant at engagement event, Birmingham)

PCTs' early focus had been on maintaining or repairing the relationship with dentists. The amount of work involved and the unique nature of dental commissioning was perhaps underestimated.

“We did our best with something that wasn't very clear.”
(Commissioner at engagement event, Bristol)

The transition worked best in areas where there had been good preparation and communication about the forthcoming changes and where there was a commitment from the leadership of the organisation. These areas focused on regular meetings with dentists, established good communication channels, used the knowledge of existing or retired dentists and gave support to meet contractual commitments, including training and equipment.

“From the commissioning side it's not well understood and quite understaffed. Some PCTs have dentists working for them. In such instances, they understand the issues dentists face... others don't.”
(Participant at engagement event, Bristol)

The new system had many benefits from a PCT perspective. These included ensuring that the location of practices served local need and that UDAs were allocated to meet need. In theory, it brought expenditure under PCT control and, in principle, nearly all treatments, both simple and complex, were available on the NHS.

However, three years on, many PCTs are still not using the flexibilities introduced in 2006. Initially some directors of finance worried about the estimate of patient charges that would be returned and were not always clear about how their allocations had been developed. This resulted in natural caution about using available monies and a focus on ensuring delivery of UDAs. Many of the commissioners involved were junior, which may have contributed to the difficulties.

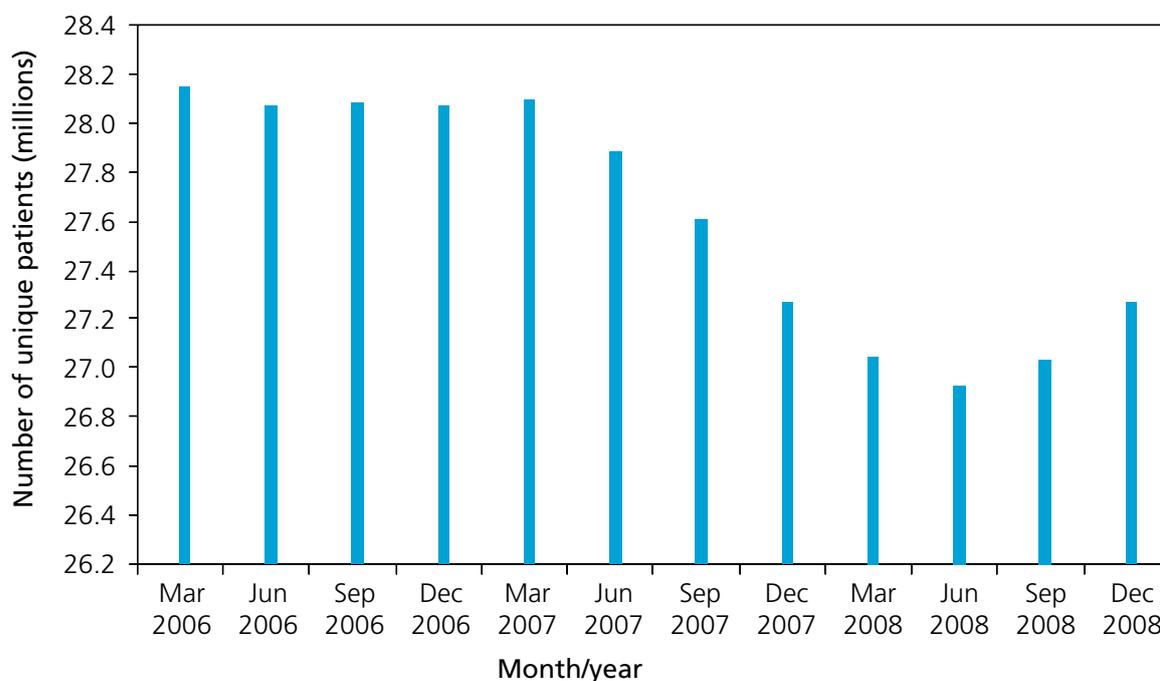
“Examples of good service are happening in spite of the contract, not because of it.” (Dentist at engagement event, Manchester)

Measuring performance

Once services have been commissioned, the main way for a PCT to measure whether a practice is performing or not is based on whether practices hit UDA targets. In this context commissioning on price makes perfect sense to finance directors, if not to clinicians. The clinical problem is that there is no clarity about what patients are actually receiving for the UDAs commissioned on their behalf and there are few ways to find out.

Measuring the performance of PCTs presents a different problem. Improving access to NHS dentistry has become a government priority and is the prime performance measure for a PCT. Unfortunately, during the period after the contract was introduced, measured access fell further. This was compounded by the small net loss of dentists from the system in April 2006 (see Figure 2).^{14,15}

Figure 2: Patients seen within the last 24 months (quarterly data)



“The biggest frustration is that the targets are all about access, but the currency is all about UDAs.” (PCT commissioner)

The measure of access is problematic: the market has become increasingly mixed, and the mixed market sends mixed messages. Where there are high levels of private care access levels may appear low, despite many patients receiving dental care outside the NHS in a clinically appropriate environment, but patients may be being denied choice. By contrast, in other areas there can be a lack of access to any dentistry, which statistically appears similar. It was, and still is, difficult to distinguish.

The initial allocation of funds was based on previous service provision and not on patients' needs. Some PCTs with historical access problems and high deprivation lost out and the access problems were perpetuated.

The new contract has also seen concerns about treatment patterns, for example, extractions increasing and endodontic care decreasing.^{16,17} Also, the National Institute for Health and Clinical Excellence (NICE) guidelines on appropriate recall intervals between appointments do not appear to have been well communicated to patients nor used by dentists.

“The NICE recall has not been done properly and the preventive tool kit isn't being used properly either.” (PCT commissioner)

The wider NHS and the Department of Health

Over recent years there has been a substantial increase in funding for dentistry. Nevertheless, even with more resource, access continued to fall until very recently. This suggests that practice behaviour was not as expected.

The money is paid to providers, so a logical conclusion might be that providers are getting more money for doing less, or perhaps for doing something differently. In other words, despite the protestations of the profession, dentists are doing rather well overall. There are still no data yet to provide a definitive explanation of changing clinical activities.

Dentists have to provide basic data to claim for UDAs, and they are now asked to record some core clinical data. This is starting to provide an indication of the range of clinical activity, but the data is limited and needs careful interpretation.

More broadly, dentistry is still not always seen as part of the mainstream NHS. Only a few of the SHA regional pathway visions, as part of the Next Stage Review in 2008, picked up dentistry. Dentists are now set to become part of the new regulatory regime, and will fall under the auspices of the Care Quality Commission (CQC).¹⁸ Other recent developments in primary medical care, such as the Quality and Outcomes Framework, have not yet found parallel approaches in dentistry.

What is NHS dentistry for?

There are some very thorny problems that are unique to dentistry in the NHS. Oral health is subject to highly variable personal values and attitudes. Many people value regular attendance and are worried if they cannot achieve this. In contrast, some are concerned about the cost of regular attendance. Others are happy to visit if they have a problem, but with the expectation that this problem will be addressed promptly.

“I've hardly ever had anything done. I go every year or so, he never finds anything, but it's still quite reassuring to hear that it's all fine.”
(20–35 patient, London)

“I can’t see any need to go, my teeth are fine, I’ve had no problems and whenever I do go, the dentist says the same so I can’t see the point of going.” (20–35 non-attender, London)

Some people will spend a lot of money on a little dentistry; others are reluctant to spend anything at all. Younger people with little experience of dental disease do not see the need to attend but aspire to the whitest of teeth. For others, constant maintenance is essential simply to retain some natural teeth to help with eating. In the eyes of the patient, good oral health can vary from absence of pain to the desire for a perfect smile, and everything in between. What should the NHS support?

The phrase “cosmetic dentistry” is often used by dentists and patients to define certain practices and procedures, but there is a wide, blurred and costly middle ground between necessity and vanity.

Different patient values

“Every tooth in a man’s head is more valuable than a diamond.”
Miguel de Cervantes, *Don Quixote*, 1605

Work at Newcastle University, running parallel to the review, sought to identify how patients value a single molar tooth. A total of 212 patients, from a full range of backgrounds, incomes and occupations, were asked to put a theoretical financial value on a treatment to save a molar rather than have it extracted. The range was from nothing for those who would just have it out, to £10,000 for those (like *Don Quixote*) for whom, it would seem, the loss of a tooth is seen as a major health event. The NHS has to find a way to deal with such variation in personal values equitably.

Dealing with the varying needs and aspirations of all of the consumers of dental care is a particular challenge for the NHS and is one that needs to be addressed by the NHS. This is about clarifying what is offered, what commissioners buy, what dentists provide and what patients get.

The impact and cost of dental disease is life long. The NHS in 2009 is still dealing with, and paying for, the consequences of disease that occurred more than 50 years ago. We need to deal with this burden of the past and manage the demands of the present, but we need to keep a very clear focus on the future so that we can minimise the risk, discomfort and costs for future generations.

NHS dentistry could take a huge step forward but, in order to do that, one notion is critical: there is a difference between an oral health service and a dentistry service. So long as we see value for taxpayers' money as measured only by the production of "widgets" (fillings, dentures, extractions or crowns), it is difficult to escape the cycle of intervention and repair that has persisted from a different age. Just as health is the outcome of the rest of the NHS, so health should now be the outcome for dentistry, and good oral health the means by which the success of NHS dentistry is measured.

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3 Principles for the delivery of oral health to NHS patients

Dentistry as part of NHS healthcare

This chapter looks at where dentistry fits in the wider NHS. It seeks to clarify the responsibilities of patients, dentists and the NHS to each other, reviewing to what extent they are being met and concluding that each group is failing to live up to its responsibilities to some degree. We go on to identify how we might improve this by defining more clearly what NHS dentistry might offer, and why. The chapter finishes by explaining how this might be fitted to a patient pathway, built around prevention, high-quality treatment and continuing care. The pathway is there to ensure that all stakeholders can be clearer about the goals of NHS dentistry and about their responsibilities in meeting them.

The NHS was created in 1948 offering to promote a universal and comprehensive set of services to all:

“a comprehensive health service designed to secure improvement in the physical and mental health of the people... and in the prevention, diagnosis and treatment of illness.”¹

Even from its inception, that definition has unequivocally included dental services. The purpose of dentistry’s inclusion was clear – oral health is not separate from people’s overall health and the prevention and treatment of oral disease is part and parcel of the NHS. This founding ethos has been continued and updated throughout the years, most recently in the NHS Constitution, published in January 2009.²

The NHS Constitution propounds a set of principles by which the NHS should operate, including aspiring to services of the highest standards of excellence and professionalism, working across organisational boundaries and being accountable to the public, communities and patients it serves. The Government is currently legislating to ensure that all providers of NHS services, the dental team included, have a legal duty to have regard to the NHS Constitution.

The NHS Constitution sets out many of the key rights patients have in the NHS, which pertain also to NHS dentistry. The Constitution includes a commitment that the NHS should provide convenient access to services. The handbook that accompanies the NHS Constitution makes clear that this includes the pledge that, by 2011, all PCTs should be able to provide access to dentistry for anyone who seeks help in accessing services.”³ Everybody already has the right to access an NHS dentist but the purpose and the extent of that service and what people can expect if they use it need to be clearer.

While the Government has been clear about its commitment to dentistry in the NHS, dentists and patients are less sure. With stronger central commitment, dentists, patients and PCTs would be confident in the future of NHS dentistry and their places in it.

We recommend that the Government and the NHS re-affirm their commitment to NHS dentistry, recognising the importance of good oral health to good general health across a lifetime.

A healthcare system has to balance rights with responsibilities. In order to deliver an appropriate range of treatments as well as to deliver the prize of a truly lifetime focused-service, we require a fresh look, particularly at these responsibilities and how well they are being met.

Responsibilities of patients to the NHS and dentists

The NHS Constitution highlights the responsibilities of patients, including looking after their health, keeping appointments and sticking to agreed courses of treatment. These apply equally within the dental context and relate to appropriate use of public resources.

Dental patients can do a great deal to look after their own health with relatively little effort. Despite a clear intention to maintain a clean mouth, 72% of the population had significant plaque deposits in the last adult dental health survey,⁴ while sugar consumption also remains high. Could patients do more to maintain their own oral health? And how can dentists and the NHS help?

Responsibilities of the NHS to patients

The NHS is responsible for performing a number of distinct functions on behalf of patients and taxpayers:

- It provides quality care free to those who are eligible – approximately 48% of patients who go to an NHS dentist within a two-year period are exempt from paying patient charges (of which 57% are children). In 2007/08, these patients received 51% of the total UDAs (of which 43% were for children).
- It subsidises dental care for all other NHS dental patients.
- It oversees a “price regulated” market for those who do make a personal contribution – that is, it sets out clear national patient charges which help protect against market failure and increased costs. The importance of this for patients should not be underestimated.
- It now has a clear responsibility to manage the quality of provision.⁵
- The NHS, through PCTs, also has a responsibility to provide access to appropriate dental services for the people in the PCT area.

Access is an area that some PCTs have found particularly difficult, and it is discussed in Chapter 2. Management of the quality of service has not hitherto been part of NHS dentistry and is far from embedded in the system.

Responsibilities of dentists to patients

Every healthcare professional has a responsibility towards, among other things, impartial advice and sound clinical practice. These are basic aspects of professionalism that the public has a right to expect. The dentist has a large number of specific professional responsibilities, which include:

- using a combination of evidence and experience to provide care that is in the best interests of the patient

- dealing with long-term solutions to problems created by disease, not just performing “quick fixes”
- offering good and honest communication
- displaying behaviours that unambiguously put the patient first
- helping patients with their own self-care responsibilities.

Some of the very honest accounts we have heard from the frontline of dental provision as part of the review suggest that these responsibilities are not always universally accepted nor always discharged. Sometimes dentists say they find it difficult to do so because of the system, but for many of these responsibilities blaming the system is an inadequate response.

Responsibilities of dentists to the NHS and the taxpayer

Those of us providing NHS services forget, at our peril, who provides our income. NHS dentists have a clear responsibility to spend the public’s money in the best interests of their patients – whether that money is received from the private purse, the public purse, or a combination. In return, the professional can reasonably expect to have a status and an income commensurate with the extremely high-level competencies and skills they possess, the risks they face and the professional responsibilities they take on.

It is difficult to know just how wisely public resource is used, but if treatments are provided that have little clinical benefit or are based on achieving contracted UDAs rather than good dentistry, as many dentists have intimated during the review, then at least some and perhaps quite a lot of this resource is not being used effectively.

British-trained dentists have been trained at the taxpayers’ expense. Around £170,000 is spent from education and NHS budgets to train a new dentist. Undergraduate students now contribute to their fees, but this represents just a fraction of the real cost. It has been cogently argued that NHS trained dentists have, in the eyes of the taxpayer, a responsibility to give something back to the people who supported their training.⁶

Responsibilities of the NHS to dentists

The NHS has a responsibility to allow the healthcare professional to undertake their tasks in line with the responsibilities described above, and to support them to make their decisions freely but in the interests of the patient. This means that the NHS does have to ensure appropriate remuneration but also that systems are in place to monitor the activities of the clinicians it pays.

The system of payment can influence the ability of committed dentists to make the best decisions. The variation in the level of the UDA rate means that it is easier for some than for others to take on certain treatments, potentially affecting patient care and the equity of the service.

We have described failures to deliver on all of these responsibilities. The rest of this report aims to find ways to support all stakeholders in meeting them more successfully.

Aligning behind a clear view of what NHS dentistry should offer

In our view, the overall ambition of the NHS dentistry service should be to be a lifetime-focused, evidence-based oral health service, which aims:

- to prevent oral disease and the damage it causes
- to minimise the impact of oral disease on your health, when it occurs
- to maintain and restore quality of life when this is affected by the condition of your mouth.

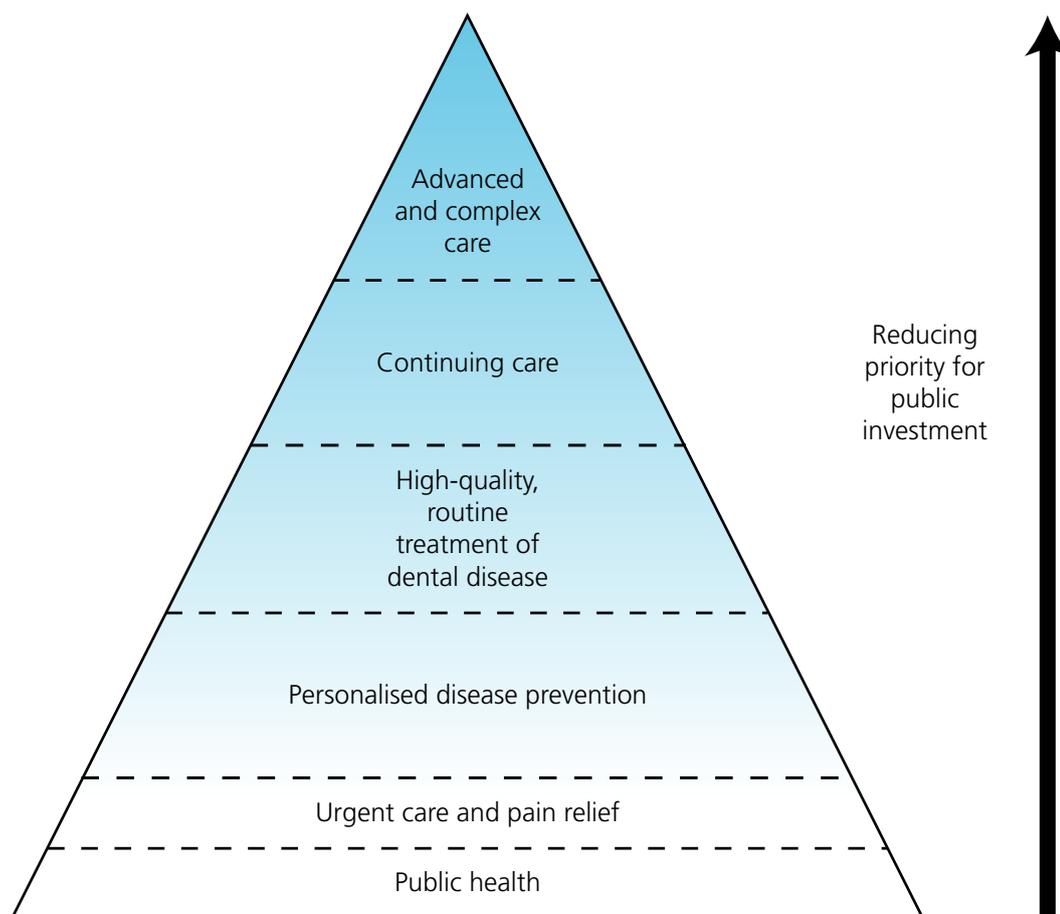
So, how do we begin to assign the responsibilities to deliver on this ambition?

We would like to start by setting out a clear view on which dental services it might be appropriate for the NHS to commission on behalf of its patients. At the moment we have over 10,000 different versions of “what you will get” as a patient, depending on which practice (and indeed which dentist) you attend. It is time to bring some clarity and consistency to what NHS dentistry can and should offer to patients.

We have started by identifying the components of a modern service and then ordering them, by building foundations based on what patients need. This is illustrated in Figure 3 in the form of a pyramid. Towards the base are some things which are at the very heart of any dental system and, at the top of the pyramid, there are some advanced and expensive services which it is not unreasonable for a modern developed country to consider offering, if public resources stretch that far.

This is about making sure that the resource we have is invested properly in health, looking at a long-term oral health goal. The hierarchy represents the extent of what NHS dentistry can offer, and later we will fit the various levels to a simple pathway so that patients and dentists can see where and how they are offered it.

Figure 3: Priorities for public investment in oral health



It is this set of priorities, in this order, that we should aim to achieve through the system of professional obligations, contracts, charges and regulation we create.

The priorities are as follows, in order:

- There needs to be a strong, co-ordinated public health system, recognising the common risks to oral health and health overall and providing support to the profession and information to patients about how to minimise these risks.
- Any dental service should then be able to provide quick and definitive pain relief to anyone who needs it. This should not be a large or expensive part of a service, but it must be there.
- Preventing the damage caused by disease at an individual level is a high priority for investment. Every cavity or periodontal pocket represents irreversible damage, with lifetime consequences and costs.
- Treating disease is still inevitable where prevention fails, but treatment can be damaging, so minimising damage through quality restoration is an essential step.
- Oral health is a lifetime concept, so we propose actively facilitating continuing care arrangements to allow long-term relationships to be established between dentists and patients.

- Oral health is subject to huge variations in personal values. There is a difficult area related to the provision of a range of advanced, complex and expensive treatments aimed either at managing patients outside mainstream services or at delivering quality of life rather than disease management. These treatments are not the highest priorities, but the NHS can, and does, provide such care. These services should not be seen as an automatic right for everyone, but the investment should be targeted to where risks are managed and where need and benefits are greatest.

On the basis of this, a broad offer might be described as follows.

People choosing to use NHS dental services will receive a lifetime-focused oral health service, based on evidence where possible, which will:

- help them to prevent oral disease and the damage it causes
- provide effective and prompt urgent care when required
- minimise the impact of dental diseases when they occur by providing proper assessments, treatment to manage disease and the opportunity for regular maintenance and review for those who want it
- provide treatments to maintain and restore quality of life subject to a stable oral environment being achieved, and subject to pre-set criteria for appropriate NHS care, built around long-term health gain.

Making “the offer” real

As we listened to dentists it was clear that most dentists want to do good dentistry, to take a role in prevention and to be rewarded for successful care of their community. In common with many patients and dentists we listened to, we also believe that continuing care is an important concept in dentistry and one that can help to deliver good dentistry to any community.

We recommend that NHS primary care dentistry should be staged around a pathway through care. This should allow and encourage continuity of the relationship between patients and dentists, for those who want it, built around the most appropriate recall interval for the patient and using oral health as an outcome.

Associated with this pathway there should be clear signposting for patients and dentists and that patients should have easy access to the information they need.

However, it was clear when we talked to patients that not everyone wants or will use continuing care, and that all patients have the right to access appropriate services. There needs to be provision for urgent and casual care for those who do not have a relationship with a dentist, and this should include a gateway to more comprehensive services for these patients.

Figure 4: Proposed patient pathway

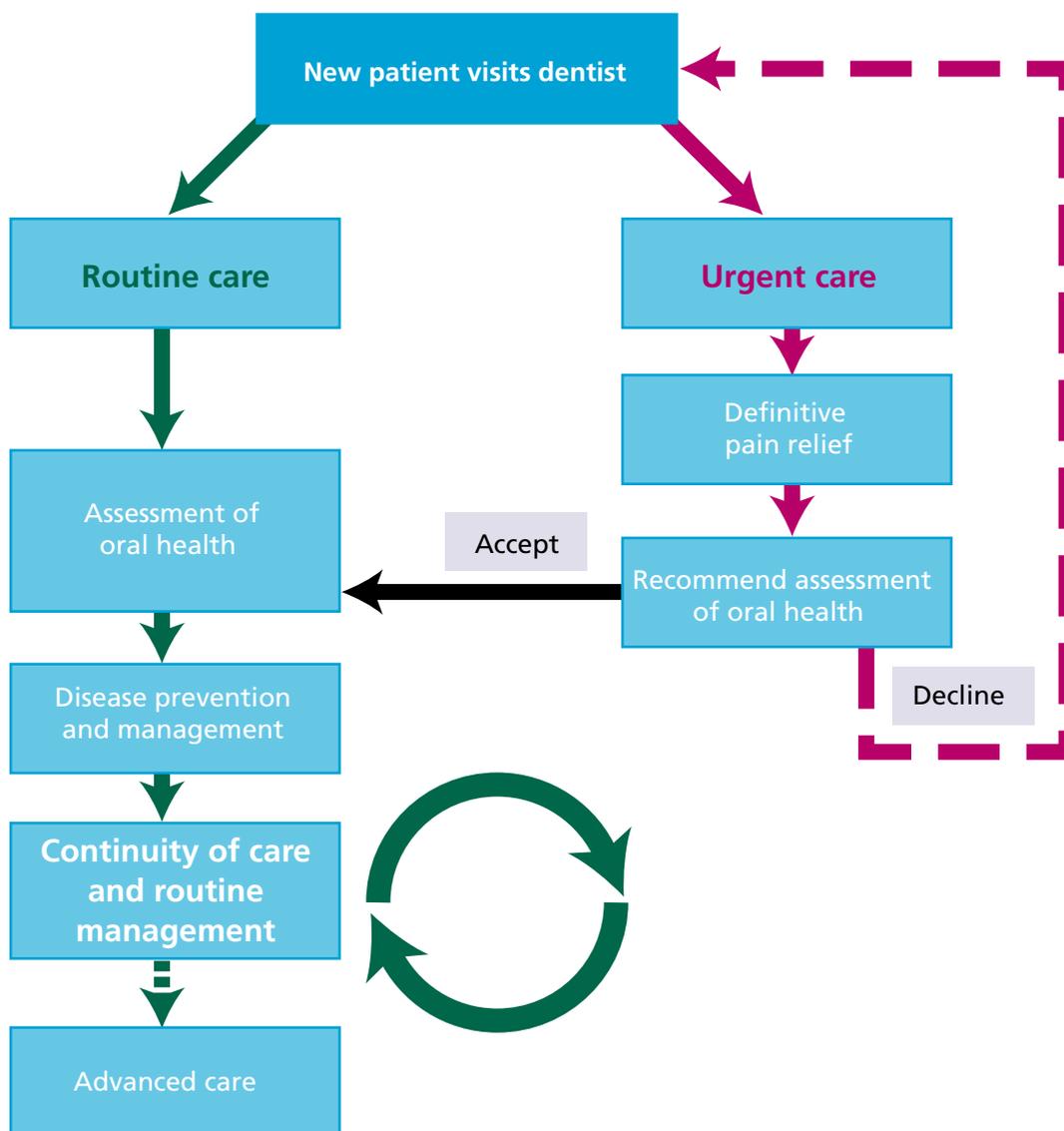


Figure 4 shows the patient pathway that we propose. This is built on the priorities described above. The essential features of the pathway are as follows:

- The opportunity for urgent care for everyone when required.
- For those without a regular dentist, the opportunity to enter continuing care.
- For new patients there should be a formal oral health assessment to evaluate the risks of all major dental disease (decay, gum disease and oral cancer) and the need for treatment. Personalised prevention should be started.
- For existing patients who are in a continuing care arrangement (who are returning within an appropriate period, depending on recall interval), there is an assumption that the dentist is aware of and managing their preventive needs.
- Advanced aspects of restorative care are provided only when there is a stable oral environment, where disease risks are managed and when the patient is established in a continuing care relationship.

- Entry to advanced care is dependent on professionally derived clinical guidance, based on evidence or – where there is insufficient evidence – best practice, with clear evaluation and entry criteria.
- A key element of this is that quality measures should fit the pathway. Progression through the pathway and a visible reduction in risk will be key performance indicators for NHS dental providers.

We recommend that the pathway is staged and based around: making urgent care available; assessing risk and preventing disease; routine management of disease; monitoring during continuing care; and provision of advanced services intended to restore and maintain quality of life.

We recommend that there should be a defined route from urgent care or for new patients towards continuing care arrangements if they wish, but through a formal oral health assessment.

We recommend that complex and resource-intensive services should be provided, but subject to nationally agreed guidelines. The guidelines should be professionally determined and evidence based where possible. For some services, a stable and low-risk oral environment would be a prerequisite.

Such pathways are not a new idea and delivery on these recommendations is relatively straightforward, given intelligent commissioning. For example DH, along with the British Association for the Study of Community Dentistry, recently published evidence-based guidelines on prevention entitled *Delivering Better Oral Health*.⁷ This outlines a clear set of measures that dental teams should implement for patients based on patient age and risk of disease.

Some PCTs are already starting to use these concepts when commissioning care, and are successfully building quality measures around them. However, for the patient, the clinician and the NHS there would be considerable advantage in having a basic shared national pathway around which contracts can be built, and which everyone understands.

A new dental quality framework for Manchester, based on earlier work in Salford and Oldham, has sought to build dental care around a dental pathway. The pathway is supported by new contracts or contract variations and key performance indicators related to quality of service and access. The key performance indicators are specifically built around preventive protocols, the availability and use of information and appropriate recall rather than volume of activity. Importantly, the indicators are not static: it is planned that they will evolve with time as the services develop.

In an ideal world, each step of the pathway and every treatment decision would be based on a good understanding of the evidence. The treatment offered by the NHS would be evidence based, as it should be in the NHS.

However, many of the clinical interventions in dental practice lack a strong evidence base and are based on assumed best practice.

There are, at the time of writing, 89 systematic reviews of evidence on the Cochrane oral health database.⁸ Perhaps only 13 of them relate to routine operative or periodontal procedures, which account for about 70% of UDAs. Among those there is rarely a firm conclusion to support or refute common practice. The use of pre-2006 treatment data from the NHS shows what can be done simply by using what we can easily collect to supplement controlled trials.⁹⁻¹³

If we are to secure best value for the investment that the state makes in NHS dentistry, then we need to establish whether or not our long-held clinical assumptions are correct. Research and development in primary dental care, specifically including good use of better NHS data, can allow us to hone the service to greater efficiency.

We recommend that research and development priorities are focused on strengthening the evidence base within the pathway approach we have outlined.

The National Institute for Health Research has the resource and capacity to facilitate this in conjunction with the wider academic community.

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4

Delivering
oral health
in the NHS:
the patient

In this chapter we examine how the NHS could and should be improved from the point of view of dental patients. Building on a clearer approach to defining what the NHS should offer patients, and developing the idea of a patient pathway, we will make some recommendations aimed at helping patients to access appropriate services and clarifying what they might expect at different points in the pathway. We also discuss the way in which patient charges are structured.

Equity and equality

The NHS strives to address poor oral health for everyone, and not just for those who use it or wish to use it. There is a wide range of needs, from the challenging clinical problems of the very old to securing the dental futures of a young population who could have much healthier dental futures than their predecessors. There is also a diversity of individuals, including those with disabilities, people with language barriers, ethnic minorities, refugees and many others, all of whom have specific needs.

NHS dental services need to be able to meet the needs of all of these different people, and the value of local commissioning is that PCTs can be flexible. In line with the NHS Constitution, we suggest that the key principles for dentistry should be as follows:

- Everyone should have the right to access routine dental services but, for those who choose not to, other services should be provided to meet their needs for urgent treatment, when required.
- Where people have particular needs that are likely to be better met by more specialist services, for example associated with a disability or language difficulty or an acute fear of dentists, suitable dental services should continue to be provided locally.

In responding to this review, DH should conduct a full equality impact assessment before implementing any proposed changes. Pilots and their evaluation evidence can be used to enrich the impact assessments; they can also inform the NHS on how dental services can help to reduce health inequalities and provide services to all who wish to exercise their right to use them.

However, the core clinical principles of NHS dentistry are the same for all, and the pathway we suggest can be applied to any patient in England. This section of the report sets out to describe how a service built around the offer and pathway we have described should look to patients, and makes a series of further recommendations to support this.

Getting the environment right: the role of public health

Dental public health has a broad remit. Dentistry is only one part of delivering oral health, and trying to deliver oral health through the production of “dentistry” alone would be hugely inefficient. Establishing an environment where health can be maintained is arguably the most important contribution a government can make to healthcare.

Under the Choosing Health banner, DH has published *Choosing Better Oral Health: An Oral Health Plan for England*,¹ which sets out the importance of putting oral health within the context of wider public health and policy developments.

In dentistry, the extension of water fluoridation is a part of this, and should confer a benefit at all ages,² but it is only one part. There is a wider responsibility, and it is important that oral health is embedded into general public health initiatives in a holistic way.

The options for initiatives on public health are many. In Scotland, the Childsmile scheme has taken an innovative multi-professional approach to preventing dental caries by bringing together health visitors, schools, dentists, dental nurses and others. It is ambitious and has involved considerable investment, and evaluation suggests that it is working to reduce inequalities.³ Similar initiatives are being used on a smaller scale elsewhere, but a co-ordinated approach may be valuable in maximising the potential.

Social marketing development and ambitions should incorporate dental behaviours in future work. These can build on the importance of the Brushing for Life campaigns. The development of the “healthy foundations life stage segmentation model” described in *Ambitions for Health*⁴ could provide a good basis for DH to examine, improve and monitor simple dental behaviours, such as regular brushing with a fluoride toothpaste.

Blackpool PCT has developed a suite of leaflets aimed at different segments of the community that give key information on lifestyles which will support good oral and general health, contain information on the use of fluoride toothpaste and give clear information on how to get access to a local NHS dentist.

Brushing your teeth for two minutes twice a day with a fluoride toothpaste plus regular dental check-ups can help prevent most dental problems

Dental Helpline
For advice on how to find a local NHS dentist or for urgent treatment call
01253 655 200

Monday to Friday 9am – 5pm (Calls Monday to Friday between 6pm and 9:30pm, weekends and Bank Holidays are for emergencies only)
Saturday 10am – 2:45pm
Sunday 10am – 2:45pm
Bank Holidays 10am – 6pm
www.blackpool.nhs.uk

NHS Blackpool

Taking care of your teeth for teenagers and young adults

Bad breath, stained teeth, tooth decay, gum disease, tooth loss, dental erosion

If you don't look after your teeth and gums properly you could suffer from any of these conditions that will make you stand out from the crowd for all the wrong reasons! Teeth do many different jobs. Teeth help us to chew and digest food; they help us to talk and pronounce different sounds clearly and help to give our face its shape. A healthy smile can be a great asset and because this is so important, it makes sense to give your teeth the best possible care.

Keeping your teeth and gums healthy

It is easy to get your mouth clean and healthy, and keep it that way. A simple routine of brushing and cleaning between the teeth, good eating habits and regular dental check-ups can help prevent most dental problems. A few changes to your daily routine can make a big difference in the long run.

Brushing: hints and tips

- Brush your teeth twice a day – clean teeth last thing at night before bed and at least one other time each day
- Use fluoride toothpaste (1350 ppm fluoride or above)

Eating healthily

- Try to reduce the frequency and amount of sugary foods and drink you consume
- Try to limit sugars to meal times only (including drinks)

Blackpool's GoldenSmile:
THE NEW CARE OF YOUR DENTAL NEEDS

There are multiple opportunities to embed oral health in public health: national campaigns around preventive behaviours to support patients in taking greater responsibility for their own health; monitoring and promoting good oral health behaviours alongside alcohol reduction and smoking cessation programmes; recognising the common risks shared with major oral diseases (decay, gum disease and oral cancer);

and defining actions to create a healthier environment (e.g. working with the food industry to reduce levels of sugar).

We recommend that every opportunity is taken to place oral health firmly within public health and vice versa, with activities such as diet improvement and smoking cessation mainstreamed within dentistry and oral health risks addressed by wider public health initiatives.

Once again there are examples of good practice, and this recommendation simply requires will and co-ordination.

Accessing a dentist: capacity

There is a widespread perception among the public that it is difficult to find an NHS dentist. In Chapter 2 we presented some recent findings which suggest that the problem is localised, but locally severe. Access is not just a matter of geography: some specific groups, such as Armed Forces families, nervous patients, patients with special needs and many others, also have specific problems. Where access is a problem, the lack of capacity has a major impact on local people's lives and it is right that DH addresses this as a priority.

Official access statistics, as they are currently measured, calculate the proportion of patients in a PCT who have been seen by an NHS dentist over a two-year period. This does not take into account those who have not tried to access the service nor those who are willingly in private arrangements. More subtle and meaningful measures are being developed and are essential to ensure that resources go to where they are needed.

DH has already set up a programme to support PCTs in closing the capacity gap by March 2011, and is committing considerable additional resource to this. This is an important part of addressing the problems of poor access, and the review team has been working with the access team as the review progresses.

We recommend the continued support of the dental access programme, but recommend that key recommendations from this report are piloted through the current round of procurement.

Important though capacity is, our work suggests that simply increasing capacity will not necessarily address all the problems of access, nor ensure that people get the services they expect from their NHS dentist. There are simple steps relating to information and organisation which may make a substantial difference to perceptions of access.

Accessing a dentist: information

From the work of this review and that from other consumer organisations, there is a clearly expressed need to empower patients by improving the provision of information on how to find and use dental services.

Many people looking for a new dentist find it difficult to find one even when the area is well provided for. The telephone directory is ill equipped to provide up-to-date information about NHS services.

The route with the most accurate information is usually to call the local PCT's dental helpline. However, many people have never heard of the PCT, let alone know where to find it, what it does or that it has a helpline. There is a significant mismatch between the way information is provided and the way that people want to use it.

The following strategies would be relatively easy to implement and would substantially help to close the information gap:

- Aligning NHS Direct, NHS Choices and the PCT helplines. There should be one common, updated source of information. The NHS Choices website may be the most obvious common source.
- Assigning local and national responsibility to keep the NHS Choices website up to date.
- Promoting helpline numbers more widely.
- Placing information on how to find a dentist where the public tends to look (telephone directories, GP surgeries, etc.).
- Requiring NHS dentists who cannot take new patients to direct them to the appropriate source of information.
- Providing clear, appropriately distributed information on the rights and responsibilities of patients and clinicians.

We recommend much more co-ordinated communication, nationally and to local populations and through the most appropriate media, on how to find a dentist and what to expect from a dentist when you get there.

Some PCTs are using social marketing strategies already, but there may be a case for imaginative national initiatives as well.

Access to pain relief and urgent care

When a dental problem such as a toothache or abscess occurs, the pain experienced can be considerable, intractable and distressing to the individual. If dental care is not available, for whatever reason, sufferers can be driven to extreme measures in order to address their pain.

There are also wider social costs that arise when people cannot access urgent care easily: increased demands placed on accident and emergency services, costs to employers and reduced productivity. There is a strong case for urgent treatment to be as definitive as is possible in an emergency setting, so that the problem does not recur. Poorly delivered services can cost a lot of money and time, without solving the problems that they are there to solve.

For example, data on dental prescribing^{4,5} indicate high levels of antibiotic prescription. In 2008 nearly 3.7 million antibiotic prescriptions were issued by dentists, representing 9.4% of all antibiotic prescribing in the NHS. Many patient histories we heard reinforced this, describing repeated episodes of pain managed ineffectively with antibiotics and without dental intervention. While antibiotics certainly have their uses in dentistry, managing simple toothache is rarely one of them; there are much better dental solutions which every dentist is equipped to deliver.

All PCTs offer urgent care services but they are not always well co-ordinated. Information about services in and out of “normal” hours is sometimes not easily available. When patients find urgent care, the service they receive is variable. Some is outstanding (see below). The quality of services provided for every PCT needs robust evaluation, with an aim of bringing them all up to the level of the best. For patients who are in continuing care arrangements it seems reasonable that the dentist who is paid to look after their continuing care should take responsibility for their urgent care.

We recommend that each PCT should provide an accessible and effective service offering definitive urgent care with built-in quality measures, specifically including low levels of antibiotic prescription.

We recommend that for patients in continuing care arrangements it is their own dentist’s responsibility to ensure that there is prompt pain or emergency management in the first instance (during opening hours).

The Rocky Lane Dental Practice in Salford provides out-of-hours care for seven PCTs which commission co-operatively. Clinical care is available up until 10pm every day, including weekends and public holidays. Some 15,000 patients have received clinical treatment in three years, and everyone is eligible if they meet the triage criteria. Patients are given a written report to take back to their own dentist, if they have one. As part of the contract, quality measures are applied, including no more than 10% of patients requiring prescriptions and more than 95% of calls being answered within 60 seconds. These were ambitious targets when they were set, but the practice is now very close to meeting them.

Access to prevention and treatment of dental disease

Because of the long-term impact of dental disease, making provision for its prevention is good for the patient and for whoever is liable to pay, minimising the long-term damage to oral health and its cost.

For new patients entering NHS dentistry, prevention is an essential first step, but it has to be customised and properly delivered. Preventive treatment is not always about providing some sort of treatment: it is often about being able to assess the risks and communicate them to the patient. This is unfamiliar territory for many patients, who like to feel that they are getting something more tangible. Separating out this process on a pathway is a first step to address this.

An appropriate mechanism to ensure that this happens is to use a formal oral health assessment (OHA) at the point of entry to NHS dentistry. An OHA is more than a checkup – it is a formal evaluation of risk and treatment need linked to the provision of a longer-term care plan.

We recommend that new patients seeking treatment should receive a standardised initial assessment of their oral health, their prevention and treatment needs. This should be accompanied by a written report to be given to the patient.

The purpose of such an assessment is to mark a clear starting point in the pathway from which progress can be monitored, helping the dentist to assess risks and needs and providing a mechanism to share that with the patient. It takes a little time, but it should be a sound investment for all parties.

For patients who already have a continuing care relationship with their dentist we should assume that dentists have assessed risk and addressed it. There may be a strong case, however, for a formal OHA to be made at various points through the patient's life even for those in continuing care. The current "heavy metal generation" in their 40s, 50s and 60s (see Figure 1, Chapter 1) may particularly benefit from this sort of approach as they reach retirement, allowing them to understand and plan for their longer-term needs, options and costs as they age.

When prevention fails, even the fillings used to treat the disease have a preventive function. Well delivered, these minimise disease progression, the need for replacements and therefore cost. Premature failure of treatment should not cost the patient or the taxpayer, and in the next chapter we will discuss the need for longer periods of indemnity for dental restorations, with the responsibility falling on the provider.

Access to continuing care

Continuity of care is about patients being able to get their routine care from the same dental practice over time. While not strictly necessary as a model for delivering care, there are significant benefits for the clinical relationship between patient and dentist.

It implies responsibilities: if the dentist is to be paid for taking responsibility for the patient, then that includes urgent treatment; equally, the patient has a responsibility to abide by the recall intervals advised by the dentist and to take reasonable steps to look after their own oral health.

There are considerable advantages to the patient in continuing care. A dentist who knows that they have a long-term commitment has a strong incentive to provide good preventive advice and support and to carry out the treatments that they believe will have a long-term benefit to the patient. Even for those at low risk of conventional dental disease, regular oral checks serve a purpose in the early detection of other oral conditions, not least oral cancer.

In continuing care, the dentist can also make an informed assessment about how often they need to monitor the patient. This is a vexed area: NICE guidelines recommend a variable interval – from three months to two years based on risk – but both dentists and patients are finding it difficult to break the habit.⁶

Longer recall intervals are a marker of success, not an abdication of duty, and the recall interval is integral to a continuing care arrangement. A move away from the six-month interval should be the prize of a preventive-led service, releasing resources for other services. Subject to emerging evidence, strong and aligned messages may be required to help patients to understand the advantages of longer intervals. The essential element of continuing care is about the relationship, not the frequency.

Allowing for continuity of care in the system does not mean that patients do not also have the right to change their NHS dentist should they choose to. While allowing for continuity of care, the system must also allow patients to exercise informed choices on which dental practice they will attend.

We recommend that the rights and responsibilities described in the NHS Constitution underpin and are articulated for patients in continuing care. These should be nationally applied and should include the right to return to the dentist for urgent care if required and dental checks and treatment as deemed appropriate by the dentist.

There will need to be some further consideration of how these responsibilities may be articulated, for example related to how long a patient can be considered as “registered” with a practice and what the obligations are on patient and dentist, but we believe that the principle is clearly in line with the NHS Constitution.

Access to advanced and complex care

According to the pathway, advanced treatments such as crowns, bridges and molar root treatments are rightly part of the NHS service, but only when subject to certain conditions being met. These services have always been present and represent a substantial cost to the taxpayer and usually to the patient themselves.

Providing such time-consuming, technically demanding care can be a good investment where it will be valued by and provide benefit for the patient, and where it will survive the rigours of the mouth. Providing such care in an environment where risk is not managed or where mechanical survival is unlikely is a waste of personal and public resource. Making the decision about when it might be appropriate to treat is not easy and requires clear guidance.

We recommend that patients should be offered the advanced services from which they will benefit, consistent with evidence-based guidance where possible and best practice guidance where not.

From the point of view of the patient, the rationale for separating out advanced and complex services from routine care is that:

- it allows these technically demanding procedures to be undertaken by dentists who are best equipped to do the work
- it should allow the best return on patient and public investment by ensuring the best clinical result.

Not every individual dentist can, or will want to, provide all of these services, though in a large dental practice a full range of treatments may be available. The balance between providing convenient services as well as providing high-quality care will be for local PCT commissioners to consider.

Advanced care of a different kind is required for people with additional or specific needs who find it difficult to access care from a conventional “high street” general dental practice. This might be because of a complex medical history that impacts on treatment planning or delivery, or it may be a result of a disability that means that the dentist needs to adapt the way in which care is provided. Such patients often come under the umbrella of special care dentistry, which is frequently provided by the Salaried Dental Services (usually a provider arm of the PCT). However, some such care can be provided in general practice if there are dentists who are equipped and able to provide it.

The remit of the Salaried Dental Services is not always well understood, with the potential for inappropriate referrals and patients bounced between providers, sometimes also including hospital services. It is important that special care services are used appropriately. *Valuing People’s Oral Health*⁶ provides advice in this area and commissioners should use this to help align services to need. Local services for patients could also be helped by local patient pathways and clinical networks involving specialists in special care dentistry, supported by commissioning plans and providing local information to patients and their carers.

Patient charges

Patient charges for NHS dentistry have existed since 1951, and they provide an important source of revenue to support the provision of NHS dental services. In 2006, the patient charges system was changed, reducing the complexity of patient charges from over 400 fees to three broad bands. This dramatic simplification of the system was intended to make patient charges far clearer.

However, our research found that many people who use an NHS dentist still did not know what the new patient charge system is, what is included in each charge band or how much they would pay. Anxiety about cost is considerable.

In many cases, patients were surprised by how little they would have to pay. Patients also liked the simplicity of the system, but it is not perfect: the three charge bands mean that different patients can be paying the same charge but be receiving very different amounts of treatment. This is not necessarily fair and does not always provide incentives for good self-care.

Having considered the evidence we have gathered, we think that there are some broad principles that should be applied to any future charging regime. Charges:

- **should be simple** – our research suggested that up to around 10 price bands would be acceptable
- **should be fair** – the charge should broadly reflect the cost of providing the service
- **should provide incentives for patients towards good self-care.**

There are inevitable trade-offs between these three principles and no system is perfect, but the weighting of the current system is perhaps too simple. Furthermore, the current system is directly aligned with the UDA bands, which determine the remuneration of dentists. This is limiting and not necessary.

Patient charges do not need urgent reform. In changing charges, there is inevitable uncertainty about the effect on services. Contractual changes we recommend could result in a rise or fall in patient charge revenue, and this should be tested carefully through piloting before it is considered whether the charges need to be altered.

We recommend that DH review patient charge structures in light of evidence from piloting the contractual changes. Any revisions to patient charges should be within the principles that they are clear, fair, simple and support appropriate behaviour.

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5 Delivering oral health in the NHS: the dentist

In this chapter we will explore how the system can help dentists to take back responsibility for their primary role: the delivery to patients of excellent clinical care. We outline the potential to realign contracts through blended arrangements, including payment for continuing care, activity and quality. We also discuss how more complex treatments may be handled and the potential for using the workforce more imaginatively.

Basic contractual structures

If we are to realise the ambitions in Chapter 3 then we need to learn from the experiences the past 50 years, as well as using what we know about the current system to align the incentives to the vision we have described.

Our review has highlighted that there is no single contract currency which is capable of reflecting the complex nature of the delivery of modern dental care.

We therefore recommend that the current contract framework is adapted to support dentists in improving oral health by using a contract built around two parts: routine care and advanced services. Both parts should ensure much clearer incentives for improving health, access and quality.

The routine care part of the contract would largely be delivered to patients within a continuing care relationship, and **we recommend that the contract framework is developed to allow payments for continuing care responsibility (the number of patients) and quality, as well as for activity.**

Successful practices (those achieving high-quality scores and expanding access and with a good patient experience) should be allowed to expand. In contrast, practices where quality, patient experience or access are poor, while being supported in trying to improve, should not be completely protected by a guaranteed income. This will require greater flexibility and also careful management and excellent commissioning, but the principle of competition on quality and access rather than simply cost is important if standards are to continue to improve.

Dentists are responsible for ensuring that their premises match patient expectations, and of course that they are compliant with legislation. PCTs have a role to play here by auditing dental estate so that they can aid dentists in identifying problems and also help them to target capital in a rational and cost-effective way. A national template for such an audit, perhaps operated through Primary Care Contracting, would provide a much clearer picture of current national needs.

Continuing care payments

Paying dentists per registered patient is not a new idea. There was a component of continuing care in the 1990 contract and in the PDS pilots leading up to the contract change in 2006. The impact of capitation payment in terms of activity and patient charge revenue remains an important consideration. In addition, the levels of intervention and management required to keep a patient fit are open to variation, depending on the practice profile.

We recommend that the basic value of the capitation payment should be nationally determined, but then weighted in a predictable way to take account of the practice profile.

We propose that this should be done using the key demographics of the patient population. Deprivation, age and perhaps region (for instance, to account for fluoridation) are probably the key predictors of need. Appropriate weighting of the payment should help to ensure equality of opportunity for all population groups.

Activity payments

Part of the contract value should be activity payment, but with a better match between the work involved and the level of payment. This would mean that payments should be banded more sensitively, with a better match to volume of care. For example, single small fillings would receive a much lower fee than several large fillings or a root filling. Specifically, there should be identifiable payments for preventive activities such as diet and hygiene advice. These would all be subject to quality measures based on improving outcomes.

We are suggesting that certain advanced treatments should be covered as a separate schedule to continuing care, including many of those in Band 3, so a realignment of the levels of activity payments is inevitable and desirable.

Furthermore, as activity payments would provide only a proportion (potentially a minority) of the total contract value (subject to evidence from piloting), the individual payments for activity will be much lower than they are now under a blended contract. It will not be possible to achieve the contract value without activity, but the risks resulting from coming in above or below the target activity would be substantially reduced. Initially, flexibility will be required.

There is excessive variation in existing activity payments, as measured by UDA values. This is not equitable for dentists or patients; the variation is likely to affect marginal decisions about what to provide and how it is provided.

It is also important that time spent supporting individuals to look after their own health is recognised as a bona fide activity within the activity section of the contract.

We therefore recommend that the activity payments have a more sensitive banding structure and less range in value and explicitly recognise preventive activity. There may be a case for specific payments related to taking on new patients, where the level of activity initially may be higher.

This is about a fairer redistribution of resource to help payments to map better to activity and to reduce some of the perverse incentives. The number of bands and their effect on activity will need to be piloted.

The routine scale and polish represents a particular challenge in terms of activity, because it represents a substantial opportunity cost. In some cases it may be no more than a cosmetic procedure; in many others it has a high clinical value. A formal scientific assessment of the efficacy of routine scaling in the absence of severe periodontal disease is overdue.

Quality payments

A system that rewards quantity alone is no longer appropriate: it misinterprets the purpose of dental care, reducing it to a shopping list.

The best dentistry in England is outstanding. The review team was fortunate to visit some remarkable practices and hear from innovative dental teams and satisfied patients. However, even the best can get better and there is substantial evidence from patient data and from dentists themselves of variation in service delivery. This is why we have suggested that a part of the contract value should be subject to meeting quality targets.

In his Next Stage Review Lord Darzi described a vision for an NHS built around quality of care.¹ In dentistry, as in the rest of healthcare, quality is a necessity not a luxury. Lord Darzi described three aspects of quality:

- patient safety
- patient experience
- effectiveness of care.

All of these have resonance for dentistry, but all three need to be interpreted for a dental environment. All of them also have to be measurable and measured. Addressing these three aspects of quality is the means by which the NHS will drive improvements in dental services.

Responsibility for quality

To assure quality at its most basic level, the Government intends to bring primary dental care providers within the scope of the registration system.²

This means that, for the first time, all of the approximately 9,000 high street dental practices will be required to register with the Care Quality Commission, regardless of whether they provide wholly private, wholly NHS services, or a mix of both. It is expected that all dentists will be registered by April 2011.

The Care Quality Commission's role in registering providers of services will complement and help strengthen PCTs' core responsibility for managing primary care contracts, will provide broader information about primary care services to the general public and will tackle unacceptably poor or unsafe performance.

However, quality in dentistry goes well beyond the remit of the Care Quality Commission. The dimension of quality with the most demanding and unique requirements for dentists is related to effectiveness. As a precise and surgical discipline there are technical aspects

to quality, for example restoration longevity and outcome, that go to the heart of primary care dentistry. Work that does not fail does not cost. Who is responsible for this element of quality?

The individual dentist, or “performer” in NHS terms, has a responsibility to use taxpayers’ and patients’ resources in the best interests of the taxpayer and the patient. However, many dentists work for a provider, the contract holder – usually another dentist. Ultimately it is providers who are responsible for delivering the quality that the NHS expects. They take the financial risks to set up and maintain the business of dentistry, but they also receive a substantial payment from the taxpayer.

We recommend that ultimate responsibility for the quality of all dental work should fall on the provider.

This includes the longevity of restorations, on which a large proportion of NHS money is spent. **We recommend that the free replacement period for restorations should be extended to three years and the provider should bear the full cost of replacement, rather than the PCT or patient.**

Measuring quality

There are other challenges. To be able to demonstrate that what we do is effective we will need to communicate well and demonstrate that, while we talk about prevention, we can actually make it work. The change in emphasis from quantity to quality will be a considerable challenge for the profession: it will require a different mindset and a different approach to care.

If quality really is to be at the heart of NHS dentistry, the environment and structure of the service will have to allow it, incentivise it and reward it. The offer, pathway and contractual structures described here are intended to create an environment for this to happen.

Quality measures have been used in dentistry, but sparingly.³ Some examples of quality metrics built around the pathway model might include:

- the rate of new patients progressing to continuing care
- the proportion of new patients or of returning patients whose risk is lowered (as demonstrated by a move to longer recall intervals)
- the increase or decrease in the rate of restoration, across a sample of patients, year on year
- the proportion of continuing care patients seen in out-of-hours emergency services
- the rate of antibiotic prescription.

The starting point for metrics such as these will be different for every practice and, for reasons out of the control of the practice, the improvements that are possible will also vary. However, all should show improvement with time and good practice and all should be broadly similar when practices with similar profiles are compared. The purpose is to pull quality up towards the best, not to impose sanctions on the worst.

We recommend that the contract framework should explicitly reward the contribution of the dental team to improvements to oral health, reflected in patient progression along the pathway, compliance with nationally agreed clinical guidelines and the achievement of expected outcomes.

We recommend that quality outcomes are supported by nationally derived quality measures.

These will also require data and information. The way this information is used by dentists and PCTs is critical. The profession knows what quality looks like and professional involvement is essential in developing the best ways of measuring it. Quality payments will be dependent on reaching minimum targets and then demonstrating improvement. DH has already taken initiatives to develop quality outcomes for dentistry through its Clinical Effectiveness and Outcomes Group. This is now an urgent requirement and it is important that this is a national activity.

There is an opportunity to establish new quality standards and guidelines through the quality standards programme being set up by NICE in response to the Next Stage Review.⁴ Existing guidelines and standards are few in dentistry, and the need to develop these is a high priority.

Advanced care

By taking the most demanding types of care out of the routine and continuing care part of the contract, but linking them to the pathway as an additional step, it is possible to do five things:

1. Improve efficiency by directing the care to those who most need it.
2. Improve efficiency by ensuring that it is the practitioners who are equipped, skilled and willing who undertake the procedures.
3. Achieve better long-term outcomes.
4. Ensure that the oral environment is good and risks are reduced before decisions to invest in complex treatments are made.
5. Allow career development for young dentists, who can invest in a growing skill base over time.

The report of the Health Select Committee was concerned about a fall in “complex care”, identifying this as a marker of limited access to quality.⁵ But complexity and quality are two different things. When it referred to complex care, the Health Select

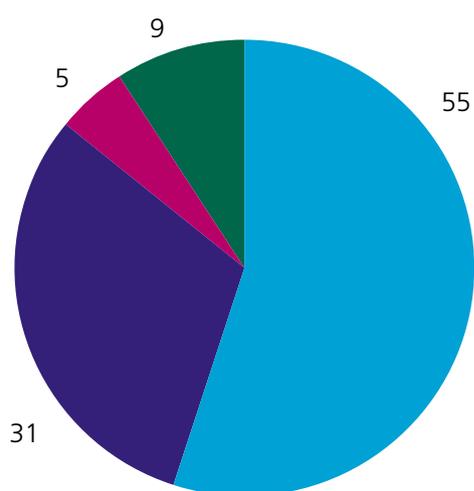
Committee was referring to Band 3 treatments – those requiring laboratory work. However, many complex procedures are outside Band 3, and complexity can relate to the patient as much as the procedure.

Clinical decisions in dentistry do not lend themselves to algorithms or a simple assessment of “need”. They are dependent on subtle judgements, so are easily influenced by financial or other incentives. There are a number of reasons why Band 3 treatments reduced, some good reasons and some poorer ones. Throughout this review it became clear that it was impossible to identify a “correct” level for complex care from existing data. At present, Band 3 treatments account for only 4.7% of courses of treatment but 26.3% of UDAs (closely approximating to cost).

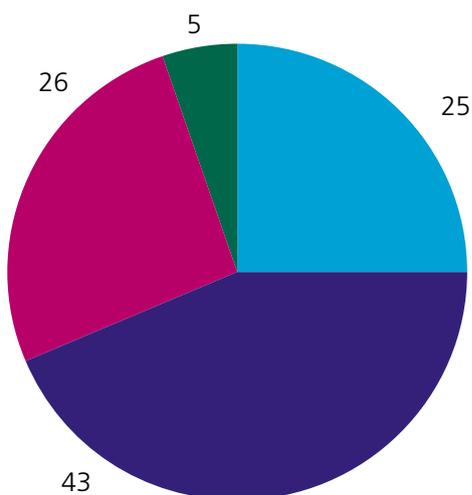
Figure 5: Band breakdown

These charts show the breakdown of the different bands for adult patients in 2008 – both as the proportion of courses of treatment (Chart a) and as the proportion of UDAs paid for (Chart b). Band 3 treatments (requiring laboratory input) account for over a quarter of UDAs.

a) Courses of treatment by band (%)



b) UDAs by band (%)



■ Band 1 ■ Band 2 ■ Band 3 ■ Urgent

Number of UDAs per band

Band	UDAs
1	1
2	3
3	12
Urgent	1.2

This area needs fresh thinking. Further reductions in certain treatments should not be seen as a problem provided the reasons for the reductions are understood, and indeed reductions might be expected in a more prevention-orientated NHS dental service. The priority has to be to provide advanced care for the most appropriate cases, where clinical benefit is highest and risk is lowest. For the last 60 years of NHS dentistry the financial incentive has been to do a lot of treatment often, rather than to do it to last. Complex treatments, whether Band 3 or not, consume the resources of the taxpayer, the patient and potentially the dentist, so they need to be provided to a high quality to minimise the risk of failure. It is primarily for this reason that we suggest that they are managed separately, outside the main continuing care contract.

In large practices the full range of possible services may be available, with individual performers taking lead roles in specific areas; in other cases, patients may have their advanced care needs met by a dentist in a nearby practice. Local networks in advanced areas of care already exist in NHS dentistry, and these can provide an important clinical governance function.

Examples of services for patients with specific management needs:

- domiciliary care
- sedation services for anxious patients
- urgent services out of hours or for casual patients.

Examples of advanced/high-skill treatments:

- advanced restorative care including multiple crowns, bridges and occlusal rehabilitation
- complete dentures (potentially through clinical dental technicians)
- molar endodontics
- minor oral surgery
- treatment of aggressive or advanced periodontal conditions
- straightforward orthodontics
- implant retained overdentures.

It would be the provider's role to ensure adequately trained and supported performers. Formal qualification is not always necessary, but appropriate training would be. The building blocks for these arrangements are already in place in some areas.

The Faculty of General Dental Practice (UK) and DH have set out guidelines and competencies for dentists with a special interest, and these can support commissioners and providers in developing advanced and complex services.⁶

Activity payments for high-skill procedures need to be set appropriately, bearing in mind that what is described above should lead to efficiencies and better targeting of care. The resources currently paying for work that is not clinically appropriate would be better invested in treatments that are, and in doing them better, lengthening the life of the treatment and freeing up resource in years to come.

For some of these very high-skill procedures there may be a case for reviewing patient charges, as there may be an impact on overall patient charge revenues. This will require the evaluation of appropriate pilots.

Investing in quality

A recent large study of an insured US population showed that the rate of survival for 1.5 million root-treated molars was 97% at eight years.⁷ A recent, smaller, UK study based on pre-2006 data suggested failure of 2.7% per year, implying 78% survival over the same period,⁸ supported by national data showing a similar rate.⁹ While this seems reasonable, it still describes a different trajectory from the US and this is important when the next stage of treatment is likely to be tooth loss. The question is, what investment would be required to improve on this? It might be relatively small if we were able to target resources to the most appropriate cases, doing fewer better, by dentists who are the most skilled and equipped to do them and ensuring follow-up restoration with a crown, which is a major determinant of success.

We recommend that contractual schedules are introduced, through which the more complex and demanding treatments are provided appropriately by dentists skilled and equipped to provide them to a high quality.

The ability to deliver this is dependent on the contractual adaptations already described, and this concept should be piloted along with the other contractual alterations. However, the basic concept is already being used in some areas where dentists have small orthodontic or sedation contracts.

Work requiring dental laboratory input

There are some very specific issues related to the production of dental appliances such as crowns and dentures in dental laboratories. Because the cost of the laboratory fee is incurred by the dentist, there is an incentive to seek the lowest price, even to the detriment of quality or even necessity. There are also financial temptations for the laboratory, again working against the patient. Costs can be kept down by using inferior materials or by sub-contracting work overseas without necessarily having tight quality assurance.

This is a very difficult area: choice, equity and resource need to be balanced. There are various possibilities to address this imaginatively, including direct payment by the patient to the laboratory (perhaps from an accredited list of laboratories) or by the use of a voucher system, with or without top-ups. The latter would increase patient choice but may raise questions of equity.

The appliances made in dental laboratories are medical devices and subject to EU medical devices legislation, which require a Statement of Conformity to be issued. There is no real reason why this should not be passed on to the patient as a matter of course. Despite the technical nature of the document, making it available might empower the patient and the NHS.

Quality assuring laboratory provision and ensuring patient choice are important, and these are all worthy of consideration in the longer term.

A high-quality dental workforce

In the course of our review we have received formal and informal submissions from a variety of groups with an interest in the dental workforce, highlighting the importance of effective training and development of the whole dental team. These range from hygienists and therapists, for whom there are now many formalised courses and clear pathways, to clinical dental technicians who could provide an important service for older people but for whom there is not yet a fully established training pathway.

Over recent years there have been a number of changes to the regulatory framework, which means that there is less restriction on delivering dental care, providing opportunities to increase the range of dental professionals in the dental team. The General Dental Council now registers the following categories of dental care professionals:¹⁰

- dentists
- dental therapists
- dental hygienists
- dental technicians
- clinical dental technicians
- dental nurses.

Earlier in the report we described our vision for a care pathway which has implications for the whole workforce.

Providers gave mixed accounts of their experiences using, for example, dental therapists, with some seeing it as a false economy and others seeing it as a good business model. Providers will only use the full range of professionals available to them if it helps to deliver a cost-effective and high-quality service. The onus to use a flexible workforce cannot fall only on providers: commissioners need to recognise the possibilities and facilitate the process.

We recommend that commissioners should find ways to support dentists to make best and most cost-effective use of the available dental workforce.

We recommend that PCTs and Deaneries should work together to align their educational programmes to support the future models of service delivery.

The changes to the dental system outlined within this report will have implications for the training and development of the dental workforce in the future. This includes consideration of the numbers of dental professionals trained and systems for retaining them within the workforce. The Dental Programme Board of Medical Education England has been established and will factor this into its work programme.

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6 Delivering oral health in the NHS: the role of primary care trusts and the Department of Health

In this chapter we examine the steps that PCTs and the NHS could take to develop better services. These include suggestions for a fairer allocation of resources to PCTs, and clearer structures and lines of responsibility across the NHS to ensure high quality of commissioning. We identify the quality of data, and the information derived from this, as essential for monitoring and improving the quality of care and we also make specific recommendations about the collection of data and the appropriate use of IT.

Role of commissioning in dental care

PCTs are the agents of the public. It is their job to plan services to ensure equity of provision and, through the commissioning process, to convert taxpayers' money into high-quality, safe and effective services.

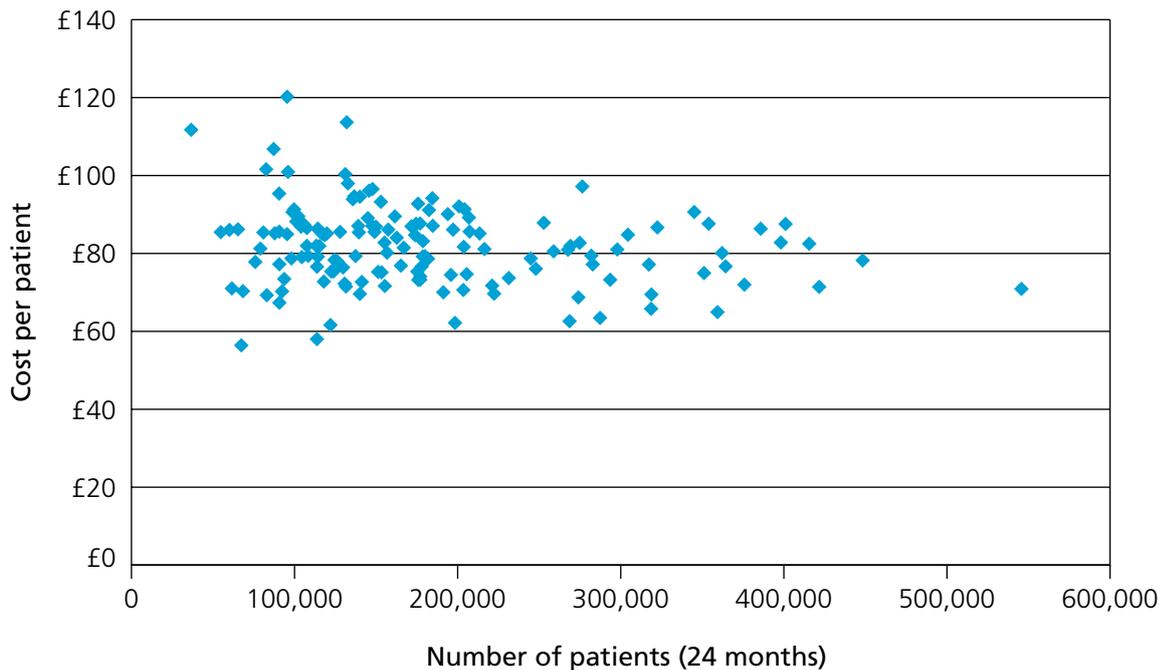
“When thinking about a service, everyone is urged to think of the same two questions – firstly, is this a service that I would be happy for a member of my family to use? Secondly, if this were my own money, would I be content with the way the money is being used? If the answer to these questions is ‘yes’, we are succeeding; if it is ‘I don’t know’, then we need to find out, and if it is ‘no’ – then action is required to remedy this.”¹

We believe that the local commissioning of dental services, introduced in 2006, was the right thing to do. Retaining money and responsibility at a local level means that the NHS can develop the most appropriate services and target resources to where they are most needed. Our review has shown that there is some very good commissioning taking place but it is by no means universal. The aim should be to ensure that all PCTs operate at the best possible level.

Aligning PCTs' resources to need and demand

Currently, money is neither distributed evenly nor according to need, but is allocated largely on historical activity levels under old contractual arrangements. This is true both for overall PCT allocations and for the distribution contract values within a PCT area. PCTs are spending widely differing amounts per person in their areas, with especially wide variation in those PCTs with fewer people accessing dentistry.

Figure 6: Number of patients seen in previous 24 months against cost per patient for each PCT (2008/09)



In order to understand how funding allocations could provide more support to the commissioning of NHS dentistry at a PCT level, we commissioned an analysis of the factors that influence spending on NHS dentistry. The following factors were potentially significant in determining appropriate funding:

- Population – analysis suggests that population alone can account for over 70% of the variation in dental activity across PCTs.
- Demographics – age is a clear driver of need, though the overall cost impacts of different age groups are hard to determine.
- Socio-economic factors – dental activity was at an increased level where unemployment was higher and professional employment was lower.
- Local market factors – the main resource allocation to PCTs already contains a market forces factor and this should apply to dental resources also, as some areas are simply more expensive to operate in.
- Access issues – some areas are lacking in NHS dentists and, in principle, may need additional funding in order to attract dental capacity.
- PCT cross-border flows – people are free to access NHS dentistry wherever they like, so significant provision occurs in major employment areas.
- Patient charges – PCTs also rely on patient charge revenue (PCR) to support funding of dental services. PCR can fluctuate depending on the ratio of activity for exempt and non-exempt patients.²

We recommend that funding is allocated to PCTs on a per capita basis, adjusted for need by taking into account the factors described above. DH should aim to begin applying these principles in the funding allocations for April 2011.

This approach of using weighted capitation is consistent with the approach taken to allocate the majority of NHS funding to PCTs. The allocation should aim to ensure equal access for equal need, for all those who want to access NHS dentistry.

PCTs' infrastructures for local commissioning

In our review we have found some examples of excellent commissioning of dental services at a local PCT level. Where this occurs there is often a clear infrastructure in the PCT, supported by demonstrable leadership – both clinical and executive.

Clinical leadership typically comes from consultants in dental public health, who are effectively the patients' advocates and should have responsibility for ensuring that PCTs have plans in place to meet their population's needs. Ready access to advice from a consultant is essential in all PCTs. Dental practice advisors offer recommendations to PCT commissioning managers about clinical issues and also have important roles to play.

DH has commissioned a review of the capacity and capability of the dental public health workforce and, once published, this should help to ensure that PCTs have access to appropriate advice and strategic planning.

Good advice is an essential part of effective commissioning, but good partnership working with local dentists is every bit as important. Where relations between the PCT and a representative local dental committee are at their most professional, contractors understand what PCTs want from their investment and PCTs understand the needs of the contractors.³ A good relationship is better for everyone – particularly the patient.

Previously, we outlined the responsibilities of providers and performers for overall contract delivery and for the quality of clinical care. Dentists need enhanced management and leadership skills and greater involvement in order to deliver this. For example, few PCTs have a dentist on their professional executive committee. Given the unique needs of the dental service, we consider it will be highly desirable in the future to include a dentist on the committee.

We recommend that clinical leadership in NHS dentistry is promoted actively and included in other NHS leadership initiatives, as well as in local engagement.

All of this planning, advice and communication needs to be backed by support from executive and non-executive directors to ensure that the PCT is meeting its responsibilities. However, we found that dental commissioning is often undertaken by relatively junior members of the commissioning team who have to juggle multiple responsibilities with little senior management support, and sometimes without the appropriate dental public health support.

We recommend that PCTs are held to account, as part of the World Class Commissioning assurance process, for their effectiveness in commissioning dental services, particularly with regard to the PCT's leadership, public engagement and clinical engagement (specifically using consultants or specialists in dental public health).

We recommend that SHAs, as part of the assurance process of World Class Commissioning, should be responsible for ensuring that PCTs have appropriate commissioning teams in place and should provide robust support and advice about appropriate organisational structures where these are lacking.

We also recommend that DH should monitor and support this process.

If dental commissioning is to become truly world class, as outlined in *World Class Commissioning: Improving Dental Access, Quality and Oral Health*,⁴ then much greater emphasis needs to be placed on the quality aspects of the stages of the commissioning cycle.

Quality in assessing need and strategic planning

We found that in areas where local commissioning is working well, there is a clear strategy for improving the oral health of the local population, which is agreed at board level and is regularly updated as part of the core business of the PCT. Such strategies and commissioning plans are important in communicating the direction of services.

Cumbria PCT has developed an oral health strategy and commissioning plan that was signed off by the professional executive committee and which provides the strategic direction for the PCT. A number of new services have been commissioned in line with the plan and it has been discussed by the overview and scrutiny committee. The plan has allowed the PCT to be clear about its commissioning intentions, both to the local public via local press and radio advertising, and to prospective providers through market stimulation events. It has provided clarity on developing clinical networks for specialist and complex care in association with local secondary care providers.

Oral health strategies and commissioning plans should include elements of public health activity that lie outside those treatments which are provided to patients in the dental surgery.

Quality in procurement

It is important that commissioning organisations develop processes for selecting providers that are fair and robust and, importantly, that ensure the best value for taxpayers' money. Experience is developing but there are concerns about commissioning based on price and not on quality. Because of the long-term implications, low initial cost can prove to be a false economy.

To guard against this, PCTs should develop clear service specifications that include quality indicators and standards. This is particularly important for advanced services, which require appropriate levels of skill, staff and technology to ensure that best value is delivered for patients and taxpayers.

Some PCTs are now seeking to commission collaboratively, especially for advanced services such as conscious sedation, salaried dental services and more specialist services such as orthodontics.

We recommend that, for some advanced services, PCTs consider combining commissioning resources and expertise.

Quality in the contract

In Chapter 3 we set out a vision of the type of service that befits the modern NHS. The contract put in place between commissioners and providers is crucial to its successful delivery.

The contracts that PCTs can put in place to deliver primary dental services are governed by regulations, and while PCTs have flexibility in developing contracts and interpreting the regulations, there is little evidence that they have used this. Most have tended to continue with the nationally developed model contracts and have focused heavily on performance of UDAs.

In our review of contracting forms, we found that simply contracting on the basis of numbers of treatments tends to encourage the delivery of those treatments at the expense of quality and prevention.

Some PCTs though have started to use the flexibility available to them. They have introduced more specific requirements and levers in the contract, reflecting their ambition to improve quality or to focus on prevention. These approaches need to be developed in order to support the vision of care we have outlined.

We recommend the development of contracting forms and incentives to reward continuing care, activity and quality. These should be developed via a centrally managed set of pilots and robustly evaluated.

NHS Bradford and Airedale PCT identified poor oral health and dental access as key issues for its local population. In February 2007 the board agreed a substantial investment in three new dental practices alongside a new commissioning approach, creating a contract that rewarded quality, oral health promotion and disease prevention as well as dental activity.

This required the development of new funding mechanisms that made clinical quality and oral health pathways integral to the contract value.

The contract ensures that all patients have their oral health risk assessed before they enter an evidence-based preventive care pathway appropriate to their needs.

Oral health outcome measures have been developed in partnership with providers and have been linked to the contract payment mechanism, ensuring that payment is linked to oral health improvement.

These developments have involved engagement with local clinicians and providers of the new services, and have been piloted with a peer review group of local dentists prior to implementation.

Board-level leadership, a strong commissioning team and the involvement of key stakeholders throughout the process have been vital in the development of such new initiatives.

Within revised contracts, access to dentists needs to more appropriately match patient need. For example, contracts should ensure that there is availability at times which will be convenient for patients, perhaps early or late sessions or weekend opening. Restricting opening hours is not good use of expensive premises and equipment, is not good for the wider economy, does not widen access, and does not help the perception of access. This is for commissioners to address in consultation with providers, and is one way of expanding successful practices where they compete with each other on quality.

National definitions of quality that do currently exist are almost exclusively geared to narrow measures of access.⁴ In examples of some of the best dental commissioning available, several PCTs have developed local schemes to build quality measures into contracts and have also engaged patients and dentists. However, there is a real danger that different quality systems will arise in different PCTs, leading to further tensions between the dental profession and the NHS, duplication of effort and difficulty for larger contractors and software suppliers that operate across PCT boundaries.

We recommend that representatives of the NHS and the profession develop a common set of national indicators that can be used locally to measure the quality of processes and outcomes delivered by providers in a meaningful and appropriate way.

When these become established there should be no reason why providers' results should not be made available to the public, for example through NHS Choices.

Quality in contract review, research and audit

Almost everything we have described so far, including the recommendations we have made, requires data and information if the NHS is to deliver better care. The source of this information is the data recorded concerning treatment and advice, which is catalogued at thousands of consultations between dentists and patients every day.

The lack of information and data to support meaningful contract review has been a feature in many of the discussions we have had with dentists and commissioners.

If the benefits in effectiveness and quality are to be realised then there must be a step change in the approach to data and information. We have discovered that only around 70% of current providers submit the current limited dataset using electronic means; many still use paper-based systems. We think that this approach is unsustainable in the modern NHS.

We recommend that a clear commitment is made to ensure that all NHS dental practices are computerised by the end of 2011 in a way that allows easy transfer of data from chair-side to NHS Business Services Authorities and PCTs.

We recommend that the capacity to collect and analyse these clinical data at the level of the individual tooth is rapidly re-established and piloted.

Following discussion with suppliers of dental clinical software and the BSA, we are advised that they would be able to implement the collection of such datasets and their transmission to a central source within a 12-month period.

In 2005, £30 million was earmarked within the NHS's National Programme for Information Technology to bring NHS dentists into the programme. Some PCTs have recognised the benefits of this approach in communicating with and supporting their dental providers. Unfortunately, there has been no national progress on this issue.

In 2006, Sunderland PCT invested in IT facilities for all of its primary care dental practices. At a minimum, it offered a single terminal in order for the PCT to communicate with the practice. As an alternative, the PCT offered a fully linked IT system that used clinical software from one of the major suppliers. This allowed detailed clinical data to be stored on a central PCT server and accessed by the practice. The PCT did not have any access to clinical data, though the longer-term aspiration was the ability to generate detailed reports.

There were considerable problems as the system bedded down as well as anxieties among practitioners relating to the accessibility of data, but it is now functioning well. Clearly the lessons of experiences like these need to be shared with all PCTs if a truly integrated system is to be possible.

We recommend that there should be a formal national IT strategy for NHS dentistry, aiming to link all dentists to the wider NHS within five years.

Inspection and regulation

NHS dental practices have to comply with a range of standards, from health and safety to clinical outcomes. We have already described how important it is to be able to measure and monitor quality. Dental practices are subject to substantial bureaucracy around the processes of reporting and inspection. We have already described how the CQC will include dental practices in its regulatory processes from 2011.

With the PCT, the Dental Reference Service and the CQC all involved in inspection and regulation, not to mention Deanery inspections for vocational training and voluntary arrangements such as the BDA Good Practice Scheme, the risk of duplication of effort is considerable.

We recommend that all parties involved in inspection, certification and regulation investigate how they can work together to provide robust mechanisms for inspection with the minimum disruption and bureaucracy.

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7 Implementation

In Chapter 1 we showed how the population's oral health has been changing since the establishment of the NHS. There has been a growing realisation over the years that the role of NHS dentistry needs to change with it. The proposals in this report, and the ideas that underpin them, are not revolutionary – far from it.

In the course of our work we looked at previous reviews of NHS dentistry and several have made similar recommendations to those we make in Chapter 3. Most recently there was *NHS Dentistry: Options for Change* in 2003,^{1,2} but as long ago as 1981 the Dental Strategy Review Group Report sought to encourage preventive activity, to increase access and to encourage continuing care. It identified issues such as the inequalities in the distribution of services, wastefulness arising because of inappropriate or ineffective treatment and blurring between NHS and private care.³ Nearly 30 years on, these issues still exist.

“The biggest risk is the third failure in less than 19 years... a political risk... whoever brings it in will risk failing NHS dentistry. Dentists might leave the profession to go private as has happened before.”
(Participant at engagement event, Newcastle)

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

We wanted to test the vision and the main ideas set out in this report, and to start to identify the critical factors which will support or hinder change. Consequently, we undertook a series of stakeholder events around England. For further details on stakeholder engagement see the web appendix.

The broad aims of the review were generally well supported by the stakeholders, indeed it is difficult to argue against pathways, prevention and oral health. We have sought in this review now to go further and to identify responsibilities: who is responsible for what. If there is now to be progress in implementation, all parties have to live up to these responsibilities

“I like the look of it as it appears to offer more security, seems patient friendly and allows a practice to resolve services to need far better than the present system.” (Dentist at engagement event, Birmingham)

Almost all stakeholders were naturally concerned about the implementation of the suggested contractual adjustments. These present a challenge, but are essential if we really are to realign the provision of NHS dental services towards improved oral health. However, we have made a number of recommendations which should be straightforward to implement, such as better information for patients, robust organisational structures at PCT level and the development of quality indicators.

“It is important to ensure that any change is communicated effectively to patients and dentists with clarity of treatments/charges.”

(Patient representative at engagement event, Manchester)

In the course of our review we came across many examples of local PCTs and dentists working together to deliver the type of vision we have tried to set out. There were already statutory, professional and other groups looking at or developing various elements of this model. This now needs co-ordination to align the goodwill and best intentions of all parties.

Does this require evolution or revolution? How the recommendations are perceived perhaps depends on where you stand. Contractual changes might seem like revolution and yet the concepts of local commissioning, of a contract value and even of quality payments are already firmly established and consistent with our recommendations. The current contract regulations are flexible and what we are suggesting is probably best done by moving in increments, not least because piloting is an essential element.

Establishing the principles of the contract

A key challenge is to change the contractual relationship between dental providers who work as independent contractors for the NHS and the PCTs who commission their services.

There is an opportunity to pilot several of our recommendations, including most of the recommended contractual changes, through DH’s Dental Access Programme. In the current economic climate we must use the opportunity of the injection of resource that this programme provides to learn what we can. The timing is tight, but we have worked with the access team to try to facilitate this.

To support the delivery of a staged pathway of care, we have recommended that the current contract should be developed with much clearer incentives for improving health, improving access and improving quality. We have also recommended that the current contract is developed to allow payments for continuing care responsibility, blended with rewards for both activity and quality.

We are confident that the approach currently being taken by the dental access team in developing a contract model will allow for the piloting of these elements. However, consideration needs to be given to ensuring that while the primary aim of the procurements is to establish additional dental services, sufficient effort is put into co-ordinating and designing the testing of the care pathways and the contractual models. This is a unique opportunity.

The pilots need to be robust and to be given sufficient time to settle, helping to understand how dentists, patients and PCTs react and giving time for that knowledge to be synthesised before wholesale changes are considered.

Creating new contracts to a new framework is more straightforward than converting existing contracts. It would be a mistake, however, to see the professional levers for

change as purely financial. In the pre-2006 arrangements, there were many providers who considered the arrangements to be better than the General Dental Services contract and who came forward voluntarily to convert. If existing contract holders see the pilot arrangements as a more attractive and professional option, it would be prudent to have a clear strategy for transition.

“Could we trial it appropriately before introducing it, this time?”
(Dentist at engagement event, Manchester)

“This is Options for Change revisited and to be applauded. There are possible pitfalls... but with support and sensible piloting these can be overcome.”
(Dentist at engagement event, Newcastle)

Priorities

Although this is an independent review, the stakeholder engagements highlighted the importance, and potential, of making progress on key issues. We have therefore sought to set out some immediate priorities so that we can take the opportunities available, including those presented by new procurements, and to learn from pilots. The main priorities are laid out briefly below.

Immediate priorities (within six months of publication)

- Information on access: responsibilities need to be assigned and an organisational framework set up to ensure a single source of up-to-date information on access to NHS care.
- Build elements of continuing care and quality into existing procurement as pilots within the Dental Access Programme.
- Set and model revised activity payment bands into the same pilots.
- Develop the initial quality measures that are essential for monitoring, and do this in a way that is not tied by current data availability. This needs to pull together the initiatives already under way around the country alongside the Clinical Effectiveness and Outcomes Group set up by DH.
- Cross-check the quality measures against the pathway and the data needs.
- Work with NHS Business Services Authority and software suppliers to set up consistent, detailed data collection mechanisms at pilot sites so that the impact of the changes can be properly evaluated and quality measures derived.
- Engage with NICE to start the process of ensuring that dental quality standards are established.

Medium-term actions (18 months)

- Ensure that there are proper commissioning structures in all PCTs.
- Develop an IT plan for NHS dentistry.
- Set up and receive reports from professional guideline groups. These should be able to deliver concise and effective guidelines quickly, but liaison with NICE is important.
- Develop local networks for advanced services to support advanced care contracts.
- Introduce extended free replacement period for restorations.
- Develop leadership initiatives in NHS dentistry.

Longer-term aims (three years)

- Address public health workforce concerns (recommendations from the DH-commissioned review of the dental public health workforce, expected soon).
- Set up the mechanisms for ensuring that NHS data is used for research and development.
- Improve the co-ordination of oral health and public health.
- Revise patient charges in line with contracts, if necessary following piloting.

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