“I thank the Patients Association for the pressure they put on us to keep improving standards. Long may they continue.”

Sir Ian Carruthers, when Acting Chief Executive of the NHS

The New Dental Contract - full of holes and causing pain?

A Survey of Primary Care Trusts in England

Supported by an educational grant from

6th March 2008
Call to Action

The Patients Association calls on the Government to:

• Examine the co-payments system for dentistry as the basis for expanding the availability of treatments elsewhere in the NHS.

• Ensure early diagnosis of serious oral illness e.g. cancer by giving patients the same level of preventive care as is now planned for other specialties in the NHS. PCTs must offer a complete and safe NHS dental service to their population, which was intended to be a main benefit of the new contract.

• Remove the postcode lottery for patients which results from poor or weak commissioning by PCTs. Where PCTs offer an excellent, creative commissioning structure, they should take over the dental commissioning role of those that do not. Renewed guidance on best practice in commissioning should be issued.

• Require PCTs and dentists to ensure patients are fully aware of the important changes to their NHS dental service and charges, thereby minimising patient anxiety and financial waste.

• Ensure the same level of coverage and availability of specialist treatments, e.g. root canal, orthodontics, as applies to other specialties in the NHS.

• Require PCTs to ensure dentists comply with latest infection control guidance.
Foreword by Claire Rayner, President

For over 40 years the Patients Association has fought to give a voice to patients using the UK healthcare systems. We make no distinction between NHS and private care, believing patients are entitled to use one or other or both.

We believe there should be certainty over healthcare but when it comes to dentistry, the lines between NHS and private become blurred and, for patients, muddled. Suddenly all the rhetoric about “free at the point of need” disappears and many patients have long been made to pay something towards their dental treatment. What they pay has varied and the general confusion has undoubtedly caused some patients not to go anywhere near a dentist for fear of the payment involved. We have argued over many years that there is no reason why one’s teeth should be treated by the NHS any differently to any other part of one’s body.

In the second half of 2007 we surveyed Members of Parliament about the top three health concerns of their constituents and not surprisingly Dentistry was top of the poll. Now we have taken this a stage further by asking Primary Care Trusts in England how they are responding to the new dental contract and the needs of their patients. This Report is the result and I commend it to you.

We are most grateful to Denplan for their educational grant which has made this work possible. We look to the Government to respond to our Call to Action on behalf of patients everywhere.
Introduction to the New Dental Contract

The New Dental Contract developed by the Department of Health came into force on the 1st April 2006. Its aim was to provide better access to high quality dental services and develop preventive dental work through a new charging system.

Primary Care Trust (PCT) Responsibilities

From April 2006, PCTs are responsible for ensuring that they provide adequate primary care dental services to their respective population. They are thus charged with ensuring that all patients’ needs are met within the PCT’s geographical area. Basic services to be delivered include the provision of routine and emergency care.

PCTs receive a commissioning budget allocation. The Department of Health sets PCTs a target of determined Units of Dental Activity (UDAs) to be commissioned using the allocated budget. This floor funding is the minimum that PCTs must spend and can be used for no other purpose other than commissioning dental services. Any year-end surplus is recovered by the SHA or Department of Health. PCTs also have a target for patient charge revenue, which is netted against the overall budget. A failure to recover patient charge revenue reduces the PCTs net allocation.

Local Commissioning was supposed to provide PCTs and dentists with the opportunity to:

- Match new service developments to local needs, taking advantage of the crucial change that - when local provision changes (e.g. a dentist leaves the area) - the money previously spent on these services will be retained by the PCT, which can then decide how best to deploy this funding in developing primary care dentistry locally;

- Meet the oral health needs of the local population;

- Improve the involvement and engagement of dentists in the local NHS, including contributing to planning patient pathways across primary and secondary care.

Registration with a dentist

Patients no longer need to register with a dental practice. In addition, some dental practices offer a mixture of both NHS and private dental treatment. Other practices may treat children only under the NHS (such decisions are at the discretion of the PCT). However, dental practices are not allowed to accept children on NHS treatment on the condition their parents agree to have private treatments.

Patient Charges

Except for patients benefiting from free dental treatments (exemptions remain the same as under old NHS Dental Contract), a 3 banded system determines charges patients have to pay depending on the care they receive. This 3 band system for NHS treatment replaced the past payment-per-item complicated system that comprised more than 400 different tariffs and treatments. The charges now range from £15.90 to £194 under the following bands:
1. **Band 1: £15.90**
   This charge includes diagnosis, treatment planning and maintenance (clinical examination, radiographs, scale and polish, preventive work, e.g. oral health assessment, study models, denture eases).

2. **Band 2: £43.60**
   This includes all necessary treatment covered by band 1 plus additional treatment such as fillings, root canal therapy, extractions, surgical procedures and dental additions, periodontal treatment).

3. **Band 3: £194**
   This includes all necessary treatment covered by band 1 and band 2 plus more complex procedures and provision of appliances (complex treatment including a laboratory element, e.g.: bridgework, crowns and dentures, excludes mouth guards).

Patients are only supposed to pay one charge even if they need to visit their dentists more than once to complete a course of treatment. If patients need more treatment at the same charge level (e.g. an additional filling) within 2 months of seeing their dentist, this care remains free of charge.

**Units of Dental Activity (UDAs) and Dentists’ earnings**

The new Dental Contract was expected to focus on preventive care rather than interventionist treatment and to end the “treadmill” effect of the past dental contract. Dentists entered into fixed value contracts based on the requirement to deliver a value of Units of Dental Activity (UDAs) previously agreed with their respective PCT. Dentists are evaluated on the UDAs they achieve. These UDAs are linked to the three bands system presented above; the value of a UDA depends on the type and complexity of work undertaken by each dentist prior to the new contract. The number of UDAs to deliver over the year is based on past performance. Dentists have to be within 4% of their UDAs target. If they do not achieve this, dentists are considered in breach of their contract.

The 3 band system determines both patients’ charge and the amount of UDAs corresponding to the dental treatments provided. The classification is set as follows:

- **Band 1 (excluding urgent treatment):** 1 UDA
- **Band 1 (urgent treatment only):** 1.2 UDAs
- **Band 2:** 3 UDAs
- **Band 3:** 12 UDAs
- **Issue of prescription:** 0.75 UDA
- **Repair of dental appliance (denture):** 1 UDA
- **Repair of dental appliance (bridge):** 1.2 UDAs
- **Removal of sutures:** 1 UDA
- **Arrest of bleeding:** 1.2 UDAs

An average UDA value of £25 means a dentist is paid £300 for a single bonded non precious metal crown (12 UDAs x £25) (Under the old payment system, the dentist received a £103.55 fee). However, the UDA value for treating a patient needing 6 fillings, 3 extractions and extensive hygiene work and x-rays is 3 UDAs: the same as for a patient requiring one filling. And the same 3 UDAs for an extraction taking 15 minutes surgery time are awarded for a root filling and restoration of a tooth taking an hour and a half.
Introducing our Speakers

**Edwina Currie-Jones, Trustee of the Patients Association**

Edwina Currie-Jones was one of the nation’s best known MPs and served in the Department of Health between 1986 - 1988. She became famous for her campaigns on heart disease, women’s cancer screening and the promotion of healthy lifestyles. She was also involved in the first AIDS campaign in the UK that saved many lives. Edwina now spends much of her time involved in charity work and is a Trustee of the Patients Association.

**Dr. Lester Ellman, Chair of the General Dental Practice Committee**

Lester Ellman has practised in NHS and private dentistry since 1964. He serves as Chairman of Salford and Trafford LDC and of Greater Manchester Federation of LDCs. Lester Ellman is also Dental Adviser to Manchester.

**Dr. Anthony Halperin, Chairman of the Patients Association**

Dr. Anthony Halperin has practised in NHS and private dentistry in Central London for 35 years. He is a practising arbitrator in dental disputes and is Chief Dental Adviser to Guardian Health in policy and claims. He is on the advisory panel of the Insurance Ombudsman and is dental contributor to ‘Medical Negligence’.

**Dr. Ros Hamburger**

Ros Hamburger is Consultant in Dental Public Health. She is involved in the commissioning of NHS dentistry in the West Midlands.

**Norman Lamb, MP**

Norman Lamb is the Liberal Democrat MP for North Norfolk and the Liberal Democrat Shadow Health Secretary. He entered Parliament in 2001. Norman Lamb is known for his strong reputation as a campaigner for improved health services. He has been a critic of cuts in bed numbers and has highlighted the resulting unacceptable level of cancelled operations. Norman Lamb also considers orthopaedic waiting times in Norfolk to be problematic.

**Mike Penning, MP**

MP for Hemel Hempstead, Mike Penning was elected as Member of Parliament for the Hemel Hempstead constituency on 2005. In June 2007 he became a Shadow Minister for Health. Since the election in 2005, Mike Penning has taken up many campaigns that affect the people of Hemel Hempstead, such as the campaign to Save Hemel Hospital.

Speakers confirmed at time of going to press.
The New Dental Contract - full of holes and causing pain?

REPORT

About the Patients Association
Listening to Patients, Speaking up for Change

The Patients Association was established over 40 years ago to develop better and more responsive health services for patients, by listening to the concerns of patients and focusing its campaigns on what matters to them.

We advocate greater and equitable access to high quality care, accurate and independent information for patients, and patient involvement in decision-making as a right. Our various strands of work are important to one another and in relation to this Report, other work that has a direct relation to it includes:

• Patients’ rights – the relationship between professional and patient has changed from a paternalistic approach to a situation now where patients want to know about the skill differences between professionals, and its direct relation to their care. They also want information about treatment options. In many cases, patients attempting to exercise the few rights they have e.g. access to medical records or make a complaint, are frustrated or barred.

The Patients Association has led the patient voice in bringing this to the attention of parliamentary leaders and hopes that the renewed discussion of a constitution for the NHS will include a proper ‘customer’ focus.

• Patient choice – when patients have information about the differences between professionals and NHS trusts, they will of course exercise choice. This in turn leads to a demand for more information. The Patients Association strongly supports patients having access to the fullest information about the care they seek. Within the UK NHS, unacceptable differences have emerged between the devolved governments of Scotland, Wales and Northern Ireland in relation to England. The effects have been strongest where systems and specialties have been the most fragile.

• Infection control – until the appalling situation existing in some parts of the NHS is brought under control, we shall continue to speak out against poor practice and lack of priority. The Association was in the vanguard of the exposure of the dangers to patients and has reported annually since 2000 on different aspects of the dangers to patients. The high media profile of healthcare acquired infections (HAIs) should not diminish the importance of best practice in infection control in primary care and dentistry in particular.

• Pain management – this is of central concern to any patient’s experience of healthcare and the research we carried out in 2007, which examined the experience of the elderly in care homes and on carers, has a direct relevance to this Report and the effect of dental services on patients. Pain, or the perception of pain, is an important element in dental care and in patients failing to have regular professional dental care.
Cross-border EU healthcare options – a new EU Directive (19.12.07) has led to uncertainty about the ability of UK patients to travel for treatment elsewhere in the EU. It appears to allow patients to have treatment abroad funded by the NHS, but the Department of Health has insisted that the impact will be more limited. Only 250 patients in 2005/6 were funded by the NHS to travel abroad, but the effect of the Directive may be extensive. Patients already travel abroad for private dentistry when they are unable to access NHS dentistry in the UK.

Our Interest in Dentistry

The Patients Association believes patients should be able to access the best NHS care regardless of where they live, based on its founding principle of freedom from the financial fear of becoming ill. When it comes to dentistry, however, both these standards have fallen away since the inception of the NHS. There is no doubt that this situation has suited many involved in this area – government, politicians, NHS bureaucracy - of NHS care, except patients. Year on year the situation has deteriorated and at one time or another, dentists or their patients, or both, have been dissatisfied with the situation. While co-payments are forbidden in the NHS generally, in the dental world they are regarded as the norm. In the light of the other work that the Patients Association has done recently, as well as important projects by other organisations, it was obvious that this survey of PCTs and their dental commissioning work was needed.

In 2006 a new dental contract was introduced. The aim was to provide a better dental service to benefit both dentists and patients. A dentist’s salary was to be related to the production of units of dental activity (UDAs), the same principle which had governed the previous system related to the number of fillings, extractions, etc. Unlike the contract for GPs, where a salaried service is allowed, dentists have criticised their contract on the grounds that it has merely exchanged one treadmill for another. As with other funding of the NHS, UDAs quotas, once completed were unlikely to be added to, thus leaving patients with the possibility of lack of access because funding had been used up.

For patients, there are now 3 bands of fee payment. Band 1 covers diagnosis, treatment planning and maintenance. Band 2 is for simple treatment e.g. fillings, extractions, and surgical procedures. Band 3 covers the provision of appliances and complex treatment with a laboratory element. There is an additional band for Urgent Treatment.

The new contract also introduced new commissioning responsibilities and resources for PCTs to ensure that dentistry services are sufficient to meet needs in their areas. The priority for PCTs is to provide equal access across their area to all patients.

While this may be easier for patients to comprehend, assuming they are made aware, it may also mean that they are paying far more than previously. There is additional concern that treatments may be skewed under the new contract as the same UDA value applies to complex treatments e.g. root canal, bridges, as for the simpler ones such as extractions or plastic dentures. There is no incentive for more complex and time consuming treatments to be offered and there is a positive dis-incentive in that if targets are not reached, the dentist’s “salary” is reduced by the Primary Care Trust which holds the purse strings.

For several years, before and after the implementation of the new contract, concern has been growing in Parliament, within the NHS and among its independent contractors, NHS dentists. Questions in Parliament, Westminster Hall debates (12.01.05), reports from other organisations dealing directly with patients (Citizens Advice Bureaux, Gaps to Fill 2007, and Survey 2008), Greater London Authority (Teething problems – a review of dental care in London) all drew attention to the increasing problems for patients trying to access NHS dentistry.
There are also concerns that the situation will worsen in 2009 when the contracts are reviewed by the PCTs, with the danger that large numbers of dentists are likely to leave the NHS.

This will be the consequence of PCTs awarding NHS contracts to dentists producing the most UDAs for least money. The worries about the future quality of NHS dentistry are therefore real. Will patients be forced out of NHS dentistry and into paying for private treatment? These questions are uppermost in the minds of patients. They are also top of the list of health concerns taken to Members of Parliament by their constituents, as our poll of MPs showed in the autumn of 2007.

**Methodology**

This questionnaire was sent to the Chairman and Dental Commissioner of each of the 150 PCTs in England on 5th October 2007. Answers were requested under the Freedom of Information Act by 31st October. The postal strike intervened and resulted in extending the deadline for responses to 28th November, 2007. The questionnaire was divided into 5 sections – funding, access to NHS treatment, orthodontic treatment, dentists, and general comment.

**Responses**

We received and analysed a total of 112 questionnaires, giving us a return rate of 75%. All responses to the questions in this Report are represented as a percentage of those who answered the question.

It should be noted, however, that some questions were left unanswered by some PCTs. We also asked respondents to provide qualitative comments to add colour to their responses. These comments are listed as quotations throughout the Report.
Executive Summary

1. The majority of PCTs say they are satisfied with the level of funding and the latest increase. Most confirm that the funds are ring fenced.

   *This is in direct conflict with other facts to emerge from the Survey:*

2. PCTs complain there is widespread lack of funds for orthodontics and other specialist treatments and cite this funding gap as the reason for not implementing best practice.

3. There is increasing concern for the preventive role of dentistry in detection of oral health disease. PCTs have responsibility for public health. This should be based on NICE guidance which now recommends that patients should be seen by their dentist at intervals based on individual oral health needs. This assumes that patients are in regular contact with a dentist who can determine their oral health need.

4. Patients are confused about the new contract, new charges and NHS availability. Despite Regulations requiring information to be available, they remain confused about the new contract, the charges they are expected to pay and how to access regular (as opposed to emergency) care. This is a fundamental change in their relationship with “their” dentist which has not been explained to them. **COMPLAINTS HAVE RISEN.**

5. PCTs now commission dental services for their area. In theory this offers a new opportunity to ensure dental coverage of the population and reduce any previous variations in access. The dental reforms hailed this change as a new opportunity for patients. Despite this new approach, however, our results reveal a lack of creativity in commissioning. Administering the book-keeping element of the status quo is not what was envisaged as the new commissioning role for PCTs.

6. There is confusion among respondents about the commissioning role of PCTs and the elements which comprise the whole. This leads the Patients Association to believe that improved guidance on best practice in commissioning is required for PCTs.

7. The mixed bag of access to service, emergency and out of hours care, and preventive campaigns revealed in this survey does not constitute a National Health Service for Dentistry.
The New Dental Contract: Full of holes and causing pain?

Section 1 – Funding

Department of Health: “The resources allocated to PCTs for commissioning... (before allowing for revenue... from patient charges) totalled some £1.8 billion in 2006/7. This represents an increase of nearly £450 million, or almost a third, compared with expenditure in 2003/4.”

Question 1

In 2006/7 is funding designated for dental services ring-fenced or floor funded?

This question was asked in order to establish the basic funding for dentistry by PCTs. The overwhelming majority (87.7%) of PCTs confirmed that dentistry funding is ring-fenced. 12.3% of the Primary Care Trusts (PCTs) said the dental funding they receive is floor funded. Floor funding is the minimum spend for a PCT on dentistry.

Question 2a

In 2006/7 has funding designated for dentistry been transferred to other services?

There is always concern that designated funding is reallocated under financial pressures, but 97% responded that no transfers had taken place. 3% answered that designated funding had been reallocated.
Question 2b
If funding has been transferred, please identify to which other services:
SHA, Acute Hospital Trust services, internal PCT funding, other.
The two examples of transferred funding given to us were a) back to the SHA and b) to other internal PCT funding.

Question 2c
If funding has been transferred, please indicate which percentage of the dentistry funding has been approximately transferred to other services in 2006/7:
Less than 10%, 10-30%, 30-50%, 50-70%, 70-90%, more than 90%.
In both the replies to this the percentage was "less than 10%.

Question 3
Please list any aspects of dental services you find difficult to fund:
NHS dentistry staff, dental appliances/equipment, maintenance/handling of dental appliances, cost of dental cleanliness/hygiene, specific treatments (e.g. crowns, bridges), other
The graph below shows clearly that “other” was cited by the majority of respondents (59.6%) Within this category respondents included difficulty in funding orthodontic, periodontic and endodontic treatments. Shortage of funds means waiting lists for patients, but in the case of children, delay for orthodontics often renders treatment pointless. There was increasing reluctance by many dentists to carry out restorative care (crowns, bridges, orthodontics, with sedation services). In addition, PCTs pointed out that the opening of new practices and the provision of NHS dental support staff remain problematic. Finally, “Other” also included the view of some PCTs that the total number of UDAs is insufficient to meet existing dental needs.

All these responses stand in stark contrast to the satisfaction stated in Q.4b below.

“Single use instruments for endodontics”
“UDAs insufficient for needs”
“Flexibility to increase controls and practices”
“Orthodontics demand outstrips current commissioned service.”
**Question 4a**

Compared to 2006/7, how does your dental funding for 2007/8 compare:  
The same, lower by %, higher by %?

The vast majority of PCTs indicated an increase in their dental funding in 2007/2008. Generally, 2007/8 is a 4.4% increase on the previous year.

**Question 4b**

How satisfied are you with the dental funding you received for the year 2007/8?  
Really unsatisfied, unsatisfied, rather unsatisfied, rather satisfied, satisfied, very satisfied

The majority of PCTs generally are satisfied with their dental funding (57.6%). 42.4% are not satisfied with the dental funding they received for the year 2007/8, including 1.1% describing themselves as “very unsatisfied”. These answers are in contrast with the answers to Q.3 and make odd reading. If PCTs are as satisfied as they profess, the answer to Q.2 should not be as it is, and the answers to the questions that follow should also be different.
**Question 5a**

Is a proportion of the dental funding used to attract new dentists to your area?

The new dental contract gives the dental commissioning role, for the first time, to PCTs, to ensure full and proper coverage by dentists in their area. Previously, dentists set up their practices where they chose with consequent gaps in coverage. We wanted to see how this new role was being conducted, including as it does public health requirements including preventive care, specialist and emergency care. Just over a third (37%) were using their funding to attract new dentists which in our view is not fulfilling their commissioning role.

**Question 5b**

If yes, approximately what proportion of your dental funding does this represent?

Less than 10%, 10-30%, 30-50%, 50-70%, 70-90%, more than 90%, or unknown

Nearly three quarters (70.2%) of PCTs said that they use less than 10% of their dental budget to attract new dentists. 19% of PCTs said that 10% to 30% of their funding is dedicated to this task. 10.8% do not know.
**Question 6a**

Are you regarded as an example of best practice in dental funding?

The majority, 55%, did not believe they were regarded as an example to others of best practice in this area.

![Pie chart showing 45% yes and 55% no]

**Question 6b**

If yes, please give your area of best practice

This question resulted in the answers below. To encourage best practice we will be pleased to provide details to those PCTs or others requesting them.

**Innovative commissioning**

- Managing the contract
- Commissioning UDAs
  One of the highest % of NHS practices in London
- Relocation of patients following retirement
- Out of hours, relationships with local dentists and LDC
- Innovative needs-based commissioning using recommissioning opportunities
- Addressing high levels of oral illness
- Reduce waiting times by transfer of oral dental surgery from sec to primary care
- Open access dental care
- Increased access
- Commissioning of out of hours
- Referral management & treatment services
- Improved access within budget
- DW SPI workforce/skill mix to increase access for NHS dentistry
- Current benchmarking by BSA
- Temporary dental service pending longer term contract solution
- VFM recommissioning contracts on practice change of ownership
- 27000 additional UDAs commissioned within budget
- Contract management; Dental commissioning
Financial Management

Ensure all dental budgets spent
Offered additional grant payments to fund IT improvement
Linked to LDP
Excellence of financial support from PCT
Improved access within budget
Dental provision maintained despite no add funding
Followed legislation & guidance
Investment in NHS dentistry
Policy of practice sales

Premises

Lift premises with dental teaching, salaried service & GDS

Infection control

Infection control audit of dental practices – adopted elsewhere
Assessment + targeted funding for access & infection control

Question 6c

If not, why not?

Of the 55.9% giving a negative response, most PCTs blamed lack of funding for their situation. This is an interesting reply given the response to Question 4b in which most PCTs were satisfied with their funding.

“Inadequate funding to cover recent increase in demand for orthodontics, following introduction of NHS referral criteria”

“Historically under-funded and consequently constantly fire fighting”

“Some practices over performed on their agreed contract values and no extra funds available to pay them”

“Whilst the gross allocation per capita is one of the highest in the country, the net allocation (net of patient charge income expectation) results in the PCT showing a financial deficit against patient charges actually received. This has to be managed through general PCT funding.”
Section 2 – Access to NHS treatment

Department of Health: “Patient access has stabilised over the 12 months of the reforms … There are numerous examples of PCTs commissioning new services to improve patient access… Since April 2006 there has been an upward trend in the number of dentists providing NHS services … Patients should have easy access to high-quality clinically appropriate dental services. PCTs should have clear commissioning strategies based on assessing local needs, engaging the local public and local healthcare professionals and developing services to reflect local needs and priorities.”

The reality for patients has often been very different to the confidence expressed above. With little official notification about local access, many patients have been frightened into assuming NHS dentistry was a thing of the past in their area. Such a view was compounded by media reports and photographs of long queues to register with NHS dentists. It all made for a confusing situation for dental patients.

Question 7
How many patients in your area are currently without access to NHS dental care who have requested it? Number of patients / percentage of total patients?

The Patients Association has received many calls to its Helpline from patients who have no dentist, hence this question. These calls are in line with the findings of the two snapshot surveys we took of the top causes for complaint to Members of Parliament in the second half of 2007. Dentistry was top of their list. These findings are confirmed by previous reports by other concerned organisations, such as Citizens Advice Bureaux.

The responses to Question 7 show that on average 1.3% of PCTs population remain without access to NHS dental care. This is extraordinary but even more so given the answer to Question 8 below. It may also account for the continuing confusion among patients about preventive work, such as check-ups which previously occurred at six monthly intervals but now, following NICE’s new guidance, will be variable, possibly up to 2 yearly, depending on an individual’s oral health.

Question 8
How many patients are currently receiving NHS dental care in your area? Number of patients/percentage of total patients

The responses from PCTs indicated that on average 49.5% of the patient population were currently receiving NHS dental care.

The responses to Questions 7 and 8 clearly do not support each other. The qualitative responses reveal the true situation. Comments such as:

“In hours access is mopping up emergency dental care”

“All patients have access to urgent dental care. Approx 50% have access to regular care.”

“Treatment is no longer based on patient registrations - NHS dental care is based on courses of treatment not patients”

“In-hours Access Scheme for residents that do not have a regular dentist. All have access to dental services for urgent dental treatment.”

17
It would appear from the statistical and qualitative responses to Questions 7 and 8 that the definition of ‘dental care’ has very different meanings to commissioners and patients. The change from patient registrations to UDAs, we believe, is the cause of confusion and has led to the problems of perception by the NHS and the patient. The registration of a patient – with its relationship between clinician and patient – has been replaced by UDAs which mean little or nothing to a patient, already lacking information about the reforms. This knowledge gap, coupled with the NICE guidance lengthening check-ups from 6 months to 2 years, has implications for prevention and early detection of serious oral illness. This should concern patients, clinicians and parliamentarians alike.

**Question 9a**

What percentage of dentists in your area have opted out of NHS care?

- Less than 10%
- 10-30%
- 30-50%
- 50-70%
- 70-90%
- more than 90%
- unknown

The responses to this question said that, in the vast majority of PCTs, (92%), less than 10% of dentists had left the NHS entirely. In 1% of PCTs answering, 70% to 90% of dentists in their area had opted out entirely from offering NHS care.

**Question 9b**

Percentage of dentists that opted out for NHS fee paying adults only?

81.9% of PCTs indicated that less than 10% of dentists in their area opted out for NHS fee paying adults only. However, 1.1% of PCTs replied that 30% to 50% of dentists had opted out.
**Question 10a**

Have you successfully offered alternative care for patients whose dentist has opted out of NHS care?

The vast majority (95.9%) of PCTs said that they successfully offered alternative care for patients whose dentist has opted out of NHS care. It should be noted, however, that 4.1% of PCTs did not, meaning that many patients remain without an NHS dentist.

**Question 10b**

If yes, please specify approximately what percentage of patients you were able to offer a successful alternative: less than 10%, 10-30%, 30-50%, 50-70%, 70-90%, more than 90%, unknown

59.1% of PCTs indicated that they offered a successful alternative to more than 90% of patients whose dentist opted out of NHS care. It is cause for concern that nearly a third of PCTs did not know. The PCT has an obligation to provide a service but with Unknowns at 31.8% the danger of patients being subjected to a dental postcode lottery is real.
**Question 11**

What percentage of dentists in your area offer both NHS and private care?

Less than 10%, 10-30%, 30-50%, 50-70%, 70-90%, more than 90%, unknown

Nearly half of PCTs said that nearly all (more than 90%) offered NHS and private care (47.5%). 71.8% of PCTs indicated that more than 50% of dentists in their areas offer both. It is matter of concern that nearly a quarter of the responses (22.2%) say they do not know.

**Question 12**

What percentage of dentists offer only NHS care?

Less than 10%, 10-30%, 30-50%, 50-70%, 70-90%, more than 90%, unknown

This posed the question of dual coverage in a different way, from which we can conclude that dual coverage is the norm. Only 1% of PCTs indicated that more than 90% of their dentists provide only NHS care. 20.2% do not know.
Question 13a
How many patients travel out of your area for NHS dental care?

Less than 10%, 10-30%, 30-50%, 50-70%, 70-90%, more than 90%, unknown

21% of PCTs indicated that 10% to 50% of their patients travel out of the area for NHS dental care. 25.3% of PCTs pointed out that less than 10% of their patients go outside the PCT to get NHS dental care. More than half the responses (53.7%) did not know.

Question 13b
Why do you think patients are travelling out of your area for dental care?

The answers to questions 13a and 13b reveal a very different approach by both PCTs and patients to dental access. The latter do not feel tied by geography to a particular dentist. Patients access dentistry outside their PCT for convenience (28.6%). This included: proximity to workplace (69%), loyalty to an individual practitioner (32.7%) or living on the borders of a PCT (10.2%). Other minor reasons included: exercise of patient’s choice (10.2%), requirement for specialist in orthodontics (6.1%) and reputation of individual practitioner (6.1%). There appears to be a lack of data collection in this regard by PCTs. One PCT gave lack of access to care as a reason (2%).
**Question 13c**

How many patients travel into your area for NHS dental care?
Less than 10%, 10-30%, 30-50%, 50-70%, 70-90%, more than 90%, unknown

41.6% of PCTs indicated that 10% to 50% of their dentistry patients were not living within the PCT area. 43.8% did not know. Absence of patient flow data must make effective resource allocation very difficult.

**Question 14a**

Has the number of complaints about NHS dentistry increased since April 2006?

55.1% of PCTs confirmed that the number of complaints in dentistry increased since April 2006. This immediately provokes the further question: if there are no problems with access as stated earlier in the responses, why is there this increase?

Complaints received by the Patients Association on its Helpline confirm the PCT comments:

“Lack of discussion /description of treatment - No advice given for aftercare – unless asked for”

“Last 2 NHS dentists withdrew from contract and due to being dependent on ill-health benefits could not afford the private costs of treatment”

“I went recently to a private dentist for a second opinion – only to find out that my teeth were in a much poorer shape that I was made to believe by my NHS dentist which I went to see regularly every 3 months.”

“Only allowed a 10 min check-up: No cleaning or scaling, etc. and this costs £15, a rinse from a plastic mug costs an extra 40p.”
And a final recent example from our Helpline: The elderly caller had suffered repeated infections and was in great pain. An NHS dentist said an extraction was needed but the root was very deep and he declined to do it. The PCT was asked to supply an NHS dentist for the work but said there would be a 6 week delay. This was obviously unacceptable so the NHS dentist referred the patient to a private dentist who carried out the procedure and charged £145. The patient called our Helpline wanting advice on the PCT’s duty of care for pain relief.

**Question 14b**

**Extent of the increase of dental complaints**

Most PCTs experienced a less than 10% increase of dental complaints. However, 9.4% of trusts acknowledged that the increase exceeded 90% of the original level of complaints.

**Question 14c**

**Please tell us the three main issues you received.**

The chart below details the main issues presenting to PCTs.

Confusion over the new 3-bands charging system (60%), general access to dental services (37.6%) and to orthodontic treatments (28.2%) were indicated by PCTs as the three main dental issues they are currently facing in complaints from patients.
Question 15

What public health measures has the PCT put in place to assist patients locally to self care, especially those unable to access NHS dentistry?

Three main themes emerged from responses to this question:

a) Oral Health Promotion Team (28 responses out of 87). This included work in schools (15 responses) and residential care settings (4 responses) as well as advice to parents in other settings

b) Public Health Campaigns. Chief among these were the Brushing for Life initiative, fluoridation of water supply, and provision of brush and toothpaste initiatives.

c) Out of Hours triage and Emergency advice (including NHS Direct and dental Helplines)

None of these are new. Campaigns come and go. Questions arise about the time-span of any one campaign.

“Out of hours phone triage and emergency dental services - public health campaigns (e.g. to coincide with oral cancer awareness week): implementation of basic stop smoking service”

“Fluoridation in certain parts of the county; Public information in schools / libraries / NHS Direct; Dental access in all areas of the county Improving services for the people with learning disabilities”

“Teeth brushing, low sugar food policies, sugar free medicines, support for water fluoridation scheme”

“Dental helpline for patients wishing to access… urgent dental care. There is a dental nurse advice service out of hours.”

“Oral Health Promotion materials, also the PCT provides a Schools programme for dentistry. Information about dental services can be found on our website”

“Fit for the Future programme has a focus on oral health promotion. Oral health educators are in post and there is a fluoridated milk scheme.”

“Specialist oral health promotion staff in dental services Salaried dental service provides NHS urgent care, Department of Health clinical triage service, regular health education campaigns, particularly aimed at children/parents”

“Community services treat hard to reach patients, acute services offer open door policy, advice available out of hours via telephone, oral health promotion team”

“Dedicated PCT dental helpline for access enquiries and signposting for routine and urgent care as well as general dental enquiries. The PCT also runs an IN and Out of Hours urgent care service. Dedicated Dental Public Health department offering a range of public health approaches to include child and adult oral health programmes, milk fluoridation for schoolchildren and tooth brushing schemes.”
“Our oral health strategy identifies existing and proposed programmes relating to promoting oral health and prevention. Evidence-based prevention will be a key focus in the future ... In addition to being a fluoridated water area, the trust has a Patient Advice and Liaison Service for patients to obtain advice and our commissioned out of hours services includes advice on self-care. We do everything possible to ensure that patients are able to access NHS dentistry and to date there are not instances where we have not been able to do this.”

**Question 16a**

**Are you aware of particular treatments ceasing to be offered by NHS dentists?**

31.3% of PCTs confirmed they are aware of particular treatment ceasing to be offered by NHS dentists but just over two thirds were not so aware. Questions arise about anecdotal evidence that NHS laboratory work is decreasing.

“I believe that access to these treatments has declined although they should be offered as part of the contract.”

“Root canal harder to access, will be done as last resort.”

“All the above are contained within the NHS dentistry terms of service. If we learn that they are not being offered we resolve it with the practice.”

“Still being provided but in reduced numbers.”
Question 16b

If yes, please indicate the treatments that are currently ceasing to be offered by dentists.

The new contract deals in UDAs (units of dental activity). Dentists get the same UDA payment regardless of the complexity of treatment. The temptation not to treat more complex needs is therefore obvious.

We offered several options:

- Root canal work - 89.7%
- Bridges - 51.7%
- Dentures - 37.9%
- Crowns - 27.6%
- Dental extractions - 3.4%
- Other 17.2%: included periodontic treatments and domiciliary care.

Not all PCTs answered this question.

“We are treating refusal to provide certain forms of treatment on the NHS as a breach of the contract.”

“Dentists are concerned about lab costs for more complex cases. We monitor complaints/contract to remind NHS dentists of their contractual obligations.”

“If we learn that they are not being offered we resolve it with the practice.”

“These treatments are still being provided but in reduced numbers.”

“This is not by all practices”.

Section 3 – Orthodontic treatment

Department of Health: “Further action will be needed in some areas to improve access to orthodontic services. The NHS invests more in orthodontic services per head of population than any other state-run health service …”

In view of this, the Patients Association questions why patients requiring orthodontic treatment find it so difficult to access.

Question 17

What percentage of dental funding is allocated to orthodontic treatment?
Less than 10%, 10-30%, 30-50%, 50-70%, 70-90%, more than 90%, unknown

This is an area of dentistry which falls increasingly into private care despite its expense. Child patients requiring orthodontic treatment need it without delay. The NHS scheme, using a scale of severity, allows only the most severe cases to be dealt with. Yet nearly half (40.6%) of PCTs indicated that they allocated less than 10% of their dental funding to orthodontic treatment. A tiny minority 2.1% of PCTs (2) acknowledged they dedicated 30% to 50% of their dental fund to orthodontic care. It is open to question how the small sums allocated to orthodontics square with the statements in this questionnaire that a complete dental service is offered to their populations. The general standards of access to orthodontic care differ widely from the access patients have to other parts of NHS care, but there is no clinical reason why this should be so.
**Question 18a**

Has the PCT put additional money into the provision of orthodontic treatment?

Although orthodontic treatments appear as one of the crucial issues faced by PCTs (see question 14c)), in nearly two thirds of PCTs (65.3%) there was no additional money dedicated to the provision of this care.

![Pie chart showing that 34.7% of PCTs have put additional money into orthodontic treatment, and 65.3% have not.](image)

**Question 18b**

If yes, what percentage of the 2006/7 funding for orthodontic treatment does the increase represent?

57.5% of PCTs with increased orthodontic funding stated that the increase was less than 10% of the original budget. Nearly 10% did not know. These results are of concern considering the important issue pointed out by PCTs regarding orthodontic treatment (see question 14c)).

![Pie chart showing percentage distribution of increased funding levels for orthodontic treatment.](image)
Question 19a

Has the PCT carried out a local needs assessment of orthodontic treatment needs going forward?

The new important commissioning role for PCTs was hailed as one of the main improvements that the new reforms would deliver. PCTs would be able to commission services based on local need. Proper assessment would give an accurate idea of local dental needs. The results of this question show that one third (32.7%) of PCTs have not carried out a local needs assessment of orthodontic treatment needs. It seems right to query therefore how PCTs can be accurately aware of the current needs of their population.

Question 19b

If so, to what extent do you think the results of this assessment were taken into account when determining the funding allocated by the PCT for orthodontic treatment?

In spite of these questions being asked under the Freedom of Information Act, only a minority of PCTs responded to this question. Of the small number answering, 79.8% indicated that the results of this assessment were taken into account when determining the funding allocated by the PCT for orthodontic treatments. 5.5% of PCTs acknowledged that these results were ignored. It is therefore all the more extraordinary that PCTs admit they are not providing full dental services as stated in reply to Question 6c and 16a.

“Results were not available as additional money is carried forward from April 06, but it is outside dental allocation.”
Section 4 – Dentists

Department of Health: “Since April 2006 there has been an upward trend in the number of dentists providing NHS services. The NHS has begun a £100 million programme of additional capital investment in dental surgeries.”

Question 20
Do any dentists play an active role in the development of operational policies of the PCT?

Nearly all PCTs (92.2%) indicated that dentists played an active role in the development of operational policies of the PCT. Examples of how this is happening may be found in the examples of best practice with the quotations from individual PCTs in reply to Question 29b. PCTs reported an improved working relationship with their dentists, a better understanding of how practices operate, and better engagement generally. The role of practitioners and the relationships developed will be central to the continuation of the service in the period up to the contract renegotiation in 2009.

Question 21a
Have you sought to recruit dentists from overseas?

There has been much media coverage of dentists being recruited from overseas, with varying results. 38.2% have sought to recruit in this way but the answers also showed that nearly two thirds (61.8%) have not.
Question 21b
If yes, which countries?

In November 2004, the Department of Health launched an international recruitment drive. Aimed primarily at dentists in Poland and Spain it was part of a government commitment to increase by 1000 the number of dentists working in the UK. The General Dental Council expressed its concern that Polish dentistry did not meet the required EU standards. The Department of Health said that, as part of the screening process, proficiency in English would be necessary. The qualitative comments in answer to Question 21c below illustrate the varying success of this initiative. Such mixed success has obvious clinical implications for patients, unaware of the variability.

91.9% of PCTs who responded to this question clearly indicated that Poland is an ideal place to recruit dentists. Spain (21.6%) and India (13.5%) were also identified as major sources of recruitment.

Other countries were also cited: Portugal, Germany and Sweden (each 5.4%), France, Greece, Pakistan, Romania, Lithuania and Hungary (each 2.7%).

Question 21c
If yes, please tell us the extent of the success you have had.

The answers below give a feel for the advantages and problems that followed recruitment.

“This was a department of health scheme which brought in five dentists."

“Mixed success - some Polish dentists have performed well but some have moved to other areas or returned home."

“One dentist recruited who left after 18months in post."

“None have remained - all were considered to require extensive training, in areas considered basic requirements/competency by employing dentists."

“Recruited 6 dentists - all are still with the PCT."

Question 22
What would be the Primary Care Trusts’ ideal profile for a dental practice in the future (after 2009)?

Again, this question required a qualitative response. Of those PCTs answering this question, 27.5% detailed the importance of putting in place multi-skilled practices with several dentists in practice together in order to comply with clinical governance guidelines. There is also an awareness of the access needs of disabled patients. PCTs viewed offering a full dental service as very important. 20.8% gave no answer to this question.

“Multi-surgery treating all categories of patients”

“A practice with at least three dental chairs working in a purpose-built health centre alongside other primary care services."

“Provide superb quality NHS services at fantastic value for money to all patients and collect huge amount of patient charge revenue.”
“Multi surgery, multi skilled, DDA compliant, decontamination compliant in a high area of need.”

“Multi surgery operation by a team of dental professionals.”

“99% NHS delivery offering all NHS treatments with the option choice for treatment privately if requested by patients. Performance monitored by a ‘basket of indicators’ not just the UDA targets. A system based on effectiveness, benefits realisation and long term care of patients.”

“One that accepts all types of patients regardless of age, income or need.”

“Clarity on NHS provision and charges. Working to NICE guidelines for check ups.”

“A practice with a minimum of two dentists with appropriate staff mix, such as therapists and hygienists, operating from good accessible premises and fully computerised.”

“Integrated within an area supporting GPs, pharmacy, social care.”

“PCT does not support practitioners who work in isolation.”

“The practice would also submit all data electronically and would be fully I.T. compliant.”

**Question 23**

If a dental practice is sold, what is the policy for informing the new contractor?

Analysis of the qualitative responses to this question shows that there are two ways of dealing with sales of dental practices:

(1) A strict policy of no guarantee that the contract will be passed on to the new practice owner (e.g. if greater need in other areas). This policy conforms to the Department of Health guidance: the former owner contacts the PCT to notify his/her intention to sell the practice. PCT organises a tender. The applicant is selected depending on local needs.

(2) Other PCTs adopt a more informal approach, merely giving advice to the new practice owner on the content of the contract. The process depends on local circumstances.

There is a danger with 2) that the status quo will be perpetuated and not lead to the creative commissioning envisaged by the reforms...

“Dentists can choose to sell their practice but not their contract.”

“Any new provider is invited to meet with the dental commissioning team of the PCT.”

“Buyers and sellers have to negotiate with the PCT before completion. Usually we would want to maintain service, but could choose to relocate services to an area of greater need.”

“A termination of contract results in a PCT re-commissioning services through one of three possible routes. (1) A practice sale. (2) A tender process. (3) A bid appraisal. In each of these circumstances, a Needs and Options appraisal is carried out and any future contractor is assessed for both quality and contractual capability.”
Section 5 – General

Department of Health: “In many areas, patients are already experiencing the positive results . . . in terms of new or developed services.”
“We are confident these reforms give the NHS a firm basis for improving patient care and give dentists a firm basis for providing good preventive care for their patients.”

Question 24

What is the average Unit of Dental Activity (UDA) value for your area?

Responses show that the average UDA value is of £22.90.

Question 25

Do you anticipate harmonising UDA values across your PCT area in April 2009?

62.2% of PCTs indicated that they do not have an intention to harmonise UDA values across the PCT area in April 2009. In spite of the comments listed below, the Patients Association has growing concern about the quality of dentistry given the variability of response. Our concern is compounded by the comments given in answer to Question 30 revealing the consequences of the UDA system for patients: reduced access, reduced quality of care, and reduction in numbers of complex treatment.

“We discourage the notion of an ‘average’ cost per UDA, as this sets an artificial benchmark. We are attempting to promote value, and it may well be that a practice delivering high cost UDAs is actually delivering better value than a practice delivering UDA at a substantially lower price. For this reason, we do not see so much a harmonisation in price per UDA, but in value per UDA.”

“UDA values do not necessarily reflect quality and long term care. There is a need to underpin dentistry with a set of tools building a reliable, auditable accreditation scheme.”
**Question 26**

Do you currently permit dentists to have limited NHS contracts (e.g. children only)?

76.5% of PCTs indicated that they permitted dentists to have NHS limited contracts. But the comments below explain the reasoning behind this.

“*But only where this was pattern of care prior to April 06.*”

“In the past, yes, but we would not approve new contracts.”

**Question 27**

If yes, do you anticipate this continuing after April 2009?

53.3% of PCTs anticipated continuing permitting dentists to have NHS limited contracts after April 2009.

“*Dental practices that previous to April 2006 operated to limited contracts were permitted to continue doing so. However, we will not offer new limited contracts, or expand existing limited NHS contracts. We are unclear as to what scope we will have to reduce or abolish restricted NHS contracts beyond April 2009.*”
**Question 28**

Have you agreed to any uplift of fees locally for endodontic (root canal treatment) following the recent “single use instruments” advice?

96.1% of PCTs indicated that there was no uplift of fees agreed for endodontic following the recent “single use instruments” advice. The concern for patients is that if the increased costs to dentists of conforming to the new advice are not reimbursed by PCTs, dentists will cease to offer this treatment. Dentists may suffer financial loss or try to pass it on but their patients will be put at risk if this treatment is withdrawn. There will be added costs through emergency treatments in secondary care.

**Question 29a**

Do you have/are you developing standardised proposals for decontamination (cross-infection control) in dental practices in your area?

The positive response from PCTs on this important subject indicates an active awareness of the necessity to develop such proposals.
**Question 29b**

If not, why not?

Most PCTs did not answer this question (86.1%). Of those who did, most (99%) were awaiting guidance from the Department of Health expected end 07/early 08.

"Awaiting revised ‘A12’ decontamination document to be agreed between DH and BDA"

The Patients Association’s continuing campaign against healthcare acquired infections means we will monitor the implementation of this guidance, as with all other infection control information to the NHS.

**Question 30a**

Overall, what positive or negative effect has the introduction of the new NHS dental contract in April 2006 had on your PCT?

Different themes emerged from the previous answers and are compiled below, with relevant percentages:

- **Awareness of local needs and inequalities – Allows addressing of these issues**
  39 responses (44.8%)
- **Monitoring of commissioning for financial value and clinical care**
  29 responses (33.3%)
- **Better working relationship between dentists and PCTs**
  25 responses (28.7%)
- **Monitoring standards and quality**
  18 responses (20.7%)
- **More patients accessing dental services**
  12 responses (13.8%)
- **Simplified payment charges**
  12 responses (13.8%)
- **Oral Health**
  10 responses (11.5%)
- **Better understanding of what is being provided / how practices operate**
  9 responses (10.3%)
- **Flexibility**
  6 responses (6.9%)
- **Ring-fenced budget**
  6 responses (6.9%)
- **Able to monitor and identify dentists that are not operating the contract correctly**
  5 responses (5.7%)
- **Influence of PCTs**
  5 responses (5.7%)
- **Improved engagement of dentists /Slowed down move to private / little privatisation**
  5 responses (5.7%)
• Got rid of dentist payments problems  
  5 responses (5.7%)

• To agree an orthodontic strategy  
  4 responses (4.6%)

• More control over dentist when they leave  
  3 responses (3.4%)

• Stop over-treatment/no incentive to do unnecessary work  
  3 responses (3.4%)

• Brought dentistry into PCT mainstream activities  
  2 responses (2.3%)

• Better out-of-hours services  
  2 responses (2.3%)

• Patient say  
  2 responses (2.3%)

• Enable patient to spend more time with their dentist  
  One response (1.1%)

• Resource follow patients  
  One response (1.1%)

  “PCT more aware of who dental performers are and what and how they are performing.”

  “Engagement with dentists … Raised awareness of dental issues within the PCT … Development of new practices …”

  “Enabled the commissioning of dental activity to be monitored for both best financial value and clinical care.”

  “PCT now has the power to influence where services are provided.”

  “Better relationship with local dentists previously they were isolated: NHS link was only for payment…Better understanding of how some practices operate - considerable support has been needed and offered by PCT.”

  “Simplified the patient payment structure … got rid of ‘piecework’ payment of dentists for their work.”

  “Able to implement oral health strategy by directing dental services to areas of need…Able to improve quality of services … Able to identify dentists who are not operating the contract correctly + do something about it … Patient charges easier to understand by patients …Selective acceptance of patients not allowed …Improved cash flow for dentists.”

  “Under the old system PCTs had no control over how much (or little) dentistry was provided locally, if dentists left the NHS PCTs had no control of local funding to replace them.”

  “Dentistry on PCT priorities list for development.”

  “We have been able to design services more around local need, for example, in … children have poor oral health… new contract has enabled us to invest in improving children’s oral health.”

  “Dental Access Network had addressed major issues.”
“The dental contractors have large sums of NHS money and there is now a system of accountability for how and where that money is spent.”

“Potential to move services from secondary to primary care in a cost effective way; allows PCT to raise and regularise standards in dentistry.”

“Inclusion of local dental providers into local mainstream NHS. Development of relationships with providers.”

“PCT is able to recover funding from dentists who fail to deliver their contracted activity so that replacement services can be commissioned.”

“Access to NHS dentistry has improved, re-commissioning of NHS dentistry in areas of deprivation and need, ring fenced budget enabled positive local management, greater contact with GDPs to discuss issues e.g. monitoring, clinical governance, feedback from patients, less child-only / child & exempt only contracts, less patient complaints.”

“PCT has greater control over the commissioning of dental services when contracts are terminated.”

“Reforms in dentistry are allowing local PCTs to develop NHS services in areas with most need, i.e. rural areas and areas of deprivation; under the old system PCTs had no control over how much or how little dentistry was provided locally, if dentists left NHS PCTs would have no control of local funding to replace them.”

“Brought dentistry into PCT mainstream activities. i.e. governance, finance. To agree an orthodontic strategy. Commission NHS dentistry depending on need.”

“Slowed down the move of NHS dentist to fully private provision.”

“Increased access to NHS dentistry. Regular income for all dentists. Simpler patient charges system.”

“Money stays in PCT, an actual contract in place, PCR clearer.”

“There is a more transparent needs based approach to orthodontic assessment and treatment - so those who require care receive it faster (than the previous system of no threshold for NHS orthodontic treatment.”

“We have much greater control over the cost of dentistry and the quality expected of dentists working for the NHS. We are now finding dentists who want to increase their NHS commitment.”

“Dentists are happy that they have a fixed amount contract, they know their targets & are working closely with the PCTs… Joint working in our borough is working very well… We have good access, however some over performance issues.”

“Ability to signpost patients to dental services reduces outpatient waiting times for consultant led services by reducing inappropriate referrals.”

“Resources now follow patients rather than dentists so that if a provider ceases to provide primary dental services, or reduces commitment to the NHS, the PCT will still hold the finances to commission services from an alternative provider.”
“Patients are better empowered to challenge dentists where they feel they have not received adequate treatment or information locally.”

“The perverse incentive to ‘over-treat’ patients has been removed... Primary care organisations can focus dental funding on the areas of highest need, rather than where dentists choose to practice.”

Question 30b

Negative effect of the new NHS dental contract

Opposing and different themes emerged from answers to this question:

Access (26.9%):

- Practices reducing NHS commitment / high turn-over of dentists
  9 responses (11% of responses)

- New contract has not improved access: has not improved uptake of patients
  8 responses (9.8%)

- Insufficient funding for orthodontic treatment – Waiting list and lack of information regarding these treatments
  4 responses (4.9%)

- Emergency patients sometimes struggle to get daytime appointments
  One response (1.2%)

Quality of care (65.8%):

- Dentists unhappy
  29 answers (35.4%)

- Dental practices focussing on targets and not on quality
  12 answers (14.6%)

- Insufficient time for/focus on/ incentive/reward for health promotion and prevention
  9 answers (11%)

- Consequence of no more patients registration: no follow-up and continuity of care
  2 responses (2.4%)

- No flexibility to end a contactor who is poorly performing
  One response (1.2%)

- If a new dentist wants to take over and do more NHS work than the previous person did at that location, he cannot
  One response (1.2%)

Patients’ charges, UDA & consequences (55%):

- Does not encourage dentist to give appropriate care due to banding system
  16 responses (19.5%)

- Unrealistic / Inequitable / Unclear patients’ charges – Confusion
  13 answers (15.9%)

- Number of complex treatments has dropped
  7 responses (8.5%)
Better for dentists not taking patients with high needs
3 responses (3.7%)

UDAs do not reflect the work done – too easy and basic
3 responses (3.7%)

UDA unit costs vary across practices/PCT
3 responses (3.7%)

Patients’ enquiries – Confusion (14.7%):
  Increase in public enquiries / Confusion about their rights
  4 answers (4.9%)
  Lack of information on type of treatment carried out
  4 answers (4.9%)
  Confusion about registration
  3 answers (3.7%)
  Difficulty in clarifying NHS/Private treatment
  One answer (1.2%)

Not turning up at dental appointment (1.2%):
  Patients do not care about turning up at their appointment as they can’t be charged
  One answer (1.2%)

PCTs and PALS (35.3%):
  PCTs not funded sufficiently to give dentist a reasonable value / Insufficient funding
  11 responses (13.4%)
  Additional work for PCT
  7 responses (8.5%)
  Greater risks for PCTs in managing dental spending floors
  5 answers (6.1%)
  PALS workload increase
  3 responses (3.7%)
  PCTs do not always have the necessary capacity and skills to manage
  2 answers (2.4%)
  PCT commissioning role not well understood
  One answer (1.2%)

Information & Data (10.9%):
  Loss of registration data / Loss of treatment data
  5 answers (6.1%)
  PCTs do not receive enough information
  2 answers (2.4%)
  Limited information available in early stages to evaluate contract effectiveness
  One answer (1.2%)
  Difficulty in accessing level of treatment provided by dentist for each course of treatment
  One answer (1.2%)
“Insufficient funding for orthodontics... Insufficient time for health promotion within current structures in pay.”

“Unrealistic patient charge allocation for PCT … Does not encourage dentists to provide appropriate care due to the banding system … No flexibility to end a contractor who is poorly performing.”

“Very worrying time … dentists and PCT still not comfortable with the new system … It has affected business planning as so many dentists think 2009 equates to Doomsday.”

“A sizeable minority of dentists not reconciled to new system … Evidence that the number of more complex treatments (Band 3) has reduced overall but, as this was an anticipated benefit of the new system, it’s not clear if this is a good or bad development … Patients still seem unclear about payment structure.”

“Some treatment options have been removed from patient care due to the cost of laboratory bills according to the service providers.”

“It has proved difficult in some cases for the PCT to develop positive working relationships with GDPs due to their concerns about the new contract … Different UDA values has caused problems as GDPs advised by DPD to negotiate with their PCT re uplifts. PCTs have not had the funding to do this nor the guidance.”

“Increase in public enquiries … Confusion among public regarding their rights … Uncertainty about what treatment available… Dentists unhappy that ‘Fail to Attend’ cannot be charged - this increases patients failing to attend, wastes patients’ time, reduces appointment time for others.”

“Target driven … Opportunity for supervised neglect to happen … High number of FTA’s reported by some practices “Patients state it doesn’t matter if they don’t turn up as they cannot be charged a FTA fee for an NHS appointment.”

“Greater risk to PCTs in managing dental spending floors … Additional work involved managing contracts.”

“The new contract ties funding to the location where the service was provided during the reference period … If a new dentist wants to take over & do more NHS than the previous person did at that location he cannot.”

“No incentive for preventive work … More referrals to secondary care. Innovation is stifled due to lack of funding.”

“The media has created a negative effect/impact on the management of NHS dentistry.”

“PCR shortfall is a pressure for PCT.”

“Implementing and monitoring the contracts represents a significant workload for the PCT, not matched by funding.”

“The PCT has overspent £660k due to insufficient funding in 06/07.”

“A huge increase in local administration and management at a time when management resources are being squeezed.”
“Loss of registration data, - loss of treatment data (specific treatment types), - restricted budget - cannot commission from new dentists wanting to move to the area so easily, - no of patient concerns increased.”

“Activity and treatment driven rather than quality or prevention. No patient registration confuses the public.”

“Has not improved access, created perverse incentive for dentists to maximise UDAs, in effect limits the expansion of services by capping activity, PCR bandings inequitable when 1 filling has same charge as 10.”

“Still recognises activity rather than patient care and outcomes (although PCTS can develop local contracts) …Practices may not wish to see high need patients …not perceived as rewarding a preventive approach.”

“More complaints. Dentists manage to get round doing the treatment they only want to do. Because of no registration, sometimes hard to keep track of population and treatments.”

“Patients still not accessing NHS dentistry. A considerable waiting list has emerged for orthodontic assessment and treatment.”

“Dentists are unhappy with the contract. They are unable to meet targets despite working harder than before. It is unreasonable to expect them to provide one filling or 10 fillings for the same number of UDAs.”

“More bureaucracy regarding monitoring… More work for PALS on helping patients find a dentist.”

“The contract is so difficult for dentists that I am not convinced it has improved patient care … Quality of care has certainly not decreased though.”

“A big opportunity lost: the old contract rewarded treatment rather than care & so does the new one… The imperative to deliver UDAs discourages innovations …The nature of the new contract creates an incentive to channel “difficult” cases into secondary care, which has caused an increase in demand for such services.”

“Less data is now collected and available to PCTs making it more difficult to manage contracts… Dentists are more selective on the NHS treatments and services they provide….New Dental Contract has significantly increased PCT workload.”

“Under-estimation by the Department of Health of the PCT’s ability to meet Patient Charge Revenue expectation resulting in PCT net budgetary deficit which requires PCT’s support to commission to historic levels of care.”

“Patient expectations were raised too high by the Department of Health. There is still a lack of understanding amongst patients of what treatments are available under the NHS.”

“There is now no data available on actual clinical interventions, only the broader brand categories … There are some instances where some patients will pay more than they would have done under the previous system … The unsophisticated nature of the treatment bandings means that some complex treatment attracts the same number of UDAs as extracting the tooth. For example, endodontic”
We have listed below a selection of the wide ranging comments PCTs were invited to add at the conclusion of their answers.

“Potentially all practices will provide some private treatment options so practices are very rarely 100% NHS, this is down to patient choice if they want cosmetic treatments.”

“Change was needed to bring NHS dentists into modern service - fit for purpose. Insufficient time/resources was put into making case for change …to dentists and their teams. BDA has often been confrontational and unhelpful - not really representative of the NHS dentists I came into contact with.”

“Under the new GDS contract no patient is registered with a dentist - the intention was to increase access but has had the effect of removing responsibility for patient care and making access more difficult. Even patients who have been at a practice for years do not have the confidence that they will be seen for a substantial course of treatment. There is confusion amongst patients (and dentists) about what treatment should be available as NHS care.”

“Prior to the contract dentists increased the level of NHS treatments they provided so they could secure a good contract value. The new contract capped their earnings at the reference period level and prevented practices from growing. The only increases practices receive are pay increases and inflationary increases.”

“UDA values do not necessarily reflect the quality and long term care. There is a need to underpin dentistry with a set of tools building a reliable, auditable accreditation scheme to provide NHS care in dentistry to patients including Oral Health assessments and treatment, planning of a system to collate the quality and effectiveness on a long term basis.”

“The new contract has its faults but it is better than the previous national terms of service contract. A problem often highlighted by practices is that patients who pay patient charges choose not to have band 3 treatments because of the jump in cost. We would like contracts to involve a patient assessment of oral health, then treatment protocols and assessment of outcomes rather than activity(or just activity) … we would like to see an exemption from charges for elderly patients.”

“We require that practices have an infection control policy. We support practices looking to upgrade their decontamination equipment through modernisation grants.”

“As dentists are no longer paid capitation fees … unable to say how many patients are receiving NHS care.”

“Almost all practices offer a mix of NHS and private care e.g. white filling. On that basis there aren’t any providers delivering solely NHS service.”

“PCT undertaking a dental procurement exercise £1.3 million … Urgent care is available to all residents who do not have access routinely to NHS dentistry … Working towards a single point of access to NHS dentistry for the PCT.”
“For PCTs under Pilot Personal Dental Services, the reforms have lead to major contractual adaptation by practices which is viewed by many as a more restrictive contract which is based more on the provision of treatment than prevention. Many PCTs worked under high trust environment under Pilot PDS arrangements. The reforms challenge this high trust environment and PCTs have to rebuild clinical engagement. Robust performance review, whilst welcomed by PCTs, is often seen as being intrusive into the professional autonomy of independent contractors. Procurement of practices is variable dependent on PCTs decisions. This had led to unrest especially to practice sale and the concept of ‘goodwill’.”
Participants

(1) Number of participants:

75% participated in this research. 38 PCTs (25%), despite the fact that all responses were asked under the Freedom of Information Act, did not send back the questionnaire we sent.

(2) Percentage of PCTs participation relative to Strategic Health Authorities:
(3) PCTs participation relative to each Strategic Health Authorities:

- London: Total 31, Effective 21
- North West: Total 24, Effective 16
- West Midlands: Total 14, Effective 13
- East of England: Total 14, Effective 10
- Yorkshire & Humber: Total 14, Effective 10
- South Central: Total 12, Effective 7
- North East: Total 9, Effective 7
- East Midlands: Total 8, Effective 6
- South East Coast: Total 14, Effective 6
- South West: Total 14, Effective 5

(4) Populations of Primary Care Trusts that participated in the survey:

- More than 500,000 inhabitants: 16.8%
- Between 350,001 and 500,000: 18%
- Between 250,001 and 350,000: 25.9%
- Between 200,001 and 250,000: 19.1%
- Less than 200,001 inhabitants: 20.2%
...how can I access my medical records?

...I’m visiting my GP and want some advice...

...how can I make a complaint...

Call the Patients Association Helpline

0845 608 44 55

The Patients Association is an advocacy group that highlights the concerns of patients. The Patients Association works with government and a broad range of individuals and organisations involved in healthcare to develop better and more responsive health services.

The Patients Association advocates for greater and equitable access to high quality, accurate and independent information for patients, for greater and equitable access to high quality care and for involvement in decision making as a right.

After 40 years The Patients Association still has a vital role to play. Our role is to help provide patients with the information that is difficult to access, often hidden away by vested interests. Our range of booklets help and so does our Helpline but this is not enough. Over the coming months and years we aim to increase the amount of information for patients so when we are offered a choice we know what we are choosing and why we are choosing it. The Patients Association is well placed as a platform to facilitate a dialogue between all the stakeholders in a patient’s care, from the NHS itself to companies that produce the medical devices across to medical insurance companies and the pharmaceutical industry. The Patients Association is in a unique position, always challenging, always independent and always there for patients.

The Patients Association helpline 0845 608 44 55 is there to help patients. It is a lo-call rate telephone number to help inform patients and gather their views.

We also have a range of booklets available for patients including Living Wills – a guide for patients. How to make a complaint, You and your doctor, You and your dentist. How to access your medical records.

We have also produced a number of reports including Infection Control & Medical Decontamination – a Survey of Strategic Health Authorities: Infection Control & Medical Devices and Tracking Medical Devices and the Implication for Patients Safety.

Booklets, reports and a lot more are available on our website www.patients-association.com

listening to patients, speaking up for change