Response to Health Committee report on dental services
British Dental Association
September 2008

Introduction

The British Dental Association opened its evidence to the health select committee with the statement that the new dental contract had failed to meet the Government’s own success criteria for the future of NHS dentistry, as set out in the Department of Health report NHS Dentistry: Options for change.

These criteria, widely supported by the profession, included enabling a more preventive approach to care, improving patient access to NHS dentistry and improving dentists’ working lives by removing practitioners from the treadmill of the existing system.

This recognition of failure to meet these success criteria was echoed in the statement issued by the health committee to mark the publication of its report in July. The committee warned the Department of Health that it had so far failed to improve dental services, as assessed by its own criteria for success.

It is of great significance that the committee accepted and reinforced the fundamental tenets of the BDA’s evidence. The BDA applauds the committee’s willingness to criticise so emphatically the Department of Health’s failure to undertake rigorous testing of such a crucial area of reform prior to its introduction. For our members and their patients, it is important that the rushed and careless manner of implementation and the ensuing uncertainty and confusion, are now a matter of public record.

It is, however, equally crucial that we move forwards, learning the lessons of the report, and taking the steps required to address the flaws and difficulties which exist in the new system which were articulated in our evidence and endorsed so compellingly by the committee. The Department of Health has since indicated its readiness to re-engage with the profession. If this is evident in the Department of Health’s response to the committee, the BDA would consider this to be a welcome step towards the reintroduction of effective and constructive consultation with the profession which was so lacking in the development and implementation of the new contract. Recent BDA negotiations with NHS Employers over the salaried primary dental care contract provide an excellent example of open and transparent talks which consistently strove to retain the confidence of all stakeholders. We believe that this sets a standard of best practice which we would welcome in all future negotiations.

Since the publication of the committee’s report, the BDA has disseminated its findings widely and held events to canvass our members’ views on the report’s
recommendations. As part of this response document, we attach a commentary on
the report’s conclusions and recommendations which we present as a positive
contribution to the process of improving the current situation for dentists and patients.

**BDA supports good practice in commissioning**

We are also committed to sharing our work on good practice in commissioning,
launched at a special conference in April and now progressing with a research
project to establish a robust evidence base for commissioning advice for members
and commissioners.

The BDA’s local commissioning toolkit, published this month (September 2008)
provides a range of options and ideas for local dental committees to use and pilot in
negotiations with primary care organisations. Over the next year, we have planned a
series of further events and activities to share best practice between providers and
commissioners. We will continue to provide individual dentists with advice on
contractual matters and run initiatives such as our series of workshops to help
dentists with the process of tendering for NHS contracts.

An important lesson to be learnt from the events surrounding the implementation of
the new contract is the problems which occur when the profession is not fully
consulted and listened to. We believe that the knowledge and expertise generated by
the activity and engagement outlined above, gives the BDA an unparalleled
understanding of the new commissioning environment and we look forward to using
this expertise to help inform debate on future developments and direction.

**BDA backs committee’s call for review**

The need for debate on future developments and direction is the single most
powerful message from the committee’s report. The report calls repeatedly for review
and particularly, for longer-term review.

The committee recommends reconsideration of some of the most contentious
aspects of the reforms, including units of dental activity and treatment bands.

The Department of Health is also challenged to publish a review of how services
might develop over the next five years.

The BDA supports these calls for review. We also recognise the significance of the
committee’s demand that the five-year review should address future levels of service
provision and the issue of to what extent NHS dentistry should offer ‘the growing
number of treatments which do not address clinical ill-health but are concerned with
improving quality of life’.

The BDA would add to the criteria for any review, the requirement to work within
the four pillars of the NHS Next Stage Review to create a system which is fair,
personalised, effective and safe.

Translating Lord Darzi’s four pillars into the dental context is a major challenge which
requires honest and open debate.
The BDA’s own work on patient-focused dentistry provides a further useful framework when considering the requirements of future provision. Our definition of patient-focused dentistry recognises that patients want to receive and dentists want to provide a high quality, clinically appropriate and personalised service. The BDA has identified the following principles to guide the development of services to achieve the goal of patient-focused dentistry:

- clinical excellence
- appropriately trained professionals
- a safe and clean environment
- good patient-clinician communication
- a focus on preventive care
- value for money
- sufficient time
- accessibility
- continuity of care.

Implicit in the NHS Next Stage Review pillars and the patient-focused concept is the awareness of how patient expectations are changing. Increasingly, it is recognised that the provision of appropriate care turns on effective engagement with patients to ensure options and choices are fully understood.

**BDA calls for costing exercise on delivery of modern dentistry**

The first step, therefore, in any meaningful review must be an exercise to ascertain the real cost of providing modern dentistry which meets the aspirations for future NHS policy as laid out in the NHS Next Stage Review and the principles identified within the BDA’s concept of patient-focused dentistry.

This costing exercise must take into consideration the time required to deliver a genuinely personalised service and the time required to undertake treatment to the quality and standard that patients have a right to expect.

In its report the health committee calls, rightly, for an urgent explanation from the Department of Health of the apparent decline in the number of complex treatments since the introduction of the new contract, and states that this trend has not as yet been explained satisfactorily.

We believe a rigorous review of costings and timings would help answer some of these issues around treatment patterns and how these are affected by different contractual models.

In the short to mid-term, this process of identifying the costings and timings demanded by modern dentistry would allow commissioners to gain a real understanding of the type of service available and its cost, and allocate resources accordingly.
In the longer term, this level of analysis together with the careful piloting of alternative contractual models could lead to the development of a system fit for purpose to meet those original success criteria identified for NHS dentistry reform.

The reality is that tough decisions about the type of treatment available on the NHS remain. What should a patient have a right to receive and what should the tax-payer be expected to fund?

As the committee has identified, it is imperative that these fundamental issues are determined by the Department of Health in its review.

In today’s healthcare environment of rapid clinical advances, an ever-expanding range of treatment options and growing patient expectation, NHS dentistry will only prosper with clear and realistic parameters within which to operate.
Response to the report’s conclusions and recommendations:

Key recommendations

1. “In the longer term we recommend that the Department review the UDA system and consider whether it is the best mechanism for delivering oral health care. Any changes should to the system should be piloted and tested rigorously.” (Paragraph 225)

The BDA agrees that the UDA is an unsatisfactory mechanism for delivering dental care or monitoring contract performance. Indeed, although the concept of weighted courses of treatment was discussed between the Department of Health and the BDA there was no suggestion then that these would ever form a practicable mechanism for monitoring the delivery of oral healthcare. It was only later that the Department of Health chose to implement, without testing, this system of UDAs with rigid targets, and the BDA has consistently campaigned for them to be scrapped as the sole contract measure ever since. The UDA relates to the consumption of time and resources but is based on an outdated model of dental care which does not emphasise quality, prevention or place patients at its heart. Consequently the UDA is a very crude measure of dental activity which introduces perversities into the system and discourages the care of high needs patients. However the BDA agrees with the committee that immediate change and further reorganisation would be harmful in an area of the NHS which has seen so much upheaval in the past few years. The BDA is committed to an evolutionary approach to contractual change focusing on local commissioning, piloting and evaluating of alternative contract models.

2. “We recommend that, as a short term measure, the Department consider increasing the number of payment bands from three treatment bands to five or more. In this way dentists would be rewarded with a greater UDA value for treatment given at the upper ends of band 2 and band 3.” (Paragraph 224)

For as long as the UDA remains as the sole indicator, the BDA would support a review of the treatments bands, particularly with regard to complex and time consuming treatments like endodontics and the treatment of high needs patients. The current three bands are overly simplistic and the difference in UDA value between band 2 and band 3 is too great. Therefore while we do not believe it would be an effective solution to simply redistribute the existing bands into upper and lower bands, we agree that further consultation should take place. We believe any review should focus on three key questions; firstly how many bands are necessary, secondly whether specific bands for some types of work should be introduced, and lastly what, therefore, the appropriate UDA value of each band should be. Nonetheless, the BDA would be cautious of endorsing any particular model without significant further work and piloting.

3. “We recommend that the Department consider further how to provide incentives for dentists to offer preventive care and treatment. Consideration should be given to the introduction of a QOF-style reward system for those dentists who through the provision of preventive care improve the dental health of their patients. The Department should consult dentists’ representatives about how a QOF-style system for dentists might work in practice.” (Paragraph 217)
Quality and outcomes framework style systems can have a role to play in improving prevention and are being developed locally by some PCTs using principles developed from the BDA’s Good Practice Scheme. The current GDS contract has not, despite assertions, tackled the output driven treadmill of dentists’ workloads. The UDA rewards treatment activity just as the previous item of service contract did. The BDA has long called for an end to this type of contracting in favour of greater focus on preventive work; we would welcome the opportunity to discuss and pilot changes aimed at releasing dentists from the treadmill and allowing them to treat their patients holistically in accordance with the principles set out by World Class Commissioning. The BDA has established a working group and research project to explore and pilot different commissioning models and we would be keen to look at QOFs as a potentially valuable tool if properly introduced and piloted.

4. “We welcome the Department’s decision to analyse how dental services might develop over the next 5 years. We recommend that the analysis be published. It should clarify the level of service which should be provided by the NHS and hence how many dentists will be needed. It will need to address the extent to which NHS dentistry should offer the growing number of treatments which do not address clinical ill-health but are concerned with improving quality of life.” (Paragraph 233)

The BDA has consistently challenged the Department of Health over the design and implementation of the GDS contract and would agree with the committee’s overall analysis. We support an evolutionary approach to contract reform focused on considered, piloted change to those elements which are problematic, with a particular focus on the role of commissioning. The BDA welcomes the Department of Health’s commitment to reviewing the development of dental services over the next five years. We look forward to more detail being provided as the BDA believes it is vital for the Department of Health to fully consult with the profession and obtain its input into the shape of future dental services. We believe that fundamental to any review must be an exercise to ascertain the real costs of providing modern dentistry which meets the aspirations for future NHS policy as laid out in the NHS Next Stage Review, in the World Class Commissioning framework and the principles identified within the BDA’s concept of patient-focused dentistry.

The provision of treatments on the NHS is a question primarily for government to answer. The BDA however firmly believes that this should be part of an open and honest conversation about what the NHS can and should provide. Clinicians have been placed in a difficult position under the current contract as it is not clear to practitioners or the public which treatments are available on the NHS. It should not fall to clinicians to explain and justify spending decisions of the NHS.

5. “We agree with witnesses that dental care is most effective when delivered over time and as part of a trusting dentist – patient relationship. We recommend that the Department reinstate the requirement for patients to be registered with an NHS dentist.” (Paragraph 219)

---

1 The BDA Good Practice Scheme demonstrates that a dental practice is committed to working to a standard of good practice. At the heart of the Scheme is the Good Practice Scheme commitment: a ten point statement for providing a quality service.
The BDA has always stressed the importance of continuity of care and is pleased that the committee recognised the importance of an ongoing relationship between clinician and patient. The BDA supports the principles which underpin registration and would in principle support its reintroduction but would highlight a range of concerns as to its meaningful implementation.

Registration in the past provided a barrier to access as it was not possible to provide for blanket registration of the population which the BDA believes would still be the case. The BDA also believes that the principles of patient care have moved forward since registration was last introduced. Both the NHS Next Stage Review and the World Class Commissioning framework repeatedly stress the importance of a patient focused NHS which is flexible to meet the needs and choices of individuals. We recognise that many patients prefer to access dental care on an episodic basis and we would not want to restrict or curtail access for those patients.

It would also be difficult to establish meaningful registration within the confines of the current UDA target driven system. If practitioners are to have a responsibility for the oral health care of their registered patients then they must be capable of treating them appropriately when required. The current system of UDAs means that practitioners can run out of UDAs before the end of the year, in such cases the practitioner cannot provide care to patients until the next year. This is clearly incompatible with registration and the resultant responsibility to patients. Similarly, if restricted to treating registered patients then it becomes even more difficult for a practitioner to predict their workload from one year to the next and, therefore, to successfully plan to avoid over performing or under performing which would result in PCTs clawing back money – which is unsustainable. A capitation model represents similar problems as it raises issues of registering across PCT boundaries and of distribution of practices.

Therefore, the BDA would be resistant to any ill-thought out reintroduction of registration which did not tackle either the problems associated with capacity or resolve the tensions between registration and the current UDA system. Any system of registration must improve rather than set up barriers to access and high quality patient care.

The BDA would welcome the opportunity to be consulted further on registration. There are two key areas which would need to be fully explored, firstly what the terms and obligations of registration would look like and secondly how registration could operate in tandem with a UDA system and episodic access.

---

2 The current dental capacity of the NHS based on the workforce and their levels of NHS commitment would not be able to support full registration of the population without generating excessive patient lists and waiting times.
New contract and implementation

1. “The Department’s original goal that patient access to dental services would improve from April 2006 has not been realised. The CDO claims that the situation has stabilised and that improvements will soon be seen as a result of new facilities which have been established. However, the various measures of access available all indicate that the situation is deteriorating. The total numbers of dentists working for the NHS and the activity (number of courses of treatment) they have provided for the NHS has fallen, albeit slightly. In addition the total number of patients seen by an NHS dentist between December 2005 and December 2007 has fallen by 900,000 compared with the two years up to March 2006. This figure possibly underestimates the decline because the data still include patients treated under the previous contract. Although in some places access to dentistry has improved since 2006, it remains uneven across the country. In many areas severe problems remain. The indications are that the new arrangements have failed so far to improve patient access overall.” (Paragraph 76)

The BDA agrees that the new contract has had a detrimental impact on access for patients and was pleased to see the committee focus on the problems surrounding defining access. The BDA is developing work on a definition of access which will enable us to better measure levels of care. We have also established a commissioning project which will look at commissioning best practice, improving access and the implications of the NHS Next Stage Review and the World Class Commissioning framework for dental services.

2. “While the Department argues that the new contract should improve preventive care and advice, this is disputed by dentists who claimed that the new contract failed to provide the time or incentive for them to do so. A survey in 2007 undertaken by the London Assembly showed that almost one third of NHS patients had not received preventive advice when they last visited their dentist. We recommend the Department undertake research to determine the extent to which the provision of preventive advice is being given and its cost-effectiveness.” (Paragraph 100)

The BDA agrees and would welcome further research. However, the new contract is as much of a treadmill as the previous one but with the added hazard of possible financial penalties. The BDA believes that to free up time and remove barriers to focusing on prevention, we need to take another look at some elements of the contract which currently discourage preventive activity, specifically the target driven approach. In particular we need to shift to one which measures and rewards preventive work as well as interventions. The BDA will be considering these issues and suitable contracting models through its commissioning working group and research projects.

3. “The introduction of UDAs as the measure of dental activity and the basis for remunerating dentists has proved extremely unpopular with dentists. The Department acknowledged that it has learned valuable lessons from the PDS pilots it had conducted from 1998 onwards, but the new remuneration system, based on UDAs was not tested through a pilot. It is
extraordinary that the Department did not pilot or test the new payment system before it was introduced in 2006.” (Paragraphs 175 & 176)

The BDA agrees. We have always remained unconvinced by the Department of Health’s assertions that primary legislation preventing changes to patient charges made it impossible for the UDA system to be trialled. The introduction of the new contract without piloting has meant that implementation caused as much trauma as the new contract itself. There was no opportunity to ascertain how the contract would work in practice, no opportunity for PCTs or practices to learn about the new systems and no opportunity for some of the problems in the system to be identified or remedied. We agree that it is extraordinary that the Government would risk patients’ oral health by implementing a new system which fundamentally they could not say with certainty would work – especially after they acknowledge the value of the information and experience gleaned from PDS pilots. We believe it is due to the hard work and commitment of NHS professionals that patient care has been sustained.

4. “Too many PCTs seem to have set unrealistic UDA targets. According to the BDA nearly half of dentists failed to meet their UDA target in the first year of the contract, if only by relatively small margins. This had financial consequences for new dentists when they failed to meet them. The Chief Dental Officer told us PCTs were applying UDAs too rigidly. We recommend that PCTs adopt a more flexible approach to UDAs as he proposed.” (Paragraph 177)

The BDA agrees. NHS Business Services Authority figures for 2006-7 showed that 48 per cent of NHS contracts in the first year of the new contract did not manage to meet their UDA target. This trend has continued in the second year of the contract with an identical 48 per cent of targets remaining unmet.3 The BDA believes this is continuing evidence of the fundamental flaws in the design of this target driven system. However, we would clarify that claw back has not just affected new dentists; all practitioners are liable for claw back if they do not meet their UDA target. We believe that UDAs are themselves an inflexible and crude measure of a practitioner’s work, where applying the targets inflexibly compounds the problem. Based on their experience practitioners can make reasonable predictions as to the patterns and level of their workload throughout the year but they should not be penalised financially or otherwise for “failing” to meet targets regardless of the patient’s best interests. There needs to be an open and constructive dialogue between PCTs and practitioners where missed targets are discussed and causes explored in a positive realistic environment with patients best interests at heart. Unfortunately, while many PCTs have tried to implement UDAs with flexibility their ability to do so has been hampered by patient charge revenue targets which are dependent on the number of UDAs the PCT commissions and achieves. PCTs also need to be given greater flexibility in their PCR targets to do as the CDO proposes.

5. “PCTs took on their new role (commissioning dental services) as a challenging time. In the summer of 2006 the Department halved the number of PCTs, in many cases resulting in a period of reorganisation or services and rationalisation of staff.” (Paragraph 122)

---

3 BDA FOI request to the BSA, 28 July 2008
The BDA agrees. The difficulties caused by introducing the new contract without piloting or giving PCTs sufficient time to learn about the new system, were compounded by introducing it at a time when many PCTs were in the midst of massive reorganisations. Reorganisations have had a long-term impact on some of the worst affected PCTs, some of which are only just returning to full staffing levels after the event. We believe this decision was unfair to practitioners and to PCTs, many of which had little previous experience of commissioning or managing dental services.

6. “We note concerns that the new GDS contract has transferred risk from the NHS to the dentists. The fixed-term contract may make dentists reluctant to make long term investments in their practice.” (Paragraph 203)

The BDA agrees. Dental practice owners have always borne the financial risks associated with running a business but the new contract has further shifted the balance of risk away from the NHS and onto the practice owner. The new contract has introduced additional financial insecurity for practice owners who are bearing the brunt of a system which is cash limited but serves near limitless demand. There has also been an increase in costs for practice owners introduced by new clinical governance and technical compliance which have not been accompanied by an increase in contract values. The new contract has introduced an absolute ceiling on NHS earnings, and therefore also on a practice owner’s ability to invest in their business. Consequently many practitioners have needed to counter this risk by adjusting revenue streams through diversification into private practice in order to protect their business. This has resulted in a reduction in available NHS dentistry which has had a detrimental impact on access and the ability of patients to obtain the NHS treatment they need.

This contract has introduced further financial insecurity through the loss of goodwill when selling a practice. The loss of goodwill further reduces the willingness and ability of practitioners to make long term investments in their practices. The BDA believes that practice owners should be able to sell on their businesses at an appropriate value without inappropriate intervention from the PCT.

---

4 BDA submission to the Doctors’ and Dentists’ Review Body, 26 September 2008
5 BDA submission to the Doctors’ and Dentists’ Review Body, 26 September 2008
Funding and charges

1. “The Department must base PCT dental funding on local needs assessment rather than historical provision. We recommend that the Department publishes the formula which it will use to determine dental funding for PCTs as soon as practicable.” (Paragraph 215)

The BDA agrees that in those deprived areas where spending has been historically low that additional investment based on a rigorous needs assessment is needed. We would welcome the opportunity to be consulted on the development of the funding formula. However, we believe it is important to highlight that as dental provision has historically been a service led by demand as opposed to need, provision and funding have also largely been configured to meet those demands. Introducing new services into previously under-served areas will need to be undertaken hand in hand with more innovative commissioning targeted towards addressing oral health inequalities, education and outreach. In particular, PCTs need to be allowed to commission services free from patient charge revenue or UDA targets. But, we would not want to see spending redistributed away from well-used services as the impact of destabilising those services would be far reaching and unpredictable.

2. “The Department’s prediction of patient charge revenue in 2006-7 was overestimated by a sum of £159 million. As a consequence PCTs went without the revenue they had planned for and had to reduce spending on dentistry or divert resources from other areas of expenditure to dentistry. The overestimate is unsurprising given that the scheme was introduced without piloting. We recommend that the Department improve its financial forecasting in this area.” (Paragraph 136)

The BDA agrees. The failure to accurately predict patient charge revenue is another outcome of introducing a system without piloting and therefore without the necessary data to make accurate predictions. The BDA has consistently called for PCTs to be allocated their full dental commissioning budget directly to avoid uncertainties in collecting patient charge revenue.

3. “We welcome the initiatives made by some PCTs and the Department to provide dental care for those people who do not currently receive it. However, we receive no evidence about how many PCTs conduct similar initiatives or about how cost-effective they are. We recommend that the Department monitor the impact of outreach initiatives with particular attention to cost-effectiveness.” (Paragraph 101)

The BDA supports initiatives which encourage uptake of dental services as maintaining good oral health is an essential part of good general health. However, it is also important to recognise that successful programmes need to be based on innovative commissioning models and require sufficient funding. Commissioning on the basis of UDAs is not appropriate in these circumstances. The BDA would be keen to review data on the impact of outreach programmes and discuss the future shape of these services.

4. “We welcome the simplification associated with the new charging system. However, there are problems. Some courses of treatment such as those involving a single filling have become more expensive. In addition different
patients are charged the same amount for very different treatments which fall within the same charging band. There is a danger that some low income patients will store up dental problems and delay visiting their dentist, at some cost to their long-term dental health. We recommend that the Department make further efforts to raise awareness among lower income earners of the assistance available for meeting dental charges.” (Paragraphs 89, 90 & 91)

The BDA would support moves to ensure those with greatest need had improved access to services.
Commissioning

1. “Some PCTs do not:

- Conduct adequate local oral health needs assessments;
- Have adequately trained commissioning staff;
- Make use of specialists and consultants in dental public health; or
- Implement the contract with sufficient flexibility. (Paragraph 211)

Without adequate oral health data on the oral health of the population, PCTs are not able to make valid dental needs assessments. We recommend that PCTs take immediate steps to widen the scope of the data they collect on the oral health of their local population. We also recommend that PCTs:

- Establish consultative committees comprising a mixture of experience and expertise including; patients, professionals and PCT personnel; and
- Employ appropriately trained staff and make full use of dental public health specialists and consultants.

In addition, the Department must clarify how it intends to improve the performance management of PCTs which are failing to implement contract with sufficient flexibility. SHAs must place greater importance on their role in managing the performance of PCTs in respect to dentistry.” (Paragraph 212)

The BDA agrees that excellence in commissioning is vital and we are committed to developing the principles set out by the World Class Commissioning framework and the NHS Next Stage Review in the commissioning of dental services. We therefore welcome the emphasis on commissioning in the committee report and its recognition that robust commissioning can only be undertaken when based on clear local data, supported by experts, and with the full engagement of professionals.

The BDA agrees that drawing on a full range of expertise in commissioning is vital, and that some PCTs do not make effective use of consultants in dental public health and their role is too often poorly understood. The BDA is committed to working with PCTs and consultants to help make the most effective use of these resources and support the training of dental advisors. However, there is currently a lack of consultants which will need to be addressed in order to ensure all PCTs are able to benefit.6 We are disappointed that the Department of Health’s Dental Public Health Capacity and Capability review is still yet to report or provide leadership in this area. The BDA would also welcome the opportunity to be consulted further on initiatives to develop consultative committees and share examples of best practice where similar initiatives have been undertaken aimed at drawing a full range of experience and perspective into the commissioning process.

The BDA also agrees that there needs to be stronger performance management and accountability for dental commissioning. We believe this would send the right signals

6 BDA submission to the Doctors’ and Dentists’ Review Body, October 2007
about the importance of dental services and ensure assistance for those PCTs that are currently underperforming. However, we also recognise that SHAs and PCTs are driven by those indicators set out by the NHS Operating Framework which currently only sets patient access targets. The BDA welcomes the inclusion of dentistry in the Operating Framework but believes a wider range of performance monitors for PCTs need to be put in place either by SHAs or through the Operating Framework. We also believe this should be set alongside additional resources for dental commissioners.

The BDA is committed to working constructively with commissioners to get dental commissioning right. We have set up a commissioning working group and research project to gather data on best practice commissioning models. Working with NHS organisations, patient groups, academic experts and providers we aim to establish a framework for dental commissioning drawing on the principles set out by the World Class Commissioning framework and the NHS Next Stage Review.

2. “Children-only contracts have been continued by some PCTs so that access to NHS services is maintained in the short term. The Department argues that PCTs should be strongly discouraged from entering children-only contracts with dentists. The Department should make it a priority to remove children-only contracts from the NHS dental service provision as soon as possible.” (Paragraph 153)

The BDA believes that the wholesale removal of child only contracts would be detrimental to patient care and patient choice. The issue of child-only contracts should be a matter for local commissioning determined by local circumstances and supported by local oral health data. Being directed by the centre to remove services undermines the principles which underpin local needs based commissioning. The BDA would also highlight the destabilising impact on local service provision and disruption to the care of those children affected. Where child-only contracts are removed this should be carefully managed to ensure that there continue to be local, accessible and suitable services for children; otherwise the result is a loss of dental services for children at a time in their lives when dentistry can have the greatest impact on long-term oral health.
Treatment patterns, referrals and data

1. “The number of complex treatments involving laboratory work fell by 50% during the first year of the contract. The number of root canal treatments has fallen by 45% since 2004. At the same time the number of tooth extractions has increased. The reason for the decline in the number of complex treatments since 2006 has not been explained satisfactorily and we are very concerned that as a result of the contract some patients do not receive the quality of care they need within the NHS. There is no evidence for the Department’s claim that the decline is to be explained by more appropriate simpler treatments. We recommend the Department publishes an explanation for this trend and commissions research into the effect of this decline within the NHS system and its impact on oral health.”
(Paragraph 106)

The BDA agrees that more expert work needs to be undertaken to consider the trends and their causes. The failure of the Department of Health to pilot the contract prior to wholesale introduction means there is very little understanding of the changes in treatment behaviour which may have occurred or the affect of the new patient charges on patient behaviour. Pilots of PDS contracts demonstrated initial changes in treatment patterns which plateau over a period. However, the lack of piloting and of comprehensive data in the first two years of the contract make it hard to establish an accurate picture within GDS.

There is also a variety of other factors which need to be taken into account such as the increased number of young and overseas trained dentists working in the NHS while many more experienced practitioners have opted out as a result of the 2006 contract changes. This may have resulted in some changes in prescribing patterns.

2. “We are concerned about the increase in referrals of patients requiring complex treatment to dental hospitals and community dentists. This can be bad for those patients who would prefer to be seen by their general dental practitioner and can also have adverse affects on patients who are traditionally treated in those settings and have to wait longer for treatment.”
(Paragraph 110)

In a recent BDA survey of clinical directors in the salaried services the most commonly cited causes of increasing referrals were a lack of GDS services in the area, increased public awareness of salaried services, and the impact of workforce changes which have led to an increased number of younger and overseas trained practitioners working in the NHS. The BDA therefore agrees that more expert work needs to be done to determine the causes of increasing referrals. We also believe that this highlights the need to ensure continued flexibility in the way in which the salaried services are performance monitored. Strict target-driven measures, such as UDAs, are completely unsuitable for those working in these types of high needs services.

3. “The Department has acknowledged that changes in 2006 to the way treatments were recorded led to a decline in the quality assurance mechanisms. In April 2008 it began to record an ‘an enhanced data set’. It is

---

7 BDA Clinical Directors Survey, 2008
too early too determine at this stage whether the enhanced data set collected by the Department will prove sufficient to improve both clinical and financial accountability. We recommend that the Department carries out a review of the effectiveness of the ‘enhanced data set’ after an appropriate time.” (Paragraph 118)

The BDA agrees that the original data set collected during the first years of this contract was insufficient. We welcomed the decision to increase the amount of data collected and would also welcome the opportunity to consult with the Department of Health about how this could be further improved.

4. “Up-to-date comprehensive data are vital to PCTs for commissioning dental services. We are therefore concerned at the uncertainty caused by the initial delay in the NHS Information Centre’s decision to commission the next decennial survey on Adult Oral Health. However, we welcome the fact that the survey is now to be undertaken in 2009, albeit a year late. We recommend the Department confirm its intention to conduct the next ten yearly child oral health survey due in 2013.” (Paragraphs 147 & 148)

The BDA welcomed the decision to commission an adult oral health survey, we had pressed the Department of Health for some time for a commitment to commissioning this. The data collected from the survey is invaluable and we were deeply concerned by the delays. We are equally pleased that the committee’s request for confirmation from the Department of Health that the Child Oral Health Survey will be commissioned has now been received.

5. “We recommend that the Department clarify the evidence on which it bases its claim that many parents do not consider their children with an IOTN score of 3.6 or above, require orthodontic treatment. We are concerned that some children who require orthodontic treatment will not receive it because adequate funds have not been allocated by PCTs.” (Paragraph 82)

The BDA supports the committee’s request for the Department of Health to clarify the evidence on which it bases this claim as we share its concerns that the IOTN score could be used to ration care. We would also raise our concerns that there is insufficient workforce to provide adequate orthodontic treatments, a situation which will deteriorate over the next ten years as more of the existing workforce is due for retirement.

6. “We welcome the establishment of Local Orthodontic Clinical Networks as making a significant contribution to improving the process by which local orthodontic assessments are made.” (Paragraph 83)

The BDA agrees. We believe that where Local Orthodontic Clinical Networks have been successfully established they have made a significant contribution to improving access to orthodontic services.
Workforce and education

1. “We note the fears that many dentists will leave the GDS in 2009. We also note the Department’s assurance that no such exodus of dentists will occur. We lack the evidence on which to judge the more likely outcome. We recommend that the Department monitor closely the career plans of NHS dentists.” (Paragraph 186)

The BDA has raised concerns about the number of dentists who have left the profession, as the committee noted, or may be planning to leave. We agree that it will be necessary for the Department of Health to monitor dentists’ career plans closely and take any necessary action to prevent practitioners leaving in large numbers with an inevitable impact on quality and accessibility of care for patients.

2. “The vocational training of newly qualified UK dentists and equivalent training for those dentists trained overseas is vital to the future viability of NHS dental services. Dentists should possess the full range of skills required to work in the NHS and vocational training provides a forum for these skills to be tested. However, we received evidence that vocational dental training has become a less attractive option. The Department should undertake research to determine whether a viable number of vocational dental trainers will be maintained in the future and take steps to ensure that this happens. The Department should also ensure that there are sufficient training places for all UK graduates to undertake vocation training and for all overseas graduates to demonstrate equivalent experience after they have passed either the International Qualifying Examination or Overseas Registration Examination.” (Paragraph 178)

The shortage of VT trainers needs to be addressed. Many potential trainers are being put off assuming the responsibility as a result of the high levels of bureaucracy, prohibitive workload levels in the practice and no space being available. The Department of Health needs to take steps to address these problems and to introduce a premium to contracts for practices undertaking training to compensate for the additional work involved.

3. “We note the BDA’s concerns that dental school graduates will choose not to practise in the GDS following graduation. The Department must ensure that GDS dentistry remains an attractive career option for dentists and dental care professionals.” (Paragraph 197)

The BDA agrees that it is paramount that the Department of Health take steps to ensure that GDS is an attractive career for graduates. Faced with the pressure of student debts and the problems some new graduates have faced in securing a VT training place many suggest that NHS dentistry is no longer an attractive career option. Indeed, the BDA 2008 Student Debt Survey suggests that increasingly students are considering entering private practice after graduation as they believe this will enable them to more quickly to pay off the debts accumulated during their training.

---

8 BDA Survey of Scottish General Dental Practitioners, 2008
9 BDA Student Debt Survey, 2008
4. “The recruitment of overseas dentists has enabled PCTs to replace much of the lost NHS dental capacity which followed the introduction of the new dental contract. There is no clinical evidence that patients’ oral health has suffered as a result, but there are concern that some overseas dentists are insufficiently familiar with the dental equipment and treatment provided within the NHS. The onus must be on PCTs to ensure that all dentists, irrespective of where they were initially trained, are of the standard necessary to provide high quality dental care.” (Paragraph 198)

The BDA agrees that it is vital for practitioners from overseas to be given appropriate support and training to ensure they are comfortable with NHS practice and procedures. PCTs have a responsibility to both patient and practitioner to ensure that this is the case and that those placed onto their performer lists, wherever they trained, can confidently demonstrate all necessary competencies.
**Factual errors to note for the committee:**

**Paragraph 183 (page 50)** states that “dentists working in the GDS before 2006 were given an income guarantee until April 2009 regardless of whether or not they met their UDA target” this is incorrect. All GDS contract holders have been subject to claw back since the introduction of this contract. The income guarantee simply stated that in determining the fixed value of the new contract, existing NHS practitioners would not be given a contract worth less than their NHS earnings in the test period. However, failure to meet the UDA targets attached to these contracts has still resulted in claw back.

**Para 187 (page 51)** states that “in 2006-7 the NHS trained 849 students in dental schools around the country” this is incorrect. Undergraduate dental students receive funding, and pay fees, on the same basis as any other student, for the first four years of their degree. It is only from year five onwards that the NHS makes a fees contribution and gives students access to a means tested bursary.