BRITISH DENTAL ASSOCIATION
Dental Commissioning Survey
June 2011
Survey background
This report details the findings from a BDA Dental Commissioning survey conducted between April and May 2011.

Method and response
The survey was conducted online. An invitation to take part was sent by email to all Dental Commissioning Leads in England. Where PCTs were working in cluster arrangements, a single response was requested to cover the whole commissioning cluster.

Fifty-one responses were received, representing 105 PCTs and giving a response rate of approximately 69 per cent.

Acknowledgements
The BDA appreciates the open and honest responses received from all participants and would like to thank them for their participation in this survey.

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Executive summary

- Improving access to dental services remains high on the agenda for commissioners.

- A third of commissioning teams (36 per cent) have reduced in size in the past 12 months with largely negative impacts on workload, morale, and ability to commission effectively.

- Over a quarter (28 per cent) of the Dental Leads are working in a cluster arrangement with other Primary Care Trusts. These arrangements were relatively recent for most, with the majority having taken effect in April 2011.

- For the most part, clustering arrangements were seen to have a positive impact on ease of contract management, making efficiency gains, and, to a lesser extent, ability to respond to local needs.

- As in previous years, there were mixed reviews about Local Dental Committees and their effectiveness/suitability for representing the dental profession in negotiations with commissioners.

- The level of contact with Local Authorities about the reforms proposed in the Health and Social Care Bill 2011 varied hugely across the country with some Dental Leads having a high level of involvement and others having had no contact to-date.

- Many of the Dental Leads expressed concerns about the NHS reforms, particularly in relation to local knowledge and responsiveness that could be lost by moving to a National Commissioning Board. Many felt that the reforms would undo the progress made in local commissioning since 2006.

- The Dental Leads held mainly positive views about how the dental contract being piloted would affect quality of care and local oral health. They held mixed reviews about how it would impact on value for money, and many felt it would make contract management more difficult. Concerns included the fact that it would only work if properly funded, the potential for supervised neglect, and IT/data capture issues.

- A third of Dental Leads had not spent their entire dental budget on dentistry in 2010/11.

- The majority of Dental Leads had their dental budgets for 2011/12 frozen at 2010/11 levels for most areas of dentistry. The area most likely to receive cuts was Salaried Primary Dental Care Services.
Commissioning priorities

Improving access to dental services was once again the most common priority for commissioning teams, mentioned as a top priority for three quarters of the Dental Leads and as one of the top three for almost all (98 per cent).

Improving quality was also high on the agenda, with one-in-three mentioning this as a top three priority.

“Improving quality through contract management.”
“Quality of Dental Services, premises and provision.”
“Sustaining high quality dental service.”

Improving oral health outcomes was a high priority for one in three commissioning teams, with reducing inequalities and improving the oral health of children specifically mentioned by several of the Dental Leads. An increased focus on prevention was one strategy for achieving this outcome.

“Promote high quality dental health and tackle dental health inequalities.”
“Public health/caries prevention/delivering better oral health.”

Contract management was also commonly mentioned, with a number of the commissioning leads planning to address underperformance. Others were focusing on promoting NICE recall guidelines. More still cited improving efficiency and balancing the books as more general priorities for their PCTs.

“Improving contract management and reducing under performance.”
“Effective contract management in line with QIPP agenda.”
“Effective performance management.”

A smaller number of PCTs are focused on specialist services such as orthodontics, endodontics, and minor oral surgery with some hoping to reduce waiting times and others aiming to reduce the number of referrals to secondary services.

Other top three priorities included improving infection control, supporting dental pilots, record keeping and clinical governance.

Dental Strategy

The Dental Leads were asked about the extent to which they were working towards a current Dental Strategy. Two per cent reported that they did not have a current Dental Strategy while a further 40 per cent have one but are only working to it ‘to some extent’. The remaining 58 per cent did have a current Dental Strategy that was guiding them.
Joint Strategic Needs Assessment

The vast majority (92 per cent) of PCTs or PCT clusters submitted dental information to the Joint Strategic Needs Assessment for their area. Where the PCT had made a contribution, the Consultant in Dental Public Health had sole responsibility in 40 per cent of the PCTs, and joint responsibility with the Dental Commissioning Lead in a further 16 per cent. Other contributors included Dental Advisors, Director of Public Health, Head of Oral Health, Medical Director and Information Support.

Just over one in five of the Dental Leads did not know who had been responsible for submitting dental evidence.
Commissioning workforce

Just under half of the Dental Leads have been in their role for five or more years and very few (two per cent) had been in the role less than a year. There has been steady improvement since 2009 when over a quarter of the commissioners had been in the role less than a year.

**Figure 3 Years in role as commissioning lead**

Almost half (46 per cent) of the Dental Commissioning Leads had seen a change to the size of their commissioning workforce in the past 12 months\(^1\). One-in-five teams had decreased substantially, while a further 16 per cent had decreased 'somewhat'. One-in-ten teams had grown in size although the increases were smaller in nature, just two per cent reported substantial increases.

**Figure 4 Size of commissioning team compared with 12 months ago**

Where there had been changes to their commissioning workforce, respondents were asked to describe the impact on: staff morale, workload, relationships with providers, and on their

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\(^1\) Where PCTs had clustered or merged commissioning functions, the Commissioning Leads were asked to indicate the change in workforce relative to the change in the size of the commissioning area.
ability to commission effectively. Figure 5 gives the results for the PCTs that had a decreased workforce.

Reductions to commissioning workforces had largely negative effects, with 94 per cent reporting negative impact on workload levels, and 73 per cent reporting a negative effect on morale. Two thirds felt that the reduction had a negative impact on their ability to commission effectively. Relationships with providers were the least likely to be affected by the staffing reductions, but, even so, 44 per cent reported negative outcomes in this regard.

**Figure 5 Impact of workforce reductions on the following areas**

<table>
<thead>
<tr>
<th>Area</th>
<th>Negative impact</th>
<th>No change</th>
<th>Positive impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff morale</td>
<td>73%</td>
<td></td>
<td>27%</td>
</tr>
<tr>
<td>Workload levels</td>
<td>94%</td>
<td></td>
<td>8%</td>
</tr>
<tr>
<td>Relationships with providers</td>
<td>44%</td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>Ability to commission effectively</td>
<td>63%</td>
<td></td>
<td>38%</td>
</tr>
</tbody>
</table>

While some of the respondents felt it was too early to comment on the impact of their workforce changes others were concerned at the longer term impact on dentistry, and felt that increased workload inevitably leads to lower quality commissioning.

“There is a risk of dentistry being reduced to a poorly supported Cinderella service overlooked by ‘National this’ and ‘National that’ until system failure demands change again.”

“With reduction of staff you can do what you need to do but it is the detail that is missing - ie you skim the surface and nothing else.”

**Clustering**

Over a quarter (28 per cent) of the Dental Leads reported that they had merged commissioning functions with other PCTs. While this reflected historical arrangements for a few of the commissioning groups, the majority had merged in April 2011.

Because the clustering arrangements were often quite new, it was difficult for many respondents to assess the impact these changes have had. On the whole, positive impacts were more commonly reported than negative impacts. Half of those in cluster arrangements reported a positive impact on the ability to manage contracts, 42 per cent reported a positive

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Due to the small number of commissioning teams that had increased workforce (five in total) it was not possible to do further analysis on these.
impact on efficiency savings, and a third felt that they are better able to respond to local needs.

None of the Dental Leads reported that the clustering arrangement had a negative impact on either efficiency savings or on their ability to effectively manage contracts to date. However, eight per cent did feel that the arrangements have had a negative impact on their ability to respond to local needs.

**Figure 6 Impact of clustering commissioning functions**

<table>
<thead>
<tr>
<th>Ability to respond to local needs</th>
<th>8%</th>
<th>33%</th>
<th>33%</th>
<th>25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency savings</td>
<td>25%</td>
<td>42%</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>Ability to effectively manage contracts</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
<td></td>
</tr>
</tbody>
</table>

**Local Dental Committees**

None of the Dental Leads reported any difficulties with Local Dental Committees (LDC) adjusting to the new commissioning clusters.

Three quarters of the Dental Leads have regularly scheduled contact with their local LDC(s) and a further 18 per cent have frequent ad hoc contact. However, six per cent have minimal contact with LDC representatives and two per cent have no contact at all.

**Figure 7 Contact between commissioners and Local Dental Committees**
The comments revealed a range of attitudes towards the LDCs, with some commissioning leads clearly valuing the contributions that their LDC makes.

“As General Dental Practitioners who have continually engaged with the PCT they have a wealth of knowledge and expertise on how general dental practices can best provide services to a diverse local population, and services that are required in secondary care and community dental services to meets the needs of their patients.”

“Local Dental Committees have ensured strong communication links to the PCT and are confident that the knowledge they have gained and contribution they have made would reflect our joint priority areas (PCT & LDC). LDC members are also respected members of the dental community and reflect the implications and impact on dental practices well for future commissioning decisions.”

“Relations have improved over the past couple of years, I believe we have an open and honest working relationship, they are a good source of local and national knowledge.”

Others felt that their LDC does not adequately represent the dental workforce and felt that wider consultation is necessary. In some cases there was felt to be a conflict of interest where LDC representatives are looking after their own business interests.

“Clearly LDCs are a source of expertise but care needs to be taken to work with all local dental teams.”

“We have a very close relationship with our practitioners; there is hardly any role for LDC to play. Although we are in regular touch.”

“Danger of blinkered views as it applies to each individual.”

A minority also felt that the LDC either did not have the necessary skills or were too negative to allow meaningful consultation.

“The majority of members are mainly private companies with only minimal understanding of NHS contractual requirements. Most have expected the PCT to ignore Regulations if it benefits them financially.”

“The PCT will be obliged to do so however this would be by rote rather than because particular expertise is available. This is not related to clinical ability (by this I mean [there is] a lack of political intelligence/ ability to see the big picture/ professionally organised and functioning group)"

“They have too many negative criticisms about changes locally and nationally.”

**NHS reforms**

Many of the Dental Leads have had no contact with their Local Authority with regards to the reforms proposed in the Health and Social Care Bill 2011. In some cases discussions were taking place at a Board or Directors level only and for others it was between Public Health teams.
“Within dentistry very little”

“None in relation to dentistry”

“None as Dental Lead although aware that PCT has had significant contact

“None at my level but we have good partnership arrangements in place locally therefore discussions will be occurring at Board level

“None personally however at Director level, lots of contact”

“None personally, but interaction will be taking place at a Senior Executive level.”

“Public health colleagues have more contact with LA colleagues”

“Meetings with dental public health colleagues”

“Discussions would take place via Public Health”

A minority reported much more active engagement with their Local Authority on dental matters regarding the likely transition of responsibilities.

“Strategic planning and development of the base for a new Health & Wellbeing Boards”

“[They were] part of the consultation on the dental commissioning strategy”

“Chief Executive is Acting Chief Executive of PCT”

“Briefings for members and officers.”

“Unitary authority and Care Trust Plus status gives us strong links”

“I keep them updated on the reforms at regular meetings.”

While most of the Dental Leads did not have an opinion on whether the proposed reforms would improve oral health in their area, those who did have an opinion generally did not agree. Forty per cent did not think the reforms would improve oral health locally, while just eight per cent did believe they would.

**Figure 8 Do you think that the proposed reforms will improve oral health in your area?**

![Figure 8 Pie Chart](image-url)
The main concerns about the reforms centred on the loss of local knowledge and responsiveness that would occur if commissioning was entirely removed to a National Commissioning Board, without retaining a local presence. There was a feeling that all of the progress made since 2006 will have been in vain if this is the case.

“I am concerned that when dental commissioning moves to the National Commissioning Board that unless there is a presence and a focus locally then we will lose local knowledge in the commissioning process. I am also concerned that we could lose innovative and successful local services.”

“In comparison to medical services (where the driver is local commissioning) it seems dental services will be commissioned at a regional or national level. In my opinion this will undermine all of the gains made in recent years through local commissioning of dental care. Local commissioners, working closely and in partnership with local Providers can shape services to meet the needs of the local population.”

“It depends on what happens with the structure and governance of the NHS Commissioning Board. If some local contract and performance management is maintained then some of the good work will be maintained.”

“They are ill thought out, demonstrate a total lack of awareness of the issues regarding access/ gaming/ claiming/ record keeping/ performer issues. An arms-length approach is not adequate.”

“The 'local commissioning' of NHS dentistry which the PCTs were charged to undertake in 2006 with little or no guidance was a steep learning curve, the outcome being that some PCT achieved better results than others for their local population. The work that has gone into building relationships, trust and confidence of the GDPs now appears to have been for nothing, as everything moves back to the 'centre' again.”

“The loss of local commissioning, local relationships, and understanding of how decisions impact on primary care will be lost as a result of the loss of PCTs unless there is some locality based arrangements at NHS Commissioning Board level”

Other concerns included the speed at which the reforms were taking place\(^3\), and the lack of specific detail about dental commissioning.

“They are being implemented far too quickly.”

“Lack of clarity about what will happen in future despite the white paper publication some time ago.”

“Uncertainty over the future makes it difficult to provide any long term assurance to dental contractors. There is great confusion about where the responsibility for dental commissioning will lie.”

“It will be crucial to get the governance and accountability arrangements right.”

\(^3\) This survey took place during the ‘listening exercise’ regarding the Health and Social Care Bill 2011.
**Dental contract pilots**

The Dental Leads were asked to comment on the new dental contract that is to be piloted. Specifically, they were asked how they felt a contract based on capitation and quality payments would impact on the quality of care, oral health locally, ease of contract management, and on value for money.

The most positive responses were regarding quality of care, which almost four in five (79 per cent) of the Dental Leads felt would be improved to some extent under the new contract arrangements. Just over half (53 per cent) also felt that local oral health would benefit.

The least positive response was regarding ease of contract management. Almost half of the respondents felt that this would be either decreased (37 per cent) or decreased greatly (11 per cent) under this type of contract. The impact of value for money had mixed responses, with 43 per cent predicting some improvement, and a third predicting a negative impact.

**Figure 9 Opinions on the impact of a dental contract based on capitation and quality payments***

*Excludes ‘don’t know’ responses

Areas of concern about the piloted contract included funding arrangements, with several of the Dental Leads feeling that the contract will not be successful unless properly funded.

“**Whilst the idea of paying practices by patient sounds attractive the reaction of dentists will depend on the level of payment.”**

“**It all depends on the money and level of PCT (or successor body) involvement with practices. They would be expected to welcome reduced NHS control and simple financial arrangements. They will hate what they see as interference and complex paper work or what may be perceived as unrealistic or unreasonable measures. The dentists level of satisfaction will be reflected in the quality of care patients enjoy.”**
Some were also concerned about the potential for supervised neglect under a capitation system.

“Previous experience does not indicate that a capitation based system improves oral health - can lead to supervised neglect and a re-emergence of access problems if dentists close lists.”

“Supervised neglect will be an issue.”

In terms of the piloting process more generally, some would have liked more involvement in the development stage. Criticisms were levelled at the planning of the pilots and there was some scepticism about whether the outcome has already been decided.

“There has been a lack of involvement with PCTs until the last minute - then requests for large amounts of data are being sent with a request to turn it around within 24 hours. It appears to have been badly planned in terms of launching the pilots, coupled with computer software not being ready to evaluate the pilots. It feels as though the decisions have been made that no matter the outcomes of the pilots - the new contract will be implemented. The variation to existing contracts have not been sent from DH, and won't be available until June/July - these will still have to be signed by the PCT as the DH has not contracting powers with providers, however, there are no details being shared with PCTs in terms of monitoring the pilots, have they gone live? Should we be monitoring on UDAs? And if not how should they be monitored? Patient charge revenue may be affected, and access figures may be affected. Having said all that, I do support some of the proposed changes, but would have appreciated being given the opportunity to feed into the proposal before it was launched.”

“Short term, not as long as initially proposed.”

Data capture and IT issues also concerned some of the Dental Leads.

“Agree with general principles but concerns that the process for capturing DQOF data will be overly complicated.”

“QOF type system will be difficult to administer and monitor effectively as IT infrastructure in high street varies greatly from very good - to none at all. Ineffective monitoring cannot prove value for money.”

The registration aspect of the piloted contract received mixed reviews about the effect it may have on access to dentistry or value for money.

“Many patients may “register” but then never return to that practice unless they have a problem so practices will be paid for patients that they are not providing care for - this happened previously under the old contract, but this was limited to 15 months, whereas the capitation/registration period will need to be extended due to NICE guidance on recall intervals being up to 24 months.
“Welcome a return to registration. Since the 2006 contracts practices have been more reluctant to take on new patients, I hope the new contract will reverse this and that practices which have always provided high levels of access will be rewarded. Also hope that practices which have worked hard to prevent caries, and promote good oral health will benefit.”

“Dentistry/ oral health/access are being politicised and used in politician games, this is not fair to patients and will not improve access as the problems with getting the hard to reach into care will not be solved by capitation etc; after all we have been down that road before. There will never be a perfect model which suits all stakeholders; this is accepted but we are not getting things right or even improving things with these proposals.”

“Many patients may “register” but then never return to that practice unless they have a problem so practices will be paid for patients that they are not providing care for - this happened previously under the old contract, but this was limited to 15 months, whereas the capitation/registration period will need to be extended due to NICE guidance on recall intervals being up to 24 months.”

**Future employment**

The survey revealed uncertainty about future employment. While the majority of Dental Leads would like to continue working in dental commissioning after PCTs have been disbanded (83 per cent), just 38 per cent thought it was either ‘very’ or ‘fairly’ likely that they would do so.

**Figure 10** Likelihood of working in dental commissioning after PCTs disband
Finance

Two-thirds of the Dental Leads reported that their entire ring-fenced dental budget was spent on dentistry in 2010/11, an improvement on the previous year when 60 per cent had done so. The minimum percentage of the budget spent was 80 per cent, also an improvement on 2009/10 when one PCT reported spending just 50 per cent of the budget⁴.

A couple of the Dental Leads reported over-spends in dentistry. In one case this was unplanned and due to a reduction in patient charge revenue. In the other, this was a planned top up of funding from elsewhere in the PCT’s budget.

Figure 11 Percentage of ring-fenced dental budget spent on dentistry in 2010/11 and 2009/10

Budgets remained unchanged for most areas of dentistry since 2010/11. Budgets for General Dental Services (GDS) were the most likely to increase between 2010/11 and 2011/12. Twenty-one per cent saw GDS budgets increase by 1-3 per cent, and a further nine per cent saw increases of four per cent or greater. Personal Dental Services (PDS) budgets rose for one in five PCTs (19 per cent), but decreased for almost as many (16 per cent). One-in-ten reported cuts of four per cent or greater to PDS budgets.

The most common areas to experience decreases were Salaried Primary Dental Care Services (SPDCS) and Hospital dentistry where 21 and 18 per cent saw reductions respectively. The cuts to Hospital dentistry budgets tended to be milder (all received 1-3 per cent cuts) while in the SDPCS nine per cent reported cuts greater than four per cent.

These cost savings were being realised through a range of initiatives and cuts, including: not reinvesting clawback; freezing a Consultant in Dental Public Health post; reducing reliance on secondary care; and through reductions in social marketing, community engagement and infection control assistance for practices.

⁴ A number of the Dental Leads (22) did not answer this question so these results should be interpreted with caution.
Figure 12 Budget changes 2011/12 compared with 2010/11*

* Excludes ‘Don’t know’ responses