



Government Response to the Health Select Committee Report on Dental Services

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
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Introduction

The House of Commons Health Select Committee published its report on dental services on 2 July 2008. This Command Paper sets out the interim Government response to the conclusions and recommendations in the report.

We are confident that the new dental contractual arrangements provide a better basis for Primary Care Trusts (PCTs) to commission services, as the new system equips them with greater powers and flexibility to meet the needs of local people. However, we accept the Committee's view that progress on improving access has been disappointing to date, and we will work with professional and patient groups to review how, both nationally and locally, we and the NHS can achieve the maximum benefits for patients from these reforms.

As well as an existing programme of work with PCTs to drive maximum benefits from the new arrangements in terms of access and quality of services, the Department of Health has begun work with Strategic Health Authorities (SHAs) to agree the high-impact changes that will most rapidly improve access to NHS dentistry. This work will be complete later this autumn and we will then be in a position to make a fuller response setting out further actions.

The Committee's report included 41 conclusions and recommendations. In this response, the conclusions and recommendations are addressed in the same numerical order, for ease of reference, as they appear on pages 61–66 of the report. Some are grouped together where they respond to the same issue. Elsewhere there are cross-references to previous responses.

1. Since the establishment of the General Dental Service (GDS) in 1948, there have been many improvements. The nation's oral health has improved significantly: in the 1940s a large proportion of the population were edentate; by 1968, 37% of the population had no natural teeth; the estimated figure in 2007 was only 6%. Increasingly the focus of dentistry has switched from pain relief to the provision of preventive care and cosmetic treatment. (Paragraph 32)
2. Nevertheless, by the 1990s there was a powerful case for reform of the General Dental Service contract. It was widely agreed that, while in some areas of the country provision of NHS dentistry was good, overall it was patchy. Moreover, the payment system lacked sufficient incentives for the provision of preventive care and advice. In addition, the Department argued that there were too many incentives to provide complex treatment. (Paragraph 33)

The Government welcomes the Committee's recognition of improving oral health and the change of focus in dentistry. One of the reasons for replacing the old contract was that it predominantly rewarded the "drill and fill" approach suitable for a population with poor oral health, rather than one where more people are keeping their teeth into old age.

The new system is intended to provide greater opportunities for preventive care and advice, and to remove perverse incentives that previously encouraged over-treatment and over-complexity.

Twelve-year-old children in England have the best oral health in Europe, as measured by the World Health Organization in its 2005 programme. Since 1973, the average number of decayed, missing and filled teeth (DMFT) in this age group in England has fallen from 5 to 0.7 affected teeth per child.

3. The Department's original goal that patient access to dental services would improve from April 2006 has not been realised. The Chief Dental Officer (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 Government agrees that progress during the first two years of the new arrangements was uneven. The evidence shows that the NHS is now commissioning a growing volume of dental services, which we are confident will feed through into higher levels of access. As well as an existing programme of work with PCTs to maximise the benefits of the new arrangements for access and quality of services, the NHS Management Board has begun work with SHAs to identify the high-impact changes that will most rapidly improve access to NHS dentistry. The work will be complete this autumn.

The measure of the number of people receiving NHS dental services within a 24-month period is necessarily a retrospective one. The figures quoted in the Committee's report cover the 24 months from December 2005 to December 2007, which included the first 21 months of the new commissioning and contractual arrangements.

This was – we acknowledge – a difficult transitional period, both for PCTs and for dentists. For most PCTs, the responsibility of commissioning dental services was a new one. The first year of the new system was dominated by the job of commissioning new services to replace those dentists who chose not to accept new contracts, and by handling cases where dentists disputed the terms of new contracts. Although new services were successfully commissioned and (in the vast majority of cases) disputes were successfully resolved, both processes were time-consuming.

Although PCTs generally made good progress in commissioning services during this transitional period, it also became clear that the level of extra commissioning was unlikely to achieve the step-change needed to address historical problems of dental access. That is why the Department increased funding for dentistry by 11% in 2008/09, enabling PCTs to commission a far greater range of new services.

It will, however, take time for the effect of this expansion of services to feed through to the retrospective data. This is reflected in the data released on 21 August 2008 by the NHS Information Centre. This showed a reduction in the 24-month figure, again reflecting the difficulties seen during the initial transition to the new arrangements. However, the data also showed that there were 2.7% more courses of treatment carried out in 2007/08 than in 2006/07, and that the number of dentists doing NHS work increased by 3.2%, with the largest cohort in the new group being young dentists (aged under 35).

This progress was achieved before any of the extra 11% investment in PCT allocations from April 2008 came into play. The volume of commissioned dental services is now growing further as a result of this extra investment. There are numerous examples across the country of new services being commissioned or extensions to existing contracts. PCTs are reporting no shortage of applicants where they tender new work and we are seeing a growth in the corporate dental sector. It is difficult to gauge how quickly these additional services will have their full impact on levels of access. However, feedback from newly established practices suggests that it takes up to 18 months to reach full clinical capacity in terms of patients seen.

In summary, the evidence suggests that services are now beginning to expand more rapidly, which will result in more people accessing NHS dental services. What is more, after initially poor relations between PCTs and dentists in some areas, there is now growing evidence of a collaborative approach. A Patients Association survey, published in March 2008, reported that 92% of PCTs were involving local clinicians in service development.

The Government fully accepts, however, that more needs to be done. In part, this involves addressing continued variability in the quality of commissioning between different areas. Those PCTs that have made the greatest progress in expanding services and meeting local needs have clear commissioning strategies, based on careful needs assessment, strong public and clinical engagement and robust procurement processes to develop new capacity. This is not, however, the case everywhere. Our response to recommendation 17 (see page 10) sets out how we are addressing this.

Another factor is that, in some areas where PCTs have commissioned new services, the public are not fully taking up the new services. In Southampton, some dental practices that are able to see patients report difficulty in getting uptake by patients. In London, the Greater London Assembly report on dentistry, published in November 2007, acknowledged that "London is well served for NHS dentistry" but went on to note that uptake remained low in many parts of the capital. We are supporting the NHS not only in expanding services, but also in promoting innovative ways of working with local communities to encourage uptake of new services.

4. We recommend that the Department clarify the evidence on which it bases its claim that many parents do not consider their children with an Index of Orthodontic Treatment Need (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)
5. 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 IOTN score of 3.6 has been used in orthodontics for some 20 years. Using this measure means that there is a consistent basis for assessing need for orthodontic services. Under the old dental contract, by contrast, there was a “postcode lottery” in the provision of orthodontic services, with high provision in prosperous areas and almost no provision in many poor areas. The assumption that many parents do not consider their children with an IOTN score of 3.6 or above require orthodontic treatment came from the same 2003 Child Dental Health Survey quoted by the British Orthodontic Society. Page 13 of the report included the following:

“Discrepancies were evident between parental views on the need for orthodontic treatment and needs as assessed by the simplified index of orthodontic treatment need. Among 12-year-olds, 19% of parents whose children were judged not in need of treatment on aesthetic grounds thought that their child’s teeth required straightening, while 48% of 12-year-olds recorded as in need on aesthetic grounds by the examining dentists were thought not to require treatment by parents.”

6. We welcome the simplification associated with the new charging system. (Paragraph 89)
7. 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. (Paragraph 90)
8. 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. (Paragraph 91)

We are pleased that the Committee recognises and welcomes the simplification associated with the new charging system. The new charges are much easier for patients to understand. We agree with the Committee about the need to promote awareness among lower-income groups of the assistance available for meeting dental charges. We will support the NHS in doing this, alongside wider activities to raise awareness of new dental services.

The banding system was developed on the advice of the Patient Charges Working Group chaired by Harry Cayton, National Director for Patients and the Public at the time, and included representation from patient groups (Age Concern, Citizens Advice and Which?) as well as representation from the British Dental Association. All members of the group signed up to the recommendations. Patient representatives on the group regarded it as particularly important that the maximum fee was reduced for all, and that the fee structure should ensure that those with high oral health needs were not deterred from treatment. Under the old fee-per-item system, patients needing extensive treatment and who were charge payers could pay up to £384 per course of treatment (2005/06 prices). Patients have benefited from the drastic reduction in the maximum charge that the new system brought in. The maximum fee payable is now just £198 (2007/08 prices).

9. 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 and the financial 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 Department will work with specialists in dental public health and dental researchers to investigate how information might best be obtained on the delivery of preventive advice in general dental practice, and its impact on patients' oral health and future dental treatment needs.

The learning from the Personal Dental Services (PDS) pilots showed a clear enthusiasm among dentists for working in a preventive way. However, the experience of the PDS pilots also showed that there was a lack of consistent understanding of which preventive procedures were evidence-based. In response to this, we commissioned guidance on evidence-based prevention in primary care from the British Association for Study of Community Dentistry, and copies of the document were sent to every NHS practice in the country in September 2007. Dental hospitals are now incorporating the principles of evidence-based prevention into their undergraduate training.

One of the most beneficial and evidence-based preventive procedures available is the application of topical fluoride varnishes to children's teeth. Evidence to support this has been available for 30 years, but there is no evidence of its widespread adoption under the old contract system. There is now growing evidence of its use, initiated both by individual dental practices and through PCT schemes. We have made this one of the measures in the enhanced clinical data set, and early evidence shows that it is increasing. It is covered by band 1 and can be provided by suitably trained dental professionals.

The most cost-effective preventive measure is fluoridation of water. In February 2008, the Department announced £14 million of funding for the next three years to allow the NHS to extend fluoridation of water, subject to consultation with local people.

10. 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 received 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 their cost-effectiveness. (Paragraph 101)

The Department will work with the NHS to investigate how information might best be obtained on this. As the Committee recognises, there is already good practice in parts of the country – for example, outreach services in Tower Hamlets and Hounslow in London. In Hounslow, the PCT piloted awareness-raising sessions in the local ASDA supermarket. In one week, over 200 children were seen, with information being given to parents about the availability of NHS services in their local area. Of the children seen, about 85% had had no previous contact with the dental health system. However, we recognise that progress across the country has been uneven. We are already working with SHAs and PCTs to identify and help disseminate best practice in commissioning and outreach.

The Department recently completed a public consultation on the use of the NHS identity in dentistry. We will now be working through PCTs to promote greater use of the NHS identity, to improve public awareness of the NHS services available and to publicise the assistance available for those on low incomes. We are also working with the Citizens Advice Bureau to quality-assure dental helplines, using “mystery shoppers” to test and assess the information given.

11. 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)
12. 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 treated by their general dental practitioner and can also have adverse affects on patients who are traditionally treated in these settings and who have had to wait longer for treatment. (Paragraph 110)

The introduction of the enhanced clinical data set in April 2008 provides a much better basis for the Department – and for PCTs and dental practices locally – to understand patterns of treatment. The Department will use the data from the new system to review trends and consider the need for additional research.

The evidence from PDS pilots was that moving away from a fee-per-item system (which encourages unnecessarily invasive and complex treatments) produced a 30% simplification in courses of treatment, without any evidence of adverse effects on dental health, and with good patient satisfaction. As noted by the Committee, the fall in the number of complex treatments pre-dates the new contract system. The National Audit Office's research into the PDS pilots (*A comparison of PDS and GDS patients in terms of number of interventions and oral health*, published in 2004) showed that the reduction in items of service did not impact on oral health.

The Government shares the Committee's concern about referrals of patients requiring complex treatment to dental hospitals and community dentists. Inappropriate referrals of the type described in some evidence submitted to the Committee are likely to be a breach of contract, which need to be handled by PCTs. We will encourage PCTs to use the new clinical data set to look for referral patterns that necessitate intervention.

13. 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 "enhanced data set". It is too early to determine at this stage whether the enhanced data 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 Dental Reference Service, which forms part of the NHS Business Services Authority, has developed and implemented a risk-based approach to quality assurance, supported by the enhanced clinical data set. The Government agrees that the Department should review these new systems once there has been time for them to bed down. In July 2008 the Dental Services Division of the NHS Business Services Authority issued new management data for PCTs, setting out key performance data and patient satisfaction survey data on each individual dental contract. This will significantly improve the information available to PCTs to support contract management.

14. The decision to allocate funds to PCTs on an historic basis made it extremely difficult for PCTs to contract additional dental providers in areas with traditionally few GDS dentists. (Paragraph 130)

15. We welcome the Department's provision of additional funding and the CDO's statement that there would be a shift towards allocating funding on a needs basis. We are disappointed, however, that the formula to be used for future funding allocations has yet to be determined. (Paragraph 131)

The Department allocated the bulk of funding on a historical basis in order to fulfil the guarantees given to dentists that their previous levels of NHS income would be protected for a transitional period.

The Government is committed to developing a fairer formula for allocating funds. In general, however, any new formula is likely to benefit the same areas where there have historically been more NHS dentists, given that these tend also to be the areas with greater oral health needs. Any formula will need to be more sophisticated than a straight population-based approach, and will not necessarily match the weighted capitation formula used for mainstream NHS allocations where age is a major factor. It will also be important not to destabilise existing dental services by redistributing the current ring-fenced dental funding.

16. The Department's prediction of patient charge revenue in 2006/07 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 Government acknowledges that the indicative estimate of patient charge revenue for 2006/07 was significantly overestimated. We do not, however, consider that it would have been fair to pilot different systems of patient charging, as patients in the pilot areas would have ended up paying different amounts for treatment than other patients. Our experience of the first two years of the new system has enabled us to improve our indicative estimates of patient charge revenue.

During the first year of the new contract, an increased number of patients seen were exempt from charges. This has some benefits, as non-charge-payers tend to have higher health needs. However, it clearly impacted on patient charge revenue, and we made an adjustment in the second year of the contract to reflect this. Patient charge revenue for 2007/08, according to figures released on 21 August 2008 by the NHS Information Centre, was £531.4 million – an increase of 11.8% on 2006/07.

Patient charge revenue will always, to some extent, reflect the commissioning decisions made by PCTs. For instance, where PCTs commission children's orthodontic services, the net cost will be proportionately higher because no patient charges will be collected.

17. In-house commissioning skills vary greatly between PCTs. As the Minister acknowledges, too many PCTs are not doing a good job, neither employing appropriately trained staff nor making full use of Specialists and Consultants in Dental Public Health when assessing local dental needs and commissioning services. (Paragraph 140)

The Committee has made a number of recommendations aimed at improving the commissioning of dentistry by PCTs. The Department has an ongoing programme of work to support PCTs in improving dental commissioning, and is reviewing this both in the light of the Committee's recommendations and to reflect the wider aims of the World Class Commissioning programme.

The Government agrees with the Committee that PCTs should use dental public health specialists to ensure that full account is taken of local oral health needs, and to help commission services that are effective, safe and that promote oral health. Such specialists can also provide professional leadership locally. The Department has commissioned a review of the dental public health workforce, with the aim of ensuring that the requisite number of specialists will be available to support local commissioning.

As stated earlier, we accept the Committee's view that progress on improving access has been uneven to date. The NHS Management Board has begun work with SHAs to agree the high-impact changes that will most rapidly improve access to NHS dentistry, and this work will be complete this autumn.

18. 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. (Paragraph 147)
19. However, we welcome the fact that the survey is now to be undertaken in 2009, albeit a year late. We recommend that the Department confirm its intention to conduct the next ten yearly child oral health survey due in 2013. (Paragraph 148)

The Government regards the adult and child dental health surveys as being of vital importance in providing gold-standard information about the nation's oral health. The Department has now commissioned the next Adult Dental Health Survey, and intends to carry out future surveys.

20. 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 NHS dental service provision as soon as possible. (Paragraph 153)

The Government agrees that child-only contracts are not a desirable model for delivering primary care dental services. In some cases it appears that they have had the effect of pressurising adults to accept private dentistry, so that their children can receive NHS care. Figures produced by the Dental Services Division of the NHS Business Services Authority also indicate that under-delivery of contracted levels of NHS activity is proportionately higher for child-only contracts.

In its evidence to the Committee, the Department accepted the need to move away from child-only contracts, but in a managed way. The Department issued guidance on this matter to PCTs in January 2008. This made clear that child-only contracts were undesirable, but that they should be managed out in a way that did not threaten children's access to NHS dental services. We will ensure that PCTs are aware of the Committee's recommendation.

It is worth adding that the old contract gave dentists complete freedom to decide to provide child-only services if they wished to. The new system allows PCTs to prevent services developing in this way.

21. In summary the National Audit Office (NAO) survey found that SHA involvement in dental services was limited, with PCTs largely left to devise and implement policy. (Paragraph 154)

The inclusion of dentistry in the NHS Operating Framework for 2008/09 has raised its profile among SHAs, but the Government accepts that more can be done to engage SHAs in supporting PCT commissioning and service development. The Department is currently working with all SHAs to look at how they can best support PCTs in this area, and how to accelerate improvements in access.

22. The introduction of units of dental activity (UDAs) as the measure of dental activity and the basis for remunerating dentists has proved extremely unpopular with dentists. (Paragraph 175)
23. The Department acknowledged that it had 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. (Paragraph 176)
24. Too many PCTs seem to have set unrealistic UDA targets. According to the BDA [British Dental Association], 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 that PCTs were applying UDAs too rigidly. We recommend that PCTs adopt a more flexible approach to UDAs, as he proposed. (Paragraph 177)

The PDS pilots had tested payment systems based on giving dentists a fixed annual contract value, just as the new contract does. The pilots also showed, however, that a more consistent system was needed to define the level of annual activity that dentists should carry out in return for this annual contract value.

The Department took the view that it was reasonable to define these annual activity levels by reference to courses of treatment (with a simple weighting system to reflect relative complexity), a measure originally developed with the BDA, and to provide that these required levels of activity (translated into “units of dental activity”) were 5% below those undertaken under the old contract – in order to address workload pressures and allow more time for preventive work. The available evidence supports the view that this has led, as intended, to a reduction in workload. For instance, statistics published by the NHS Information Centre on 21 August 2008 suggest that dentists’ working hours are shorter than they were in 2000.

For GDS contractors, contract values and levels of activity were not calculated by individual PCTs but by the former Dental Practice Board, based on each contractor’s earnings and activity in a reference period. PCTs had no discretion to set higher volumes of activity. For PDS dentists, the typical approach by PCTs, supported by Departmental guidance, was to set activity levels around 15% below the equivalent levels for GDS contractors. This does not support the view that dentists were given “unrealistic” targets.

Dental practices have the flexibility to under-deliver by up to 4% of their contract and to carry the balance into the following year. Statistics from the Dental Services Division of the NHS Business Services Authority show that 95% of contracted activity was delivered in the first year of the new system. Contracts that under-delivered tended to be smaller ones, and included a high proportion of child-only work. The fact that a dental practice does not carry out the amount of work required under its NHS contract does not in itself show that this amount of work was unreasonable.

The Government fully supports, however, the view that PCTs should work with dentists to develop other measures that can be used for contract monitoring, in addition to weighted courses of treatment. The NHS Next Stage Review highlighted the importance of developing a greater range of quality indicators, including patient satisfaction measures, across primary and community care. There are a growing number of examples of PCTs and dentists working together to develop these wider measures.

For example, the Tees group of PCTs is developing a Dental Contracting and Development Framework, which is expected to be piloted towards the end of the year. The framework includes a number of quality indicators, linked to an oral health needs assessment and including preventive measures such as the application of fluoride varnish and fissure sealants. The framework links to the wider public health agenda, with practices encouraged to participate in activities such as blood pressure checks. It also includes measures of patient access to dental services, availability of routine and urgent care, measures of staff training and development, and clinical governance issues.

In line with the overall objective of supporting continuous quality improvements across all NHS services, the Department will continue to promote these local developments, and its review of how dentistry will develop over the next five years (see response to recommendation 41) will look at what can be done nationally and locally to improve dental services.

25. 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 vocational 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 Government does not accept that there is evidence that vocational training has become a less attractive option. There have been more applications to be vocational trainers than ever before. Figures for this year show that in England there were 750 applications received to act as trainers for the 599 vocational training posts required. At this stage we are therefore confident about the provision of places, but the Department will keep this under review. Postgraduate dental deans are already working to identify new schemes to cater for increased graduate numbers from 2009 onwards. The Department has consulted deans and does not anticipate difficulty in recruiting trainers.

26. The Department asked for the contract to be assessed according to its own criteria for success: patient experience; clinical quality; PCT commissioning; and dentists' working lives. We conclude that the contract is in fact so far failing to improve dental services measured by any of the criteria. (Paragraph 179)

27. Nationally, fewer patients are visiting an NHS dentist than before April 2006 and access to dental care in many areas so far shows no sign of improvement. There is little evidence that the provision of preventive care has increased. There has been a decline in the number of complex treatments. The Department claims that this is because dentists are treating patients more appropriately, but there is some evidence that it is more likely that patients are not receiving the complex treatment they require within the NHS. It would help to clarify the picture if the Department provided evidence to back-up its claims. (Paragraph 180)
28. The CDO appears to argue that if PCTs and dentists acted more flexibly and used common sense and good will the new arrangements would work. However, we see little evidence that this will happen. (Paragraph 183)

As indicated in our response to recommendation 3, the Government accepts that progress in the first two years of the contract was uneven, but the evidence shows that the NHS is now commissioning a growing volume of dental services, which we are confident will feed through into higher levels of access. There were 2.7% more courses of treatment in 2007/08 than in 2006/07 and the number of dentists doing NHS work increased by 655. This was before the 11% increase in dental funding allocated to PCTs in April 2008, which is supporting further expansion in services.

This active commissioning of new services was simply not possible under the old contract system, where dentists could choose for themselves how much or how little NHS work to do from one month to the next.

We have acknowledged that there was insufficient focus on quality during the difficult transitional first year of the new contract. However, there is now a growing number of examples of innovative commissioning, for instance the Tees quality framework cited in our response to recommendations 22–24. In Kirklees, in the absence of fluoridated water supplies, the PCT is working with dentists and is commissioning fluoride varnishes for children from deprived communities.

It is difficult to define the “right” level of complex treatment that one would expect to see provided, based on patient needs. As the NAO study found in 2004, levels of complex interventions can fall sharply without adversely affecting patients’ oral health. The key is that individual patients receive care appropriate to their needs. Over-use of invasive treatments can be as damaging as under-treatment. The Department is working with the Dental Services Division (including the Dental Reference Service) of the NHS Business Services Authority to ensure that PCTs have expert support in identifying unusual patterns of clinical treatment, and are taking these up with local practices.

We take very seriously the concerns of the Committee about the degree of progress so far and about how some aspects of the system are working. The Department has signalled the importance that it attaches to improving dental services through their inclusion in the NHS Operating Framework for 2008/09 and through the 11% increase in dental funding this year. The Department is now working with SHAs to identify additional action that can be taken to ensure that there is more decisive and consistent progress across PCTs in ensuring that dental services meet local needs, and that there are continuous improvements in quality and patient experience. Working with the NHS to understand what adjustments may be needed, particularly to ensure that there is sufficient flexibility to drive access and quality, is a key part of this. As described elsewhere in this response, part of the role of the review the Department is planning will be to look at evidence of progress.

29. 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)
30. 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 Government notes the Committee's concerns and recommendations. There is currently no shortage of dentists interested in taking up the new contracts being tendered by PCTs, and interest in providing vocational training places is higher than ever. There is also no shortage of young dentists wanting to do vocational training and enter NHS practice.

That said, we do expect that dentists holding restricted contracts – such as child-only contracts – may decide to leave the NHS as these are phased out; PCTs will need to be proactive in replacing these services as quickly and seamlessly as possible.

The Department will, as the Committee recommends, continue to keep dental career plans under review. In doing this, it is important to bear in mind that there will always be a number of dentists who wish to practise outside the NHS. What matters to the NHS is that it can commission sufficient services to meet local needs.

31. 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 concerns 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 trained initially, are of the standard necessary to provide high quality dental care. (Paragraph 198)

Overseas dentists wishing to work in the NHS are subject to significantly more requirements than those who join private practices. All dentists working in the UK have to be registered with the General Dental Council. Those working in the NHS also have to comply with performers list regulations and, in the case of overseas dentists, pass a language test. Neither of these requirements apply to private practice.

Dental providers themselves also have a responsibility, when recruiting staff, to ensure that they are suitably qualified and receive appropriate training, induction and supervision, and carry out professional development.

The need for overseas recruitment emerged under the old contractual system, which saw a significant drift away from the NHS. The expansion in the number of undergraduate training places, and the continued positive response of dentists and corporate bodies to PCT procurements, means that national programmes of overseas recruitment are no longer required.

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

The life spans of GDS contracts and PDS agreements are not affected by the new system. All PDS agreements have been fixed-term since their introduction in 1998 and the duration can be extended by agreement of the parties. GDS contracts are not time-limited, unless a fixed term is agreed by both parties before the contract is entered into.

What is new is that NHS contracts can no longer legally be assigned to a second party when a practice is transferred or sold. The PCT is therefore responsible for deciding whether and on what terms to offer a contract to the new practice owner. However, this does not prevent the practices having what may well be an enhanced goodwill value, so long as the practice is offering services that are valued by the PCT and local patients. The key is for the practice to discuss with the PCT any proposed sale early in the process.

The Department notes the Committee's concerns in this area and will keep this issue under review. It is clearly important both to ensure stability for committed NHS dental providers and to ensure that PCTs can demonstrate that the services they commission are good value for public money.

33. 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)

34. Without adequate 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 the contract with sufficient flexibility. SHAs must place greater importance on their role of managing the performance of PCTs in respect to dentistry. (Paragraph 212)

The Committee has made a number of recommendations aimed at improving the commissioning of dentistry by PCTs. The Government supports these recommendations. The Department has an ongoing programme of work to improve commissioning, including targeted support for those PCTs identified as needing assistance. The NHS Management Board is working with SHAs to review how we can best support PCTs in developing their skills and capacity, taking into account all the Committee's recommendations.

We recognise the importance of PCTs conducting adequate oral health needs assessments prior to determining their commissioning framework. We also recognise that in so doing they should receive appropriate independent advice from specialists in dental public health, to ensure that full account is taken of local oral health needs and that the services commissioned are effective, safe and promote oral health. Such specialists can be important as change agents, and also provide professional leadership locally. However, we recognise that at present there is a national shortage of dental public health specialists, and that many existing specialists have sessions spread very thinly across a number of PCTs. The Department has therefore commissioned a review of the capacity and capability of the dental public health workforce, which it is anticipated will report towards the end of the year.

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

As indicated in our response to recommendations 14 and 15, the Government is committed to developing a fairer system for financial allocations. It is not possible in any area of NHS funding, however, to base PCT allocations on local needs assessments. Any national formula is necessarily based on a national assessment of comparative health needs.

36. 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 [Quality and Outcomes Framework]-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 such a QOF-style system for dentists might work in practice. (Paragraph 217)

The Government fully supports the case for developing incentives for high-quality preventive care. This is wholly consistent with the conclusions of the NHS Next Stage Review, which emphasised the need to give all healthcare providers a stronger role in prevention of ill health, and to drive continuous improvements in quality.

We consider that the precise choice of quality and preventive indicators is best made locally, just as we are currently exploring how to allow greater local flexibility in the choice of QOF indicators for general medical practice. We are, however, examining with our Key Stakeholder Group (KSG) how to develop a greater range of dental quality indicators, based on clinical effectiveness and health outcomes. We are setting up a group, reporting to the KSG, which will evaluate current practice and outcomes and identify ways in which quality can best be measured and benchmarked. We have written to the BDA and other stakeholders to invite them to join us in this developmental work.

PCTs have already launched a number of initiatives locally. Doncaster, for example, has a QOF-style scheme for local dental practices. Heart of Birmingham PCT is piloting an accreditation scheme, which offers an in-depth review of quality indicators.

37. 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)

The Government agrees with the Committee's views on the importance of continuity of care. We are not, however, aware of any evidence of lack of continuity in dental care as a result of the introduction of the new contract system.

It has never been a requirement that patients register with an NHS dentist. There was no registration scheme in dentistry before 1990, but patients still identified a particular dentist as "their dentist". Between 1990 and 2006, a portion of dental remuneration was linked to the numbers of patients registered with the practice (with "registration" lapsing if the patient was not seen within a period of 15 months), although this did not stop dentists from de-registering patients if they wished to do so. Since 2006, this feature of the remuneration system has no longer applied, but this does not prevent patients from receiving continuity of care.

We recognise, however, the significance still attached to the term “registration”, and we will examine the scope and options for some form of registration in consultation with the dental profession.

38. We recommend that the Department commission research, as a matter of urgency, to find out why the volume of band 3 treatments has fallen so dramatically and the likely outcome of this fall on the oral health of patients. (Paragraph 223)
39. 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 bands 2 and band 3. While there should be no incentive to provide unnecessary complex treatment, neither should there be disincentives to provide it where it is clinically appropriate. (Paragraph 224)

We are working with the University of Manchester to develop a research proposal to assess the impact of the new system on oral health, and on the ability of the NHS to commission services to meet needs and adopt a more preventative approach.

Moving away from a system that over-incentivised treatment was always intended to lead to a fall in the amount of complex treatment being given. This was piloted in the PDS scheme. The fall in the PDS pilots was broadly consistent with the fall we have seen under the new arrangements. Evaluation of PDS pilots suggested that a 30% reduction in items of treatment was consistent with maintaining high standards of oral health and patient experience.

The issue at stake is whether in each individual case the reductions have been driven by clinical needs rather than by financial advantage. Failing to provide the most clinically appropriate care to gain financial advantage is of course a breach of professional standards, of patient trust and of NHS contractual requirements. We continue to believe this would be abhorrent to the vast majority of dentists.

We take the quality of clinical care very seriously, however, and that is why we have introduced an enhanced data set to enable PCTs and practices to far more easily track the pattern of treatments provided in band 3 and in other bands. The Dental Reference Service can provide PCTs with support in examining treatment patterns in depth to ensure that clinical practice is appropriate.

The three-band system emerged as a result of discussions with the BDA and other stakeholders. We will review the bandings as part of our study of how NHS dentistry will develop over the next five years. Any contractual currency, however, whether it is based on fee per item, capitation or (as under the current system) courses of treatment, has ultimately to rely on dentists delivering care to meet clinical need, and not allowing their judgement to be affected by the degree of remuneration that an individual treatment will attract.

40. In the longer term we recommend that the Department review the UDA system and consider whether it is the best mechanism for delivering oral healthcare. Any changes to the system should be piloted and tested rigorously. (Paragraph 225)
41. We welcome the Department's decision to analyse how dental services might develop over the next five 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 Government welcomes the Committee's support for the Department's decision to carry out a review of how dental services should develop over the next five years, and what action is needed to ensure that, nationally and locally, dental commissioning evolves continuously to reflect public needs.

We will appoint an external chair and will involve key stakeholders in this work – we have already discussed the broad scope of the study with our KSG – and we will publish the findings.

This work will look at all aspects of the arrangements for commissioning, including units of dental activity and other matters of concern to the Committee. It will be guided by the principles of the NHS Next Stage Review, and the specific objectives for primary and community care. These include ensuring that services are responsive to the needs of individual patients, ensuring a strong focus on prevention as well as treatment, and driving continuous improvements in the quality of care.



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