Introduction

New contractual arrangements for NHS Dentistry were implemented in April 2006 and marked a radical change in how primary care dental services from dental practices are provided and funded in England.

In September 2006, the Scrutiny Board (Health and Adult Social Care) established a working group to investigate the impact of the new NHS Dental Contract on Leeds residents and on the dentists themselves.

The philosophy behind introducing the new NHS dental contract was to get dentists off the ‘fee per item treadmill’ and improve patient care by encouraging a more preventive approach. The new system aimed to simplify the patient charging system, improve the working lives of dental teams, and ensure that services are appropriate for the local population.

During our Inquiry we sought the views of a number of key stakeholders on the new NHS Dental Contract, exploring any barriers and opportunities for improvement.

These stakeholders included the Yorkshire and the Humber Strategic Health Authority, Leeds Primary Care Trust, Leeds Dental Institute, Leeds Local Dental Committee, and Patient and Public Involvement Forums.

Whilst the Leeds Local Dental Committee represents the views of dentists across the city, we also decided to visit a number of local dental practices in Leeds.

We would like to sincerely thank everyone for their commitment and contribution to our Inquiry.

A number of national and local issues surrounding the new NHS dental contract have arisen from our inquiry. As a result, we will be sharing our findings with the Department of Health and have made a number of recommendations aimed at improving the provision of NHS dentistry in Leeds.
Introduction and Scope

Scope

Primary Care Trusts and dental teams clearly have a major role in improving oral health which is why we agreed to focus our inquiry on the new NHS Dental Contract.

However, we acknowledge that many other organisations and individuals also have a vital role to play in improving oral health. As a Scrutiny Board, we therefore welcomed the development of an Oral Health Strategy for Leeds and contributed separately towards this strategy in July 2006.

The aim of this particular inquiry was to make an assessment of and, where appropriate, make recommendations on:

- The scale of the problem in Leeds in terms of accessibility to dental services, with particular reference to high risk groups;
- The principles behind the new NHS dental contract and how this aims to address local needs;
- commissioning, governance and monitoring arrangements for the new NHS Dental Contracts;
- Workforce development and capacity issues in delivering the new NHS Dental Contract;
- Equality and accessibility issues;
- The condition of dental premises (Do these meet the requirements of the Disability Discrimination Act and address patient privacy and confidentially?);
- The commissioning of unscheduled dental care and Orthodontic care.

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Conclusions and Recommendations

The principles behind the introduction of a new NHS dental contract

Since the establishment of the NHS, dentists have been paid on a fee per item of treatment basis.

For each of approximately 400 different items of treatment that were available on the NHS, a fee was set and the dentist would receive the fee for each item provided. We learned that over the last 20 years, a number of major reviews of the NHS dental service identified this system as no longer being appropriate as it encouraged early intervention rather than a more preventative approach. It also proved very difficult for patients to understand the large number of different treatment payments.

Earlier systems also allowed dentists to develop services at will and the Primary Care Trusts (PCTs) had no influence over what, and from where, services were being provided. Consequently, practices tended to be established where it was considered financially advantageous to do so. This often resulted in poorer provision within the more disadvantaged areas where oral health needs were higher.

To help set capacity levels and control spending for the provision of dental care in line with allocated budgets, PCTs were given the responsibility for primary dental services in the Health and Social Care Act 2003.

By devolving the national funding for NHS dental provision to PCTs, this allowed for local commissioning of services. PCTs have a legal obligation to ensure the delivery of high quality dental services to meet all reasonable requirements within their area. The PCTs are performance managed by their local Strategic Health Authority to ensure that money allocated for dentistry is being spent on dentistry.

We recognise that one of the clear advantages of this new system is that where a practice/dentist retires, moves to another area or converts all or some of their NHS patients to private care, the funding for this service will remain with the PCT for reinvestment in local NHS dentistry services.

However, we were concerned to learn that the funding made available to PCTs for the commissioning of dental services will only be ring-fenced up to 2009. After this period, the funding will feed into the PCT’s baseline budgets. In view of this, we recommend that the Leeds PCT shows a commitment to ensure that NHS dentistry in Leeds is well resourced after 2009 when the funding for dentistry ceases to be ring-fenced.

Recommendation 1:
That the Leeds Primary Care Trust shows a commitment to ensure that NHS dentistry in Leeds is well resourced after 2009, when national funding for dentistry ceases to be ring-fenced.
**Conclusions and Recommendations**

*New charging system for patients*

The new contract also introduced a simplified patient charging system for NHS dental treatment. This new system reduced the maximum charge for a single course of dental treatment from £384 to £189.

The patient charging system is based on 3 bands:

- **Band 1** - £15.50
  
  This includes an examination, diagnostic and preventative care. If necessary, this will also include X-rays and scale and polish.

- **Band 2** - £42.40
  
  This includes additional treatment such as fillings, root canal treatment or extractions.

- **Band 3** - £189.00
  
  This includes more complex procedures such as crowns, bridges and dentures.

We noted that the fee for each band is constant, no matter how much treatment is provided within that band. Whether a patient receives 1 filling or 21 fillings, the same patient charge will apply for band 2. Similarly in band 3, patients will pay the same amount whether they have 1 crown, 5 crowns, or dentures.

Whilst we acknowledge that the new patient charging system is much simpler, we are concerned that this system does not seem to benefit all patients. In particular, the system appears to disadvantage patients that would routinely attend their dental practice for short and simple treatments. These patients are likely to pay more than an irregular attendee needing a great deal of care after years of dental neglect. This therefore goes against the whole philosophy of a preventative approach which is being promoted by the Department of Health. We therefore recommend that the Leeds PCT lobbies for a national review of the patient charging bands.

**Recommendation 2:**

*That the Leeds Primary Care Trust lobbies for a national review of the patient charging bands.*

*New funding arrangements for dental practices*

In the first year of the new contract, the funding received by each PCT reflected the amount of NHS dental treatment provided in the locality between 1\(^{st}\) October 2004 and 30\(^{th}\) September 2005.

Dentists who carried out NHS dental treatment between October 2004 and September 2005 were therefore eligible for a new contract from April 2006.

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*In April 2007, the patient charging bands increased to £15.90, £43.60 and £194*
Conclusions and Recommendations

Under this new contract, dental practices are funded using a ‘points per band’ system. This new contract currency is referred to as Units of Dental Activity (UDAs).

The number of UDAs accrued from dental treatment is linked to the patients charge banding system as follows:

- Band 1 equates to 1 UDA
- Band 2 equates to 3 UDAs
- Band 3 equates to 12 UDAs

Each dental practice is contracted to deliver a number of UDAs per year based on their previous pattern of work. We noted that the first annual contract value reflected a dentist’s gross earnings for October 2004 to September 2005.

Each year, contract values are negotiated between individual dental practices and the PCT. Once agreed, the dental practices will receive their annual contract value in twelve equal monthly instalments. One of the key benefits of this new funding arrangement is that dental practices are now able to manage their budgets more effectively throughout the year.

However, one of the major criticisms of the new contract currency made by dentists is that it does not accurately reflect the work involved. A dentist will achieve the same amount of UDAs for a patient needing one filling compared to a patient needing 20 fillings due to the fact that the treatment activity levels correspond to the same patient charging band.

We have heard from local dentists and the Leeds Local Dental Committee that this new method of working is proving very difficult to manage since patient needs can vary enormously. Dentists are therefore under constant pressure to meet their UDA targets in fear of receiving a lower contract value the following year, which will result in reduced funding.

In contrast, we learned that where a dental practice is exceeding its allocated annual UDA target, the practice is not awarded any extra funding from the PCT. This therefore provides no incentive at all for dental practices to carry out any more NHS dental treatments once their targets have been met. This could result in existing and new patients being turned away for treatment.

We understand that once a contract value is negotiated and the UDA targets are set for dental practices, it is very difficult to then re-negotiate contracts to take account of any unexpected levels of demand for NHS dental treatment.

In view of this, it is vital that contracts are negotiated fairly and accurately between local dental practices and Leeds PCT. Strong communication links and robust data collection is therefore essential.
Conclusions and Recommendations

We acknowledge the work and commitment of the Leeds PCT since taking on this new responsibility and very much appreciate the difficulties associated with such a role. However, to help further reduce concerns raised by local dentists around contract values, we recommend that the Leeds PCT works closely with the Leeds Local Dental Committee to look at how communication links with local dental practices can be improved further to aid the contract negotiation process.

Recommendation 3:
That the Leeds Primary Care Trust works closely with the Leeds Local Dental committee to explore how communication links with local NHS dental practices can be further improved to aid the contract negotiation process.

Recommendation 4:
That future funding for NHS dentistry takes into account current need for NHS dental provision and not be based purely on historical trends.

Impact of the new contract on the number of NHS dental practices in Leeds

Dental practices were given a deadline of 31st March 2006 to sign up to the new contract. The Leeds PCT was therefore unable to start re-commissioning services until all the dental practices had made their decision.

The Leeds Local Dental Committee explained that the introduction of the new NHS dental contract had demoralised the profession due to the fact that last minute amendments had been made to the new contract which went against advice given to the Department of Health by the profession during the initial consultation stages. By introducing a new method of calculating dental activity, it was also thought that practices may have been struggling to adapt existing information systems to capture the new types of data required for the new contract.

We were informed by Leeds PCT that prior to the introduction of the new dental contract, 148 practices had provided some level of NHS dental care in Leeds. However, following the
Conclusions and Recommendations

introduction of the contract, approximately 110 practices continued to provide NHS dental care, which resulted in a reduction of approximately 33,000 patients receiving NHS dental services.

Dental contract statistics are periodically collated by the Department of Health from all PCTs. At the time of writing this report, the most recent statistics available from the Department of Health related to the position as at 31 January 2007. In relation to Leeds, the position was as follows:

<table>
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<th>UDAs commissioned</th>
<th>and provided</th>
<th>but not yet provided</th>
<th>total</th>
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<tbody>
<tr>
<td>1,168,549</td>
<td>6,386</td>
<td>1,174,935</td>
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<th>UDAs re-commissioned</th>
<th>and provided</th>
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<th>total</th>
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<td>76,741</td>
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<tr>
<th>Total initially in dispute</th>
<th>Contracts</th>
<th>UDAs</th>
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<tbody>
<tr>
<td>65</td>
<td>780,966</td>
<td></td>
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<table>
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<tr>
<th>Unresolved</th>
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<th>UDAs</th>
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<tr>
<td>47</td>
<td>546,201</td>
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Resolved – outcome accepted

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<td>18</td>
<td>235,015</td>
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Resolved – outcome not accepted

<table>
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<th>UDAs</th>
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<tbody>
<tr>
<td>nil</td>
<td>Nil</td>
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We noted that disputes between local dental practices and the Leeds PCT over the new contracts focused around the contract value and also the regulations, in particular the ownership of patient records and what happens when dentists wish to sell their practices. Where contracts are still in dispute between local dental practices and the Leeds PCT, it is essential that these are resolved as quickly as possible to determine whether or not re-commissioning of local NHS dental services is required.

Re-commissioning of NHS dental services by Leeds PCT

We were informed by Leeds PCT that where dental practices had delivered a universal NHS service previous to the new contract and then expressed a wish to include exemptions into their new contract, the PCT had decided not to accept these exemptions. In re-commissioning dental services in Leeds, the Leeds PCT explained that it would focus on providing universal NHS dental services as a matter of principle.
Conclusions and Recommendations

We were pleased to note that Leeds PCT would approach existing practices first to give them an opportunity to tender for re-commissioned services.

We also discussed the use of Local Improvement Finance Trust (LIFT) projects to help redress capacity issues across the city. Particular reference was made to the Yeadon LIFT building, which had been identified by Leeds PCT as a location for commissioning dental services. However, due to workforce capacity issues, we learned that some existing Community Dental Services located within LIFT buildings were struggling to fill vacancies.

Whilst we welcome the use of LIFT projects to provide dental services in areas of need, it is essential that Leeds PCT addresses the workforce capacity problems. However, we do acknowledge the wider issues surrounding workforce capacity and have made reference to this separately in our report.

Impact of the new dental contract on the Emergency Dental Service

The Emergency Dental Service provides out of hours treatment and is for the relief of pain and provision of other urgent care. It does not provide full comprehensive treatment. However, we noted that individuals were using this service as an alternative to registering with a dentist.

As this service only deals with acute emergencies, we were concerned to learn that individuals are relying on this service rather than receiving routine care from a dentist. Such individuals are therefore likely to keep returning to this service for further treatment, which is not its purpose. As this service is commissioned by Leeds PCT, we recommend that Leeds PCT ensures that the Emergency Dental Service develops a policy aimed at educating patients about the role of the service and its appropriate use.

Recommendation 5: That the Leeds Primary Care Trust ensures that the Emergency Dental Service develops a policy aimed at educating patients about the role of the service and its appropriate use.

Impact on Community Dental Service

The Leeds Community Dental Service is a PCT salaried Primary Care Dental Service providing primary dental care and specialist services and this care is free of charge for those patients who are in the exempt categories. However, those patients who fall into the non exempt category are charged for dental care in the same way as they would be charged in the General Dental Service.
Conclusions and Recommendations

We noted that the client groups historically associated with the CDS have found provision of their dental care within the General Dental Service very difficult due to time/facility constraints and also the degree of specialised services required. It was noted that there has been a 50% increase in the number of referrals received by the CDS since the introduction of the new contract in April 2006. Not only has there been an increase in the number of patients with acute problems (self referrals), there has also been an increase in the number of referrals received from local dentists, the Leeds Dental Institute and other health care professionals.

Impact on the Leeds Dental Institute

The Leeds Dental Institute (LDI) is a School of the University of Leeds, offering Dental Undergraduate, Dental Care Professional (DCP) and Postgraduate education. It is not commissioned by the Leeds PCT to deliver primary dental care. However, we noted that patients can receive access to walk-in clinics if they have no dentist and are in pain. In some cases, patients can also be accepted for courses of routine dental care. This care is delivered in teaching clinics and is only provided if a patient’s care need matches student training requirements.

LDI is also one of the Clinical Management Teams of the Leeds Teaching Hospital NHS Trust (LTHT) and as part of LTHT is commissioned by Leeds PCT to deliver a range of specialist secondary and tertiary dental services. In terms of attendance at LDI, it was noted that since the introduction of the new NHS dental contract, the number of “walk-in” patients seeking management of pain has risen. This rise is affecting both adults and paediatric patients.

Orthodontic care

We were concerned to note that the structure of the new dental contract for primary care has resulted in less orthodontic care being provided from the funding available. Without additional investment, this will lead to an unavoidable reduction in the level of treatment to what has previously been provided. We learned that priority has been given to reduce the costs of orthodontic care where possible, by looking at cost effective methods of commissioning, such as looking at skill mix opportunities.

Workforce capacity issues

It is recognised nationally that there is a shortage of dental workforce in the UK. We noted that from September 2005 there has been an increase of 170 funded dental undergraduate training places (25%). However, it will be five years before the first of these additional students graduate.

Dental graduates are required to carry out one year vocational training to be able to practice in the NHS. We were therefore concerned to learn that the
Conclusions and Recommendations

availability of dental practices for vocational trainees to carry out their training is limited. It was highlighted that where practices had taken on more UDAs to accommodate a placement, the time taken to supervise a vocational trainee would often add to the pressure of meeting the UDA target. Where practices had also taken on new patients, it was sometimes difficult to maintain these patients once the trainee had left the practice. In view of this, dental practices are more reluctant to offer placements for vocational trainees. It was also noted that as a greater proportion of female students join the Dental Register, the complexity of workforce planning will increase. Family friendly working conditions will be needed to deliver flexible working conditions if modern dentists are to be retained within the NHS.

To help improve access to dental treatment in the long term, the Leeds Dental Institute emphasised the need for plans to include the expanding range of Dental Care Professionals currently trained in the Institute. These include Dental Therapists who are trained to deliver simple adult and children’s fillings and remove baby teeth. It was also highlighted that whilst clinical dental technicians are not yet trained in Leeds, a provisional programme of education has been approved for LDI by the General Dental Council.

Having Leeds Dental Institute within the city provides an opportunity for commissioners to review the best skill mix for providing high quality dental services to the residents of Leeds. We therefore recommend that the Leeds PCT works closely with the Institute to carry out this review.

Recommendation 6:
That the Leeds Primary Care Trust works closely with the Leeds Dental Institute to review the best skill mix for providing high quality services to the residents of Leeds.

New registration processes

The previous system of registration, which was introduced in 1990/91 as part of the mechanism for paying dentists, ceased on 1st April 2006. Patients are therefore no longer on long term registers with a particular dentist.

Although the regulations do not provide for a registration system, the government acknowledges that dentists may still wish to continue to have an ongoing relationship with ‘their patients’ and keep a practice list of their own patients. However, dentists only have to see any patient if they have the clinical capacity to do so.

We were informed by Leeds PCT that a public advice line had been set up for patients regarding access to local NHS dentistry services. Whilst this advice line does not offer professional advice, its helps to signpost individuals to available dental practices. The
Conclusions and Recommendations

allocation of individuals to dental services is based on priority of need.

We noted in September 2006 that since the advice line had started in February 2006, the PCT had received approximately 10,000 calls. The data collated from this has helped the PCT in terms of assessing current service demands. However, we feel that this advice line needs to be more widely publicised. We therefore recommend that the Leeds PCT engages with Leeds City Council to potentially utilise existing communications and links with various community and voluntary groups to help significantly improve the publicity of the advice line.

Recommendation 7:
To help significantly improve the publicity of the dental advice line, we recommend that Leeds Primary Care Trust engages with Leeds City Council to utilise its existing communications and links with community and voluntary groups.

Mid Year Reviews

As part of the contract monitoring arrangements, all PCTs are required to undertake a mid year review of activity levels. These are in addition to annual contract reviews. The PCT is required to identify all dental contractors that have provided less than 30% of their total UDAs between 1st April and 30th September.

In December 2006, the Leeds PCT was part way through its mid year review. At this stage, the PCT had identified 13 contractors achieving below 30% of their total number of UDAs. We were informed that all contractors would be visited by the PCT by the end of December 2006 to undertake a review of their performance. This review will determine whether the shortfall can be made up and if so, to agree an action plan with the contractor.

National Review of the new contract

In April 2006, Ministers established an Implementation Review Group (IRG) to monitor the impact of the NHS dental reforms. The group is chaired by the Chief Dental Officer, and consists of senior stakeholders and includes representatives from the NHS, the dental profession, and patient groups.

The terms of reference of this group are to:

- identify and discuss key issues arising from the reforms, including the impact of local commissioning of primary dental care services, the new contracts for dentists, and the new system of patients’ charges, to ensure that the reforms benefit dentists and patients.
- identify, by reviewing available evidence, any significant issues that need to be addressed either by Primary Care Trusts (as local commissioners) or by the

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Department of Health in developing NHS dental services.

We understand that the Department of Health is expecting to produce a 12 month review report drawing on the work of the IRG. We very much welcome this and recommend that the findings from the review are brought back to a future meeting of the Scrutiny Board for consideration.

Recommendation 8:
That the Department of Health’s report following its 12 month review of the new NHS Dental Contract is brought back to the Scrutiny Board for consideration.

The reforms introduced in April 2006 were designed to help provide better access to dental services and simplify the system of patient charges.

However, our inquiry has provided clear evidence that there continue to be locally significant concerns about whether the new dental contract is fit for purpose.

The new contract only focuses on treatment activity levels and the length of time taken for such activities and does not appear to strengthen the preventative approach which is being promoted by the Department of Health.

We consider dentistry to be an important part of NHS care and it is vital that we make the most effective use of resources to ensure that a high quality NHS dental service is provided to meet the needs of the local population and the profession.
Evidence

Monitoring arrangements

Standard arrangements for monitoring the outcome of the Board’s recommendations will apply.

The decision-makers to whom the recommendations are addressed will be asked to submit a formal response to the recommendations, including an action plan and timetable, normally within two months.

Following this the Scrutiny Board will determine any further detailed monitoring, over and above the standard quarterly monitoring of all scrutiny recommendations.

Reports and Publications Submitted

- Briefing paper from Leeds Primary Care Trust on Contract Monitoring – Mid Year Reviews. December 2006.
## Witnesses Heard

<table>
<thead>
<tr>
<th>Witness Name</th>
<th>Position and Affiliation</th>
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<tbody>
<tr>
<td>Tracy Cannell</td>
<td>Director of Clinical Services, South Leeds Primary Care Trust</td>
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<tr>
<td>Emma Fraser</td>
<td>Head of Primary Care Contracting, Leeds Primary Care Trust</td>
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<tr>
<td>John Beal</td>
<td>Consultant in Dental Public Health</td>
</tr>
<tr>
<td>Mark Harrington</td>
<td>Business Manager, Leeds Dental Institute</td>
</tr>
<tr>
<td>Laurence Wood</td>
<td>Chair of the Leeds North West PPI Forum</td>
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<tr>
<td>Liz Croft</td>
<td>PALS Team Leader, Leeds West Primary Care Trust</td>
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<tr>
<td>Dr Jane Moore</td>
<td>Chair of the Leeds Local Dental Committee</td>
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<tr>
<td>Mr Paul Fisher</td>
<td>Vice Chair of the Leeds Local Dental Committee</td>
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<tr>
<td>Dr Betty Patterson</td>
<td>Clinical Director for Dental Services, Dental Access Centre</td>
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## Dates of Scrutiny

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