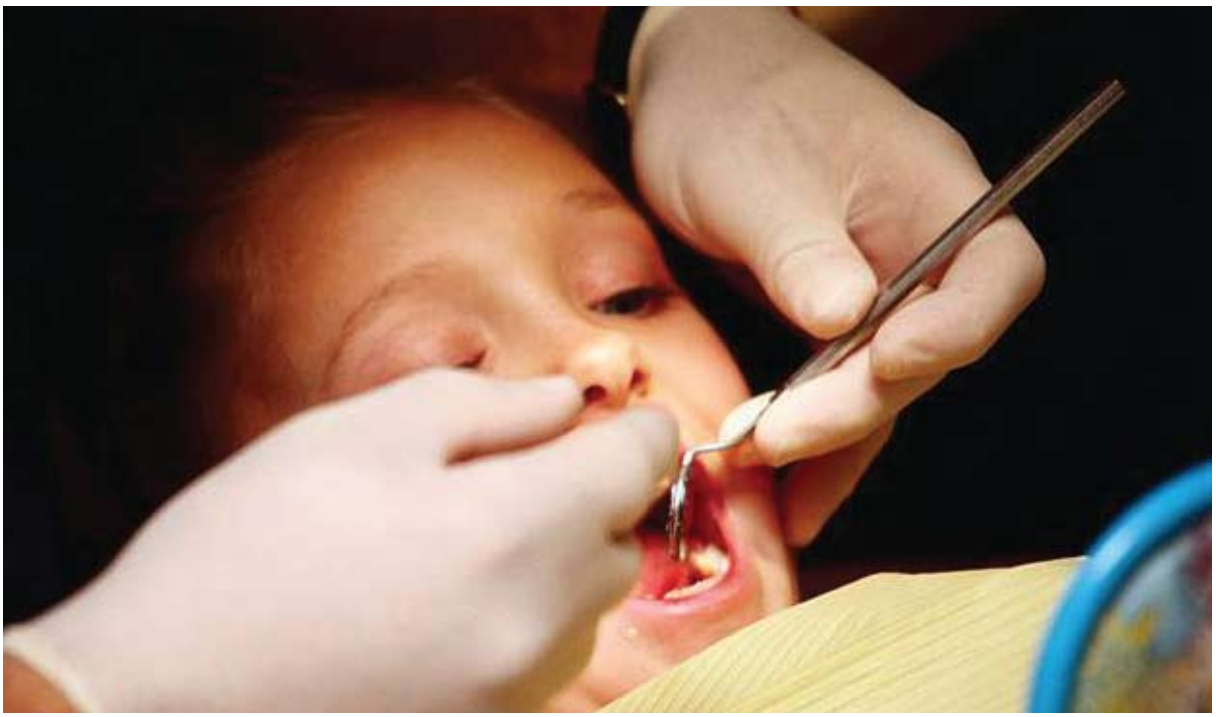
Follow-Up Review on the Provision of Dental Services in Tameside



Personal and Health Services Scrutiny Panel

Tameside Metropolitan Borough
Great lives, excellent services

September 2008

Personal and Health Services Scrutiny Panel

Follow-Up Review on the Provision of Dental Services in Tameside

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CONTENTS

1. INTRODUCTION BY THE CHAIR

I am pleased to be able to present the follow-up Review by the Personal and Health Services Scrutiny Panel on the provision of dental services in Tameside.

The original review in April 2005 outlined a number of recommendations including improved communications and better training for support staff. It also looked at the effect of closer working relationships with the PCT.

The follow up review confirms that there have been many areas of improvement made by the PCT, including the Dental Access Service that provides routine treatment and the Hyde Dental Access Centre with facilities for disabled people.

Since the original review and the introduction of the new contract there are more practising dentists in Tameside and more patients receiving treatment on the NHS.

The Personal and Health Services Scrutiny Panel will continue to monitor the provision of dental treatment in Tameside to ensure continued development with the PCT and effective training for all parties.

This Follow-up report could not have been produced without the full co-operation of the PCT, the dentists, CAB and a hard working Panel. I would like to thank the Panel and especially my deputy Councillor Eileen Shorrock who played an active part in the production of this report.

Thank you.

Councillor Richard Ambler
Chair

2. SUMMARY

In April 2005, the Personal and Health Services Scrutiny Panel undertook a review of dental services in Tameside.

The aim of the review was to consider access and availability of local NHS dental services, evaluate the effectiveness of dental health promotion schemes in Tameside, and specifically to consider the potential effects of the new contract between dentists and the PCT due to be implemented in 2006.

This follow up review will enable the Scrutiny Panel to see the progress that has been made since the implementation of the new dental contract and its affect on access to local dental services.

3. MEMBERSHIP OF THE SCRUTINY PANEL

Councillor Ambler (Chair), Councillor Shorrock (Deputy Chair)
Councillors Bowden, Doubleday, Downs, Harrison, Sweeton, Etchells, Middleton

Mr A. McDermot – Tameside and Glossop PCT/Acute Trust Patient and Public Involvement Forum

4. TERMS OF REFERENCE

Aim of the Scrutiny Review Exercise

"To review progress against the findings and recommendations of the Scrutiny Panel's 2005 review of dental provision in Tameside and make any further recommendations that the Scrutiny Panel may consider necessary or appropriate."

Objectives

a. To review progress against the findings and recommendations contained in the Scrutiny Pane Report (April 2005).

b. To consider the availability and quality of NHS dental services in the borough.

c. To assess the role of the PCT in dental provision.

5. METHODOLOGY

5.1. This Scrutiny Review was undertaken by the Members of the Personal and Health Services Scrutiny Panel, together with a representative of the Tameside and Glossop PCT/Acute Services Patient and Public Involvement Forum.

5.2. The Scrutiny Panel met with the Consultant in Dental Public Health from the Primary Care Trust who reported on the implementation of the recommendations from the initial report and on progress the PCT had made since the introduction of the new dental contract.

5.3. The Panel carried out a repeat consultation with dentists in the form of a postal survey in order to compare anticipated outcomes with actual outcomes and determine dentist's views of the new contract (Appendix A).

5.4. A Member of the Panel met with a local dentist to receive more detailed information about experiences of the new contract.

5.5. The scrutiny panel repeated the consultation with Tameside Citizens' Panel (Appendix B) about how residents felt about access to dental treatment.

5.6. The scrutiny panel received information on the national experience of the new arrangements (Appendix C).

6. UPDATE ON THE IMPLEMENTATION OF THE RECOMMENDATIONS CONTAINED IN THE INITIAL REPORT

Objective 1: To review progress against the findings and recommendations contained in the Scrutiny Panel Report (April 2005)

6.1. **Original Recommendation 1**

That the Primary Care Trust continues to seek to improve communications with dentists in Tameside and encourages practitioners who have converted to the Personal Dental Services Contract to openly discuss their experiences with their colleagues.

PCT Response:

Is committed to effective communications with the profession and will build on recent improvements.

Panel Findings:

Dentists are more positive about the support from the PCT. Nearly half of all dentists surveyed reported that the support provided by the PCT was either very good or good compared to 1 in 10 dentists in 2005. Similarly, respondents are more positive about the level of communication between themselves and the PCT, specifically in relation to the new contract. Over half were very satisfied or satisfied with communication compared to less than 1 in 5 in 2005.

The PCT have good communication networks in place to support dentists such as the Oral Health Advisory Group, the Local Dental Committee and single issue working groups. Regular meetings are also held with contractors.

6.2. **Original Recommendation 2**

That the Primary Care Trust encourages the establishment of more training dental practices in Tameside.

PCT Response:

Post-qualification training was then under review. It was also reported that there was a high number of training practices available for placements and that the PCT was working hard to ensure funding levels continue rather than being pooled for use in Greater Manchester as was being proposed at the time.

A number of initiatives were planned including outreach teaching for dental students, development and accreditation of dentists with Special Interests, personal development plans and a dental nurse cadet scheme.

Panel Findings:

The PCT has established a dental centre of excellence at Ashton Primary Care Centre with eight surgeries accommodating two trainee dentists as well as Dentists with Special Interests. The PCT was currently working to introduce 2 year foundation training at the Hospital.

6.3. **Original Recommendation 3**

That the shortage of trained hygienists and other associated dental health professionals are acknowledged and the PCT collectively encourage the Department of Health to promote more training in these professions.

PCT Response:

It would take up the issues of training with the Department of Health and that the PCT would publicise training opportunities for hygienists and therapists amongst local practices.

Panel Findings:

The PCT was working to integrate new training schemes involving hygienists and dental nurses into training practices.

7. AVAILABILITY OF NHS DENTAL SERVICES

Objective 2: To consider the availability and quality of NHS dental services in the borough.

7.1. **Availability**

7.1.1. The new contract is intended to increase access to NHS dental provision and make the cost of dentistry more affordable.

7.1.2. The Department of Health reports that access to dental provision has "stabilised" in the first 12 months of reforms. [1] The proportion of people seeing an NHS dentist at least once in two years has remained the same for two years up to September 2006.

7.1.3. The Citizens Advice Bureau (CAB) observes that provision across the country and between different sections of the community is very unequal. Patients still face a "postcode lottery". Waiting lists and long journeys were identified as barriers to accessing dental provision. Low income patients, those in rural areas and users of public transport are most negatively affected. The CAB reports that patients do not always know how to find out about services when they exist.[2]

7.1.4. More positively, the CAB finds that control by PCTs over the location of practices has begun to address the inequality of access in many areas since new practices have been opened where provision was previously lacking. The Department of Health reports that correspondence about problems accessing services fell by 65% between July and December 2006.

7.1.5. Tameside and Glossop PCT reports that the number of dentists on NHS contracts has increased by 15% since March 2006 and there are 6 more dentists per 1000 population. Tameside and Glossop PCT has also recorded a 2% rise from 2006 to 2007 in the number of patients seen by a dentist. Evidence from the repeat consultation with dentists suggests that dentists believe NHS provision is less of a problem now compared to 2005.[3]

7.1.6. Despite this, the results of the repeat consultation with Members of the Citizens Panel show that there has been a 5% decline between 2005 and 2007 in the number of people registered with an NHS dentist. [4] Evidence suggests that the main reasons for this are that there are no NHS dentists accepting new patients and patients choose to get treatment when they need it.

7.2. Quality

7.2.1. The new contract was intended to improve the quality of care provided to patients by allowing dentists to spend more time with patients and promote a more preventative approach. The 3 band pricing system is intended to limit the maximum cost of treatment and simplify the pricing system.

7.2.2. The Dentistry Watch Survey (October 2007) concluded that 93% of NHS patients were happy with the treatment they receive. 40% of patients surveyed felt that NHS charges provide value for money, 40% did not know and 21% said they did not provide value for money.

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[1] Department of Health (August 2007) 'NHS Dental Reforms: One year on',

[2] Citizens' Advice Bureau (March 2007) 'Gaps to fill: CAB evidence on the first year of the NHS', www.bda.org/advice/docs/SpecialConf28th_CAB_Gapstofill.pdf

[3] See Appendix A

[4] See Appendix B

7.2.3. According to a survey carried out by the British Dental Association, 87% of dentists felt that the fairness and affordability of dental services had not been improved by the new contract, 90% felt that continuity of care for patients had not be improved under the new arrangements and 93% of dentists did not feel that the new contract allowed them to get a balance between intervention and prevention.

7.2.4. The survey conducted by the Scrutiny Panel found that dentists felt that the contract had not had a positive impact on the quality of NHS provision. 77% of dentists said that the contract did not encourage them to take a more preventative approach to dental care and 82% of dentists felt that the new contract did not allow them to spend more time with patients.

7.2.5. The Department of Health states that their concern, in the first year of the reforms, was to improve the *quantity* of services available and that the next phase of reforms will be to support PCTs in improving the *quality* of services. In addition to expenses and net income, £100m is available to PCTs to improve the quality of premises and equipment. A 'clinical governance' framework has already been introduced which will raise standard in areas such as infection control, child protection and staff development.

8. ROLE OF THE PCT

Objective 3: To assess the role of the PCT in dental provision

8.1. Tameside and Glossop Primary Care Trust (PCT) has produced a Dental Strategy and corresponding action plan that sets out it's aim to improve oral health and ensure that all Tameside residents can access dental care at least every two years. The Strategy identifies the PCT's priorities for dental health following the introduction of the new dental contract.

8.2. One of the key priorities of the Strategy is to address problems of patient access to routine checkups and treatment. The PCT has invested in the provision of a Dental Access Service that will provide routine dental treatment to patients who are unable to obtain care in the General Dental Service. The Dental Access Service will comprise of a Dental Access Centre (DAC) to provide clinical services and commissioned access slots in General Dental Practices.

8.3. The Dental Access Centre is located in Hyde and will deliver routine dental care to patients who have been referred from Tameside and Glossop's *Assessment, Booking and Choice (ABC)* Service. Patients will receive one course of treatment to bring them to an acceptable state of oral health and then advised to seek maintenance care in the General Dental Service. The PCT has also commissioned dentists to provide access slots for routine dental treatment to patients unable to obtain routine care.

9. ACCESS FOR VULNERABLE GROUPS

9.1. The Primary Care Trust has improved facilities for disabled patients. Prior to 2005, disabled residents had been forced to visit practices in Oldham, which had suitable facilities and accessible premises. The Tameside and Glossop Primary Care Trust has invested in a new Dental Access Centre in Hyde that will have wheelchair access and a hoist for lifting severely disabled people.

9.2. Tameside and Glossop Primary Care Trust has also made significant changes and invested additional funding in domiciliary care. Prior to 2007, patients who were physically unable to see a dentist would be visited and treated on an ad hoc basis. The Primary Care Trust has introduced a central telephone number for patients wishing to have dental treatment in their own home. Patients will receive an assessment of need and a dentist will visit them if necessary. This system is considered to be a more efficient and effective way of meeting people's need.

10. BOROUGH TREASURER'S COMMENTS

10.1. The Borough Treasurer has considered this Report and advises that there are "no direct financial implications" to Tameside MBC.

11. BOROUGH SOLICITOR'S COMMENTS

11.1 This review has been undertaken under the Council's health scrutiny powers. This review links to the Tameside Community Strategy which has six aims, one of which is to achieve a healthy borough where partners in the Tameside Strategic Partnership commit to tackle the underlying causes of ill health and health inequalities.

12. FOLLOW-UP CONCLUSIONS

12.1. The Panel are satisfied with the efforts of the Primary Care Trust to implement the recommendations made in the original review in 2005.

12.2. The PCT has improved its relationship with Tameside dentists and provides network opportunities that encourage dentists to talk openly about their experiences of the new dental contract.

12.3. The PCT has established more training facilities and are working to develop further training opportunities for hygienists and dental nurses.

12.4. The Panel recognises that availability across the country is still a problem in some areas but evidence suggests that it has become less of a problem on Tameside.

12.5. Quality of care provided by dentists is still an issue both nationally and locally as dentists say that the new contract has not improved their ability to take a more preventative approach or spend more time with patients. The Panel recognise that the Department of Health will work to improve the quality of services in the next stage of their reforms.

12.6. The Panel are pleased with the role that the PCT has played in providing routine dental care to the people of Tameside. The Dental Access Service will help to deal with the biggest problem of access to routine dental provision.

12.7. The Panel welcome the facilities for disabled people at Hyde Dental Access Centre and improved accessibility for wheelchair users.

13. FOLLOW-UP RECOMMENDATIONS

13.1. That the PCT continues to develop its relationship with dentists.

13.2. That the PCT continues to promote effective training practices for both dentists and hygienists and dental nurses.

13.3. That availability and quality of dental provision be monitored by the Scrutiny Panel and the PCT.

APPENDIX A

PERSONAL AND HEALTH SERVICES SCRUTINY PANEL

REPEAT CONSULTATION WITH DENTAL HEALTH PROVIDERS IN TAMESIDE

Re-Review of Dental Services in Tameside

November 2007

1. Introduction

1.1. In April 2005, the Personal and Health Services Scrutiny Panel published its report on Dental Services in Tameside. As agreed in the Panel's work programme for 2007/08 and, as with all other Scrutiny Reviews, progress against the original findings and recommendations is now being assessed. A significant element of this progress check will be to repeat consultation carried out in 2005 by the Scrutiny Panel with dental health providers to assess progress since the initial report.

1.2. This briefing paper reports on the findings of the consultation which will contribute to the Panel's re-review of this issue.

2. Methodology

2.1. A short self-completion survey was designed by the Scrutiny Support Unit which repeated many of the same questions as in the original survey and sought views on recent experiences. The survey focussed particularly on the impact of the new contracting arrangement between dentists and the PCT introduced in April 2006.

2.2. The survey was distributed to all seventy-five dentists in the borough using information provided by the Primary Care Trust.

2.3. Dentists were initially given three weeks to respond. A reminder letter was issued mid-way through this period and the return date extended by one week.

2.4. Thirty-nine surveys were returned which represents a 52% response rate. The original survey by the Scrutiny Panel in 2005 attracted 31 responses of a possible 69 (45% response).

2.5. The majority of responses (77%) were from individual dentists as opposed to a response on behalf of an entire practice (15%) or a response from a member of the team other than a dentist (8%).

2.6. The survey covered the following areas:

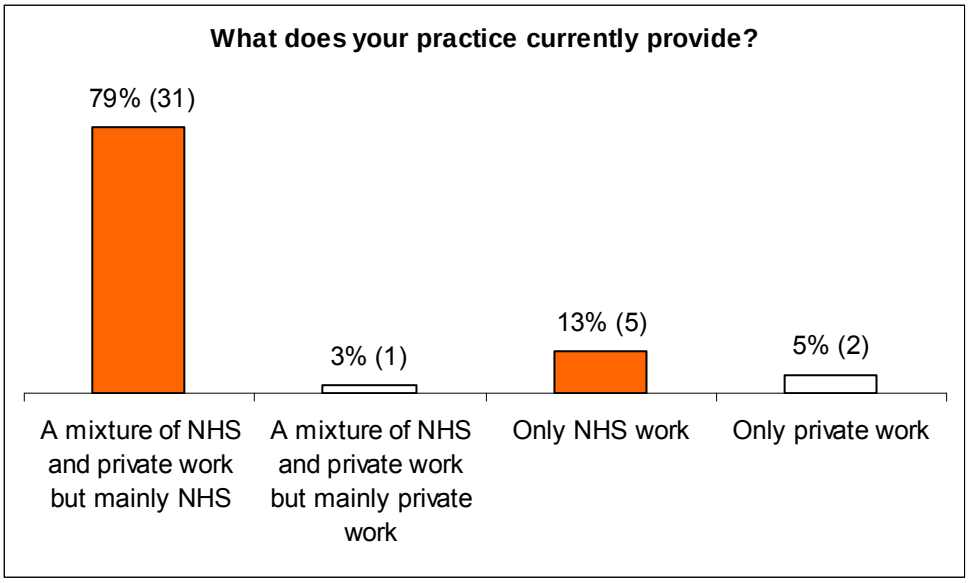
- Types of provision (NHS or private)
- Response to the new contract
- Perceived availability of NHS dental provision in the borough
- Impact of the new contract
- Communication and support from the PCT

2.7. Verbatim comments are attached as appendix 1.

3. Overview of Findings

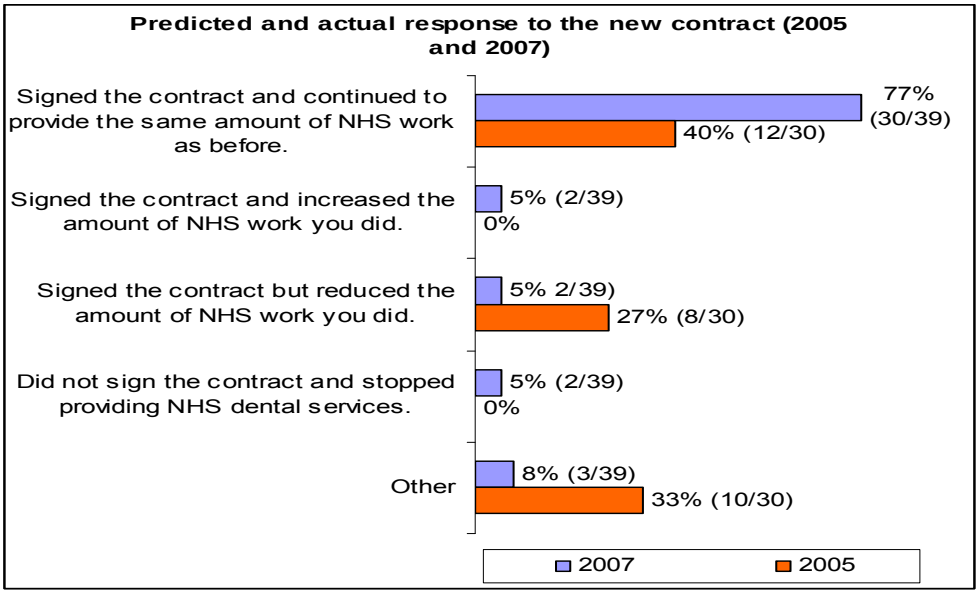
Types of provision (NHS or private)

3.1. Most respondents provided a mixture of NHS work but mainly NHS work.



Response to the new contract

3.2. In 2005, dentists were asked what decision they expected to take when the new contract came in to being. In 2007 dentists were asked to give their actual decision.

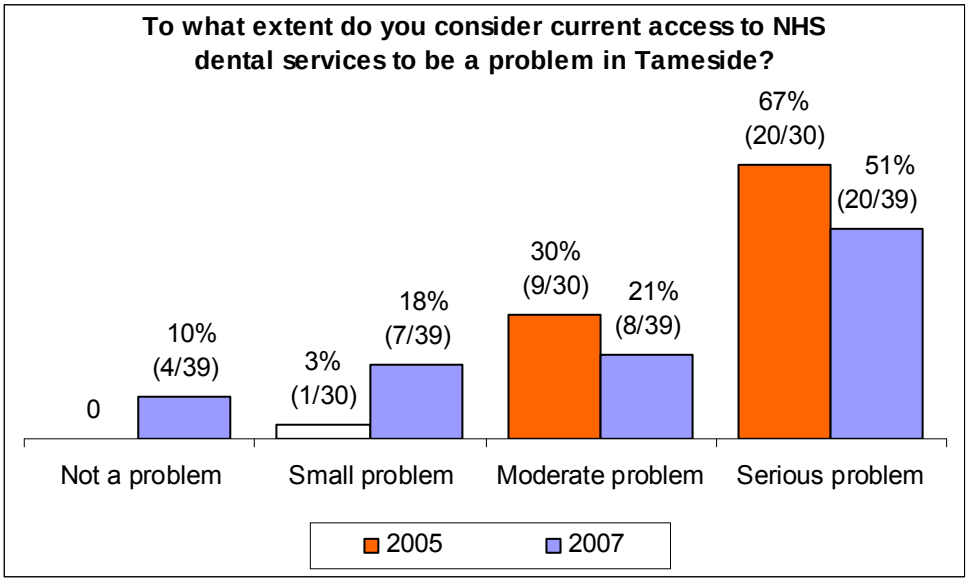


3.3. In 2005, 39% (or 12/30) anticipated that they would sign the new contract and continue to provide the same amount of NHS work as before whilst 32% (or 10/30) either did not know or where already operating the new type of contract. In 2007, 78% (or 29/39) of respondents said they had signed the contract and continued to provide the same level of provision.

3.4. In 2007, a small minority reported that they had signed the contract and increased the amount of NHS work (5% or 2/39); in 2005, no dentists expected this to be the case. A similar minority said that they had signed the contract but saw the amount of NHS work fall (5% or 2/39); in 2005, more dentists expected this to be the case (26% or 8/30). Two respondents to the 2007 survey said they did not sign the contract and therefore stopped providing NHS services (a further respondent was not asked to sign since they were an associate to the practice). In 2005, no dentists predicted that this would be the case.

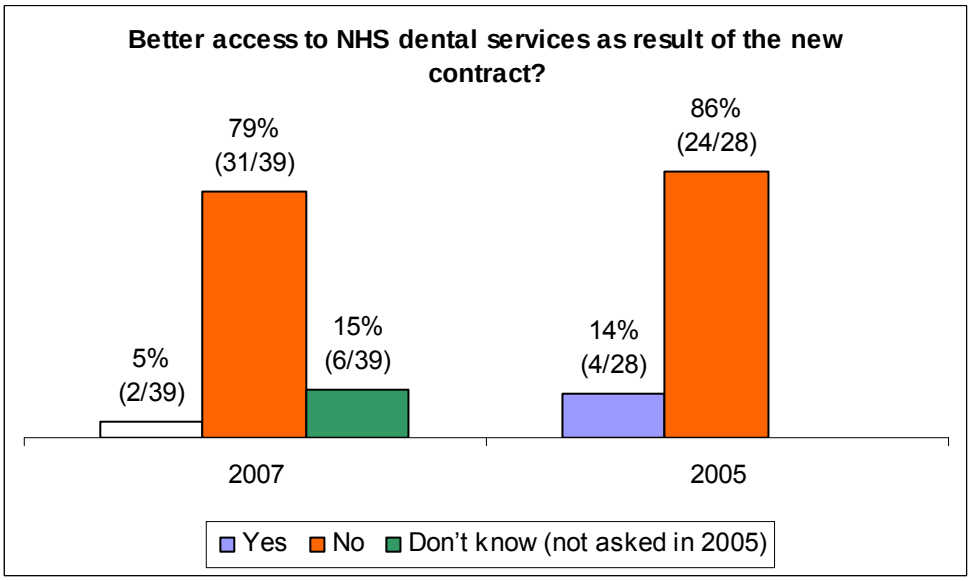
Availability of NHS dental provision in the borough

3.5. Dentists were asked how far they thought NHS dental provision was a problem in Tameside. The responses in 2007 show that it is felt to be less of a problem than in 2005.



3.6. ***Impact of the new contract***

3.7. In 2005, the majority of respondents predicted that the new contract would not have a positive impact on dental provision; in 2007, an even greater proportion feel that this is the case, despite the fact that as shown above, dental provision is perceived to be less of a problem now than in 2005.



3.8. There appear to be three main reasons for respondents reporting that the new contract has not improved access.

3.9. Firstly, the most frequently mentioned reason is the shortage of NHS provision due to full lists, completion of contracted NHS work, or growth in private provision as these comments indicate:

"Lists are full and there is no provision for new patients…"

"We cannot take them [new patients] on because we are tied to a quota by the new contract."

"We are limited to the same number of units of dental activity as during the sample year - no scope for increase."

"I finished my UDA's [Units of Dental Activity] *early and so was unable to provide any NHS treatment for my patients in March."*

"I can't see new patients because I am limited in the amount of work I can do. We are turning away large numbers of patients."

"People still cannot find many practices that are accepting new patients, as practices are full, especially as so many practices have gone private."

3.10. Secondly, many respondents sited the way in which the new arrangement based on a fixed contract is felt to be a disincentive for practices taking on new patients or carrying out more costly treatments. These issues are also related since it is felt that new patients are more likely to have not received treatment in the past and are therefore more likely to require extensive, costly treatment than long-term patients. The following comments illustrate this point:

"Many dentists have the view that they are paid for treating the same number of patients as before and say new patients are a burden and put strain on the practice due to extra need and previous dental neglect. E.g regular attendees rarely need major/extensive treatment whereas new patients almost always do. So an existing patient can earn a dentist 3 or 12 UDAs [Units of Dental Activity] *for simple work, but new patients can require many visits and much more treatment for the same credit to the dentist."*

"Because of the UDA system there is a disincentive for dentists to take on patients who need large volumes of treatment - i.e. those most in need.

"…no incentive to take on any new patients as no extra funding being provided by PCT. On fixed contracts while overheads increasing week by week e.g. laboratories increased laboratory fees 1 month ago by 10% - who is paying for this."

3.11. Thirdly, respondents site the continued demand from patients as evidence as these comments indicate:

"Patients still walking in and asking to be "registered" - inform us that nobody is taking new NHS patients."

"Because it has caused panic amongst non-attendees on a daily basis. We must get at least 30 calls from patients who can not get to see a dentist anywhere. There is not enough hours in the day to see everyone."

"Still lots of people phoning up needing NHS dentist."

3.15. For two respondents however the contra ct seemed to be having the des ired effect:

"I am treating more new patients and emergency patients than before."

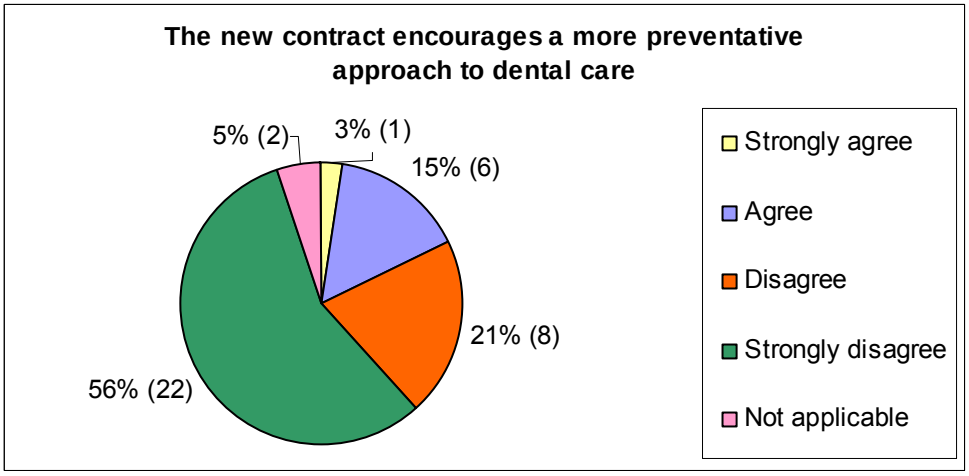
"Allowed us to take new patients."

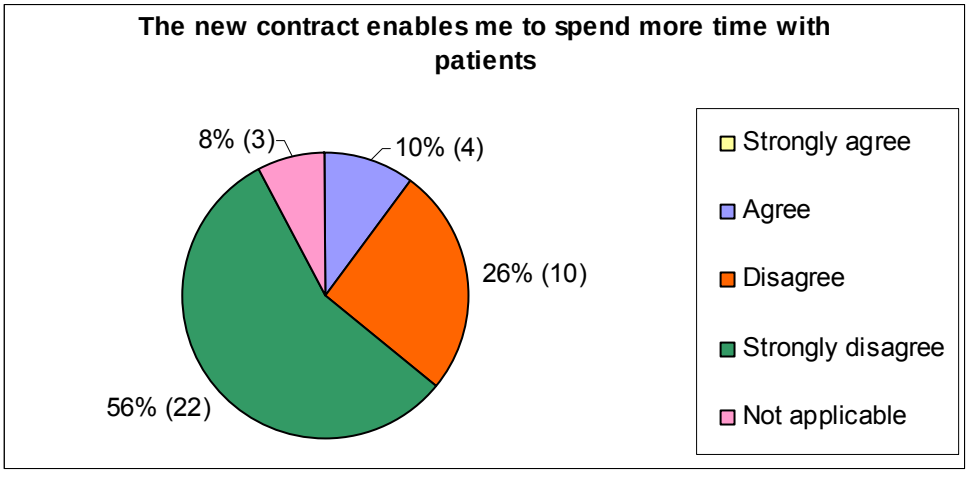
3.16. Six respondents could als o not say whet her the new contract had improved access. These comments suggest why:

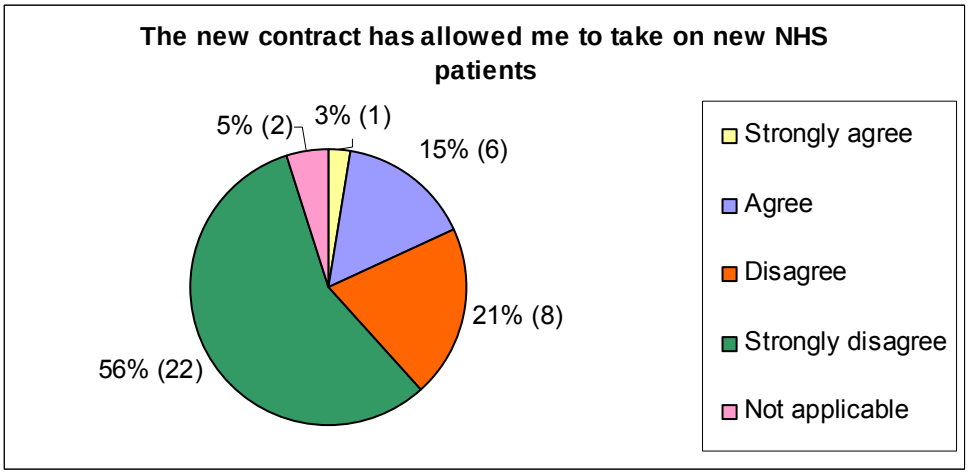
"Do not have an overview over the T&G area"

"Conflicting reports - patients seem to find NHS dentists generally"

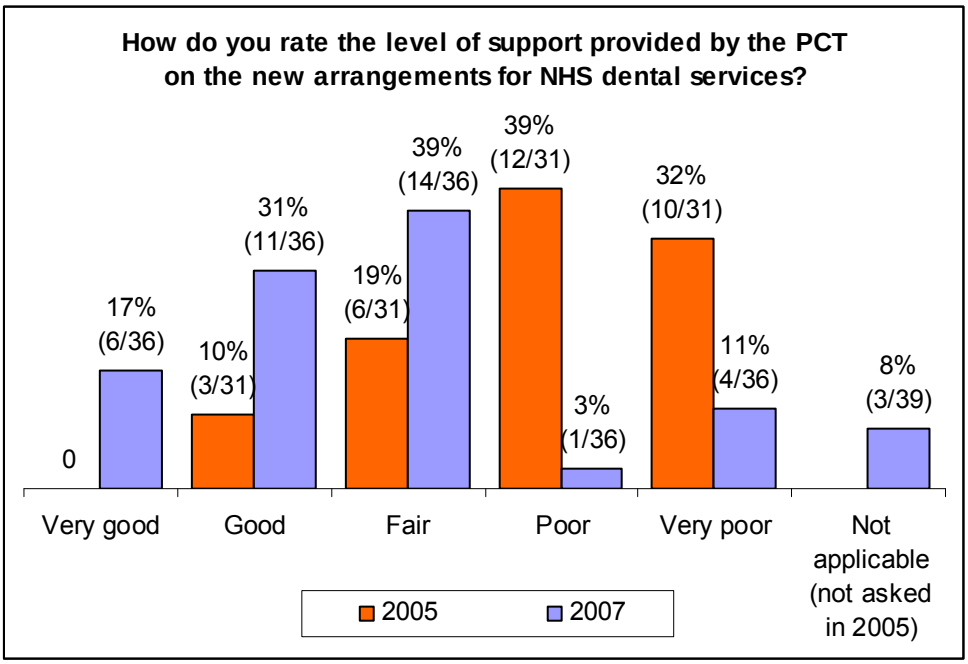
3.12. The results of the survey indic ate that respondents generally feel that the contract has not had the in tended positive impact on th ree aspects of the NHS provision.



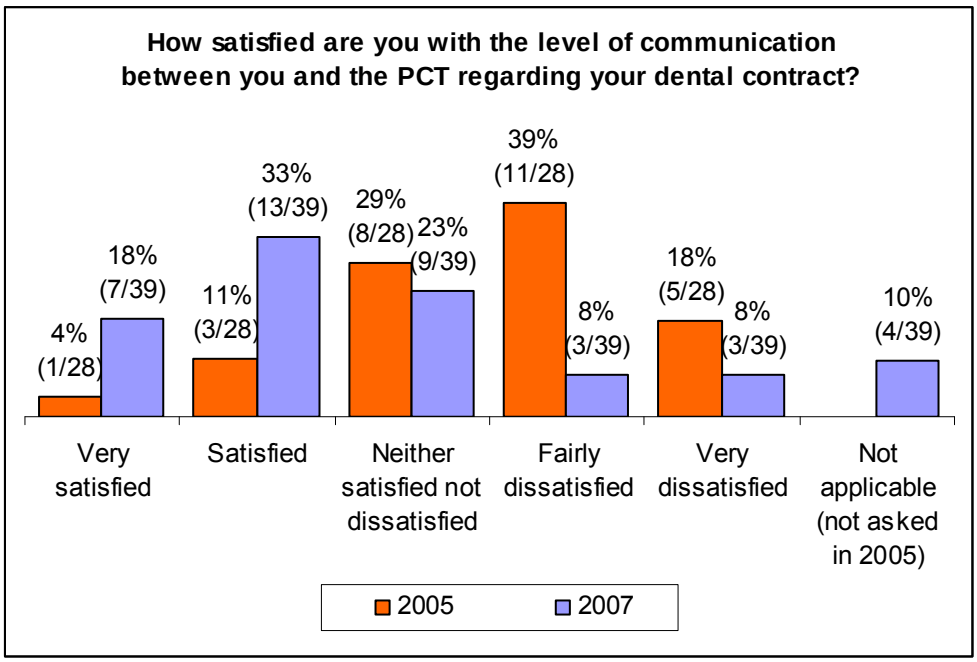




3.14. Respondents are more positive now t han in 2005 about support from the PCT during the transition to the new arrangements. Almost half feel t hat support is good or very good in 2007 compared to a 1 in 10 in 2005.



3.15. Similarly, respondents appear more positive now than in 2005 about the level of communication between themse lves and the PCT about t he new contracts. In 2007, just over half were either satisfi ed or very satisfied with communicatio n compared to less than 1 in 5 in 2005.



3.16. Comments provided at the end of the survey reflect the general negative view of the new arrangements throughout the survey. This dissatisfaction focuses on the way in which the fixed contract system is felt to discourage practices taking on new patients with potentially greater need for treatment; this is costly and time-consuming and the dentist risks being financially disadvantaged and not having the time to meet their contractual obligations for achieving a set number of courses of treatment (UDAs). It is felt that the arrangements have a negative impact on patient care and the working conditions of dental health providers. This comment encapsulates the overall view of the new arrangements:

"It is very stressful to us as a whole practice that the new dentist had targets based on her previous work, with regular dental attending patients - but now, she is almost exclusively treating new patients, who are mostly in need of vast amounts of dentistry. We do not supply an "emergency services", but a comprehensive one. So, we will probably be in a situation where we have to pay back money to the PCT as using "U.D.As" to monitor her work she is underperforming!! Yet the volume of work carried out is staggering. I believe this is a tremendous disincentive to take on any more dentists to help even more patients in dental need."

Appendix 1

Verbatim comments

Q6. Do you think the introduction of the new contract has improved access to NHS dental provision?

Yes (2/39)

Why do you say that?

"I am treating more new patients and emergency patients than before."

"Allowed us to take new patients."

No (31/39)

Why do you say that?

Shortage of NHS provision / Cannot take on new NHS patients / cannot carry out any more NHS treatment

"Lists are full and there is no provision for new patients. Fortunately acc ess services working well and there are no problems with emergencies."

"The number of people who phone or call in to our practice requesting treatment who ar e unable to find an NHS dentist. We cannot take them on because we are tied to a quota by the new contract."

"We are limited to the same num ber of units of dental activity as during the sample ye ar - no scope for increase."

"I finished my UDA's early and so was u nable to provide any NHS treatment for my patients in March."

"Because many practices have gone priv ate resulting in the NHS one's to have lon g waiting lists for new patients."

"Fewer practices taking new patients: 1) the new contract discourages dentists to take on new patients 2) once UDA requi rements have been met practices tend to s top providing NHS treatment."

"We have stopped seeing new NHS patients - our capacity is limited"

"Not many practices are taking on new patients."

"I can't see new patients becaus e I am limited in the amount of work I can do. We are turning away large numbers of patients."

"More dentists gone private. Decreased need to take on new patients as e xisting patient base sufficient for weeks."

"People still cannot find many pr actices that are accepting new patients, as practices are full, especially as so many practices have gone private."

Disincentive to carry out treatment of higher cost / Disincentive to take on new patients with potentially greater need / Financially disadvantaged by new arrangements

"Many dentists have t he view that they are paid for treating the sa me number of patients as before and say new patients are a burden and put strain on the practice due to ext ra need and previous dental neglec t. E.g regular attendees rarely need major/extensiv e treatment whereas new patients almost always do. So an e xisting patient can ear n a dentist 3 or 12 UDAs for simple work, but new patients can requir e many visits and muc h more treatment for the same credit to the dentist."

"Dentists still on treadmill; not enough dentists and hig h treatment need patie nts disadvantaged."

"Because of the UDA system th ere is a disincentive f or dentists to take on patients who need large volumes of treatment - i.e. those most in need. Those patients will t hen circulate among dentists contacted access slots having teeth out periodically when in pain - not a 21st century dental servic es. There is a further disinc entive for dentists to employ associates as UDA t argets are almost unatta inable when an associate is solely see ing new patients in need. Thirdly a number of practices in the Ac cess slots and Acces s Centres merely massage the figures and enable government to claim anyone can see an NHS dentist."

"As you know, contract devised by Dept of Health with no direct input fro m B.D. Association - consequently UDAs or points is like being at primary sc hool; only 3 bands in derisory; no incentive to take on any new pa tients as no extra funding bein g provided by PCT. On fixed cont racts wh ile overheads increasing week by week e.g. laboratories increased laboratory fees 1 month ago by 10% - who is paying for this."

"I am fully booked in advance fo r six whole weeks anyway. My existing patients still ha ve access to my services, but have to wait. I am unable to achieve my UDA contract total, which means any patients that require prol onged treatment will in crease the money I hav e to give back to the PCT. New patients will always need more treatment."

"More dentists gone private. Decreased need to take on new patients as e xisting patient base sufficient for weeks."

"Fewer practices taking new patients: 1) the new contract discourages dentists to take on new patients 2) once UDA requi rements have been met practices tend to s top providin g NHS treatment."

Demand from patients

"Patients still walking in and asking to be "registered" - inform us that nobody is taking new NHS patients."

"Because it has caused panic amongst non-attendees on a daily basis. We must get at least 30 c alls from patients who can not get to see a dentist anywhere. There is not enough hours in the day to see everyone."

"Still lots of people phoning up needing NHS dentist."

"The number of people who phone or call in to our practice requesting treatment who ar e unable to find an NHS dentist. We cannot take them on because we are tied to a quota by the new contract."

Other / not able to code

"They are 2 separate issues. The new contract was introduced so the DOH knew e xactly how much it would pay to the GDS eac h year. The access problem was caused by the closure of a number of dental s chools 15 years ago leadi ng to the current shortage of dentists."

"The consultant in dental public health has stated that access is not a problem."

"New contract has helped emergency one-off co ver but proper course of treatment now I feel much less av ailable. Certainly *I know* that much more treatment on n ew patient s would hav e been av ailable und er the old contract and we would have expanded the practice more as we have over the last ten years expanding from one surgery to three from 1993-2003."

Don't know (6/39)

Why do you say that?

"Do not have an overview over the T&G area"

"Conflicting reports - patients seem to find NHS dentists generally"

Q10 Do you have any additional comments you would like to make?

Disincentive to carry out treatment of higher cost / Disincentive to take on new patients with potentially greater need / financially disadvantaged by new arrangements

“We see new patients who do not have a dentist as emergency patients sent by the PCT in our emergency slots each week. These patients have neglected months requiring a lot of surgery time to treat them and ask if they can join the practice. The new UDA system actually discourages the dentist from accepting a patient who requires a lot of surgery time. The dentist even loses income by taking on new patients as UDAs not achieved have to be refunded to the PCT! A total disincentive. There is no reward for excellence or quality, or advanced treatments. It encourages neglect by discouraging treatment.”

The system of three points (UDAs) or a course of treatment whether there is one filling or ten fillings, root treatments, extractions etc is ridiculous and doesn't encourage you to see new patients who may require extensive treatment. It doesn't encourage sound preventative dentistry as by "finding" more extractions in a case only penalises the dentist for doing a thorough job. I find I am under much more pressure now than I have in 27 years of NHS Dentistry.

Negative impact of working life of dentists

“It is very stressful to us as a whole practice that the new dentist had targets based on her previous work, with regular dental attending patients - but now, she is almost exclusively treating new patients, who are mostly in need of vast amounts of dentistry. We do not supply an "emergency services", but a comprehensive one. So, we will probably be in a situation where we have to pay back money to the PCT as using "U.D.As" to monitor her work she is underperforming!! Yet the volume of work carried out is staggering. I believe this is a tremendous disincentive to take on any more dentists to help even more patients in dental need.”

I have never felt as pressured to work to achieve targets set by the PCT. This was not the case under the old contract; the new contract has the worse treadmill effect!!

Negative impact on quality of care

Patients, dentists and PCT have all come out of the new contract worse off. I do like not having to provide out of hours cover, but the service in place is very poor for patients.

On our part there is a willingness to offer some NHS care although we believe that as the new contract is fundamentally flawed, patient care is flawed. Many treatments (basic care) appears to either not be provided or is remunerated so badly that patient care is compromised.

Overall negative view of the new arrangements

The PCT have become power mad! The needs of primary care dental practices are ignored! The fact that many practices have stayed within the NHS system does not mean dentists are happy. This is a national problem.

Both dentists and PCTs are having to deal with an unfair, ill thought out and damaging Dental contract. Things will not improve, and at the end of the first 3 year contract I predict a mass exodus from the NHS. Promises to Dentists and patients alike have been wantonly disregarded.

National problem / national control

Until government policy changes towards NHS dental services things will get worse. The PCT are only doing what the govt tells them.

The dental contract is centrally driven - thus the PCT has very little scope for local variation.

PCT seems to be restricted by governmental decisions

More support and communication needed from PCT

I would appreciate more help from PCT regar ding [individual] [in clinical] challenges an d prompt resolution of any outstanding issues.

Other / not able to code

Not enough space here to carry on from (6) above.

APPENDIX B

PERSONAL AND HEALTH SERVICES SCRUTINY PANEL

REPEAT CONSULTATION WITH MEMBERS OF THE CITIZENS PANEL

Re-Review of Dental Services in Tameside

November 2007

Key finding:

Most Tameside residents are registered with dentists as NHS patients and some are registered privately, most often because their dentist ceased to provide NHS cover. Those least likely to be registered were non-white and disabled Tameside residents.

Of those not registered with a dentist the main reasons for this were not being able to register as an NHS patient and the cost of treatment.

Those registered with a dentist generally found it easy to get an appointment, however those registered as NHS patients reported slightly more difficulty than did those registered as private patients.

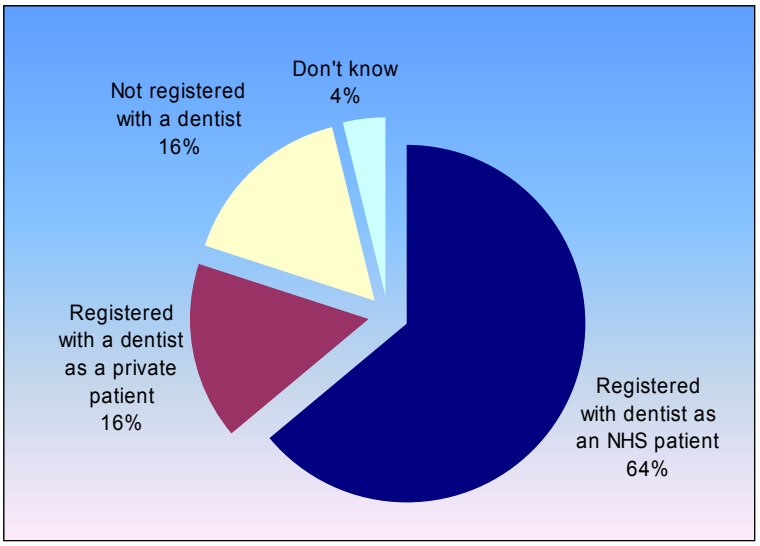
There is a mixed feeling about the provision of NHS dental cover in the Borough and dissatisfaction is highest among younger and non-disabled panellists.

In April 2005, the Personal and Health Services Scrutiny Panel carried out a review looking at the provision of NHS dental services in Tameside. As part of the review, the Scrutiny Panel consulted local residents about their views on local NHS dental services, in particular on access to and the availability of services.

To assess the take-up of dental service within the Borough, panel members were asked whether they were registered with a dentist; see Figure 8.1. Overall, nearly two-thirds (64%) were registered with a dentist as an NHS patient, 16% were registered as a private patient, 16% were not registered at all, and 4% were unsure.

Just over two-thirds (69%) of respondents say that they are registered with a dentist as a NHS patient compared with one in ten (11%) who are registered as private patient.

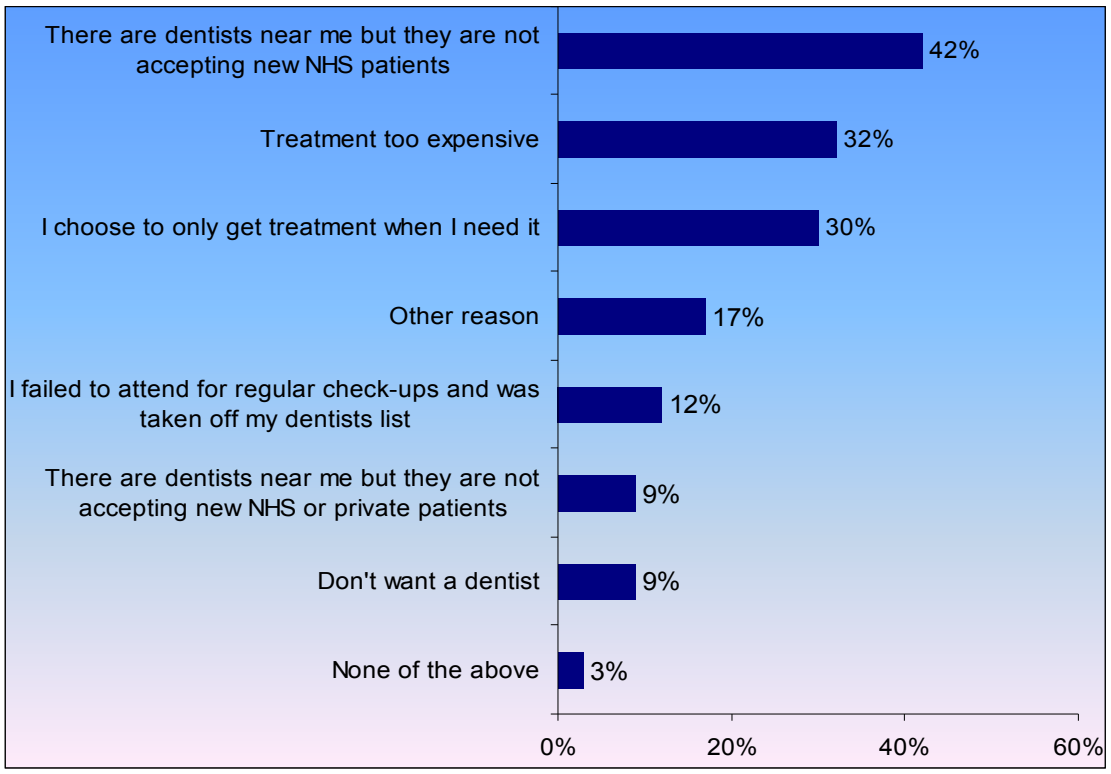
Figure 8.1: Q28 Are you currently registered with a dentist?



Sample base: All respondents– 1033 (un-weighted base)

Those not registered with a dent ist at all were presented wit h a list of possible reasons why they were not registered from which they could select all the reasons that applie d. The most common reason was that there we re no dentists nearby accepting new N HS patients (42%). For 32% treatments were too expensive and 30% chose to only get treatment when they need it.

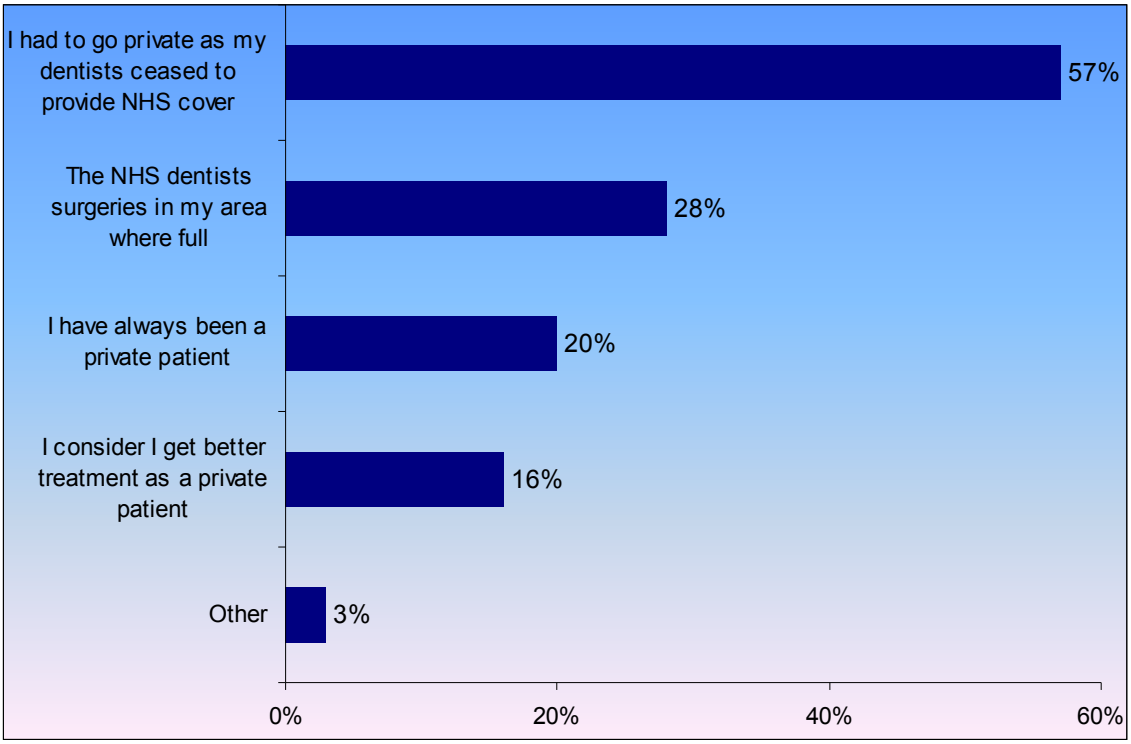
Figure 8.2: Q29 If you are not registered with a dentist please indicate your reason(s) for this?



Sample base: Respondents not registered with a dentist – 168 (un-weighted base)

Panel members who are register ed as private patients were asked about their reasons for this and could select all applicable reasons fr om a list. For over half (57%) of private dental patients a reason was that their exis ting dentist stopped provid ing NHS cover. Other reasons inc luded that loc al NHS dental su rgeries were full (28%) and participants thinking that they received bette r treatment as a private patient (16%). One in five (20%) private dental patients had always been so.

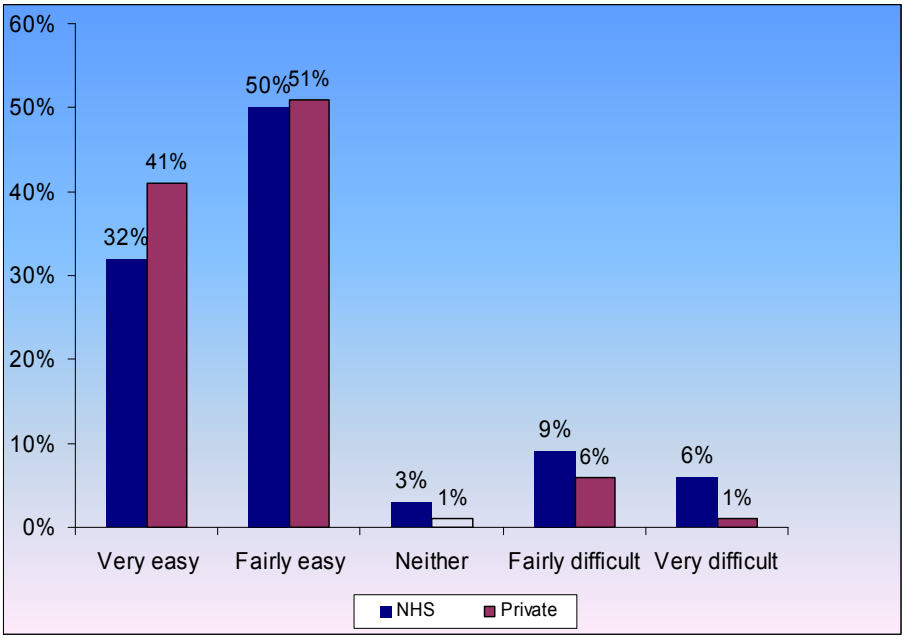
Figure 8.3: Q30 If you are registered as a private patient, what are the main reasons for this?



Sample base: Respondents registered with a dentist as a private patient – 159 (un-weighted base)

Both private and NHS dental pat ients were asked how easy it was to get an appointment to see the dentist when they need to. For almost all private patients (92%) and most NHS patients (82%) it was very or fairly easy. There was some difficulty reported for NHS patients, however, wit h 6% finding it very dif ficult and 9% finding it fairly diffic ult to get an appointment.

Figure 8.4: Q31 How easy is it to get an appointment to see your dentist when you need to?



Sample base: Respondents registered with a dentist:
as a private patient – 159 (un-weighted base)
as an NHS patient – 671 (un-weighted base)

All respondents were asked how satisfied they were with the provision of NHS dental services within the Borough. The level of satisfaction in Tameside was somewhat mixed with almost equal numbers satisfied (46%) and dissatisfied (42%); see Figure 8.4.

8.1.3 Ethnicity

Panel members from a minority ethnic community were less likely than white participants to be registered with a dentist. Nearly two-fifths (38%) of panel members from a minority ethnic community were not registered with a dentist compared with just 15% of white panel members.

8.1.4 Key differences across DAs

Almost three-quarters of panel members in Hyde and Longdendale and Hattersley were registered with a dentist as an NHS patient, compared to 64% of the panel overall.

Panel members in Denton and Audenshaw were the least likely to be registered with a dentist as an NHS patient (53% were registered, compared to 64% of the panel overall).

Panel members in Denton and Audenshaw were also more likely not to be registered with a dentist at all (22% of panel members in Denton and Audenshaw were not registered with a dentist, compared to 16% of the panel overall).

Panel members in Stalybridge were more likely to be registered with a dentist as a private patient (22% of panel members in Staly bridge were registered as a private patient, compared to 16% of the panel overall).

Among panel members registered with an NHS dentist, those in Hyde were more likely to have said it was easy to get an appointment (89% of panel members in Hyde registered with an NHS dentist said it was easy to get an appointment, compared to 82% of the panel overall).

Panel members in the following DA areas were more likely to be satisfied overall with the availability of NHS dental services in Tameside:

- Droylsden (46% of panel members in Droylsden were satisfied overall with the availability of NHS dental services in Tameside, compared to 38% of the panel overall).
- Hyde (44%).

Panel members in Denton and Audenshaw were more likely to be dissatisfied overall with the availability of NHS dental services in Tameside (50% of panel members in Denton and Audenshaw were dissatisfied with the availability of dental services in Tameside, compared to 35% of the panel overall).

APPENDIX C

Personal and Health Services Scrutiny Panel

THE NATIONAL EXPERIENCE OF THE NEW CONTRACT

Follow-up Review of Dental Services in Tameside

This Briefing Report contains information on the national experience of the new contract arrangements for dental services. This information may help the Panel to compare Tameside experiences with the national picture and raise issues during the follow-up review which have been highlighted nationally.

1. Introduction

1.1. Information about the national experience is drawn from the Department of Health, the British Dental Association, the Citizens' Advice Bureau and Which?, the consumer association.

1.2. The briefing paper reports on the impact of the reforms on the following:

- The availability of dental services
- The quality of dental services
- Dentists
- Primary Care Trusts
- The relationship between Primary Care Trusts and dental practitioners

1.3. In summary, surveys with dentists and patients show a more negative picture of availability of dental provision and of the impact of the new contract. However, whilst the DoH accepts that this has been a challenging period, there have been many examples of success and the DoH is confident that the new contract, additional support to PCTs and improvements to the workforce, will achieve the much needed improvements to dental provision both in quantity and quality.

1.4. Key messages from the national experience:

- The availability of dental services has 'stabilised'
- Provision appears mixed across the country
- Some groups of vulnerable people still find it difficult to find or get to an NHS dentist
- Significant improvements have been made which address previous unequal access.
- A 'mass exodus' of dentists from NHS provision has not materialised; PCTs have been able to find dentists to take up contracts.
- NHS patients are happy with the service they receive.
- Dentists are concerned that they are financially disadvantaged by the new arrangements and that workload has not reduced.
- In the first year of the new arrangements the DoH focussed on ensuring an adequate quantity of services; the next phase will expand the focus to quality.

- The relationship between dentists and PCTs is generally good but may have been damaged by the transition in some cases.
- The DoH will provide PCTs with more financial support alongside administrative, research and intelligence resources.

2. Impact on the availability of dental services

2.1. The new contract is intended to increase access to NHS dental provision and make the cost of dentistry more affordable (it should be noted that in the Scrutiny Panel's original report Tameside and Glossop PCT agreed that an increase in availability was not an inevitable result of the new arrangements and that other policies were in place to address supply).

2.2. The Department of Health reports that access to dental provision has "stabilised" in the first 12 months of reforms [5]. The proportion of people seeing an NHS dentist at least once in two years remained the same in the two years up to September 2006 as in the two years up to March 2006 with just over half of the population of England receiving NHS services in both periods [6]. Therefore although it welcomes the reforms, the Citizen's Advice Bureau finds that whilst access to NHS dentists may not be getting any worse, it is not getting any better as a result of the new contract.

2.3. Market research by Which?, the consumer association, in March 2007 found that half of those practices it surveyed were not taking on any NHS patients, including 75% of dentists surveyed in the North West[7].

2.4. The CAB observes that provision across the country and between different sections of the community is very unequal. Patients still face a "postcode lottery". The CAB found that in a quarter of PCTs surveyed there were no dentists taking new NHS patients. The Which? survey also found big variations in new access across the country (63% of dentists surveyed in the East Midlands were taking on new patients compared to only 13% in the North West).

2.5. Waiting lists and long journeys were identified by the CAB as continuing barriers to accessing dental provision. Low income patients, those in rural areas, and users of public transport are most negatively affected. In addition, according to the CAB, patients do not always know how to find out about services when they do exist. The DoH recognises that information is important to make sure available places are taken-up. Whist the DoH continues to develop national communication channels, some PCTs have established helplines to act as a 'one-stop' point of information (Dorset and Somerset PCT; East Lancashire; Leeds).

2.6. The CAB believes that PCTs' waiting lists underestimate demand because patients are not always aware that this is an option. The CAB feels that more should be done to ensure PCTs are fully aware of demand in their areas. Indeed, the DoH agrees that continuous local needs assessments are needed

[5] Department of Health (August 2007) 'NHS Dental Reforms: One year on' Available from

[6] Citizens' Advice Bureau (March 2007) 'Gaps to fill: CAB evidence on the first year of the NHS' Available at www.bda.org/advice/docs/SpecialConf28th_CAB_GapsToFill.pdf

[7] Which? (March 2007) Market Research Available at www.bda.org/advice/docs/SpecialConf28th_Survey_Which_26-3-07.pdf

along with public consultation to ensure that services meet local needs and priorities.

2.7. More positively however, the CAB also finds that control by PCTs over the location of practices has begun to address the inequality of access in many areas since new practices have been opened where provision was previously lacking. The Department of Health also reports correspondence about problems accessing services fell by 65% between July and December 2006[8].

2.8. Moreover, the Department of Health reports that the PCTs are commissioning more dental services than before the reforms. Examples cited by the DoH report which show how the new arrangements have increased availability include:

Oldham	Two new practices commissioned which will be able to provide for an additional 8,000 NHS patients.
Devon	In the last 18 months, 37,000 patients previously on the PCT waiting list have been found places in newly commissioned practices.
Cumbria	Eight new dentists and 20,000 more patients registered in Carlisle and Penrith. Cumbria PCT has commissioned over 62,000 new dental places since April 2006. Dental helpline enabled 66,000 people to find NHS places.

2.9. Dentists however are largely pessimistic about the impact of the new contract on provision. A survey of 615 dentists by the British Dental Association published in March 2007 (a year in to the new contract), found that:

- 85% did not believe that the new arrangements had improved access to dental services for patients.
- 89% felt the new contract had not improved patient choice about dental services[9].

2.10. Similar results were seen in a more recent survey by Dentistry Watch in October 2007 of 650 dentists. The survey found that 84% dentists "do not believe that the new dental contracts have made it easier for patients to access an NHS dentist".

2.11. The Dentistry Watch survey found that 68% of dentists are either treating the same number or fewer NHS patients in the last year. Moreover, the BDA survey indicated that the availability of NHS dentistry will fall in the next five years up to 2012:

- 23% said they expected their NHS work to stay the same
- 69% expected their NHS work to fall

[8] Dentistry Watch (October 2007) Available from http://147.29.80.160/portal/csc/genericContentGear/download/Dentistry+watch+national+summary+of+results+-+final3-15-10.pdf?document_id=116400639

[9] British Dental Association (March 2007) 'New NHS Contract Survey' Available from www.bda.org/advice/docs/SpecialConf28th_Survey_BDA_NewNHSContract.pdf

- 8% expected their NHS work to increase

2.12. However, the Department of Health reports that only 4% of contracts were rejected in April 2006 and that the "mass exodus" of dentists predicted by some did not materialise. In fact, DoH figures show that within three months the level of services commissioned by PCTs exceeded the level of contracts that were offered in the run up to the start of the new arrangements. Moreover, dentists who did not take up the new contracts were providing small amounts of NHS provision according to the DoH.

2.13. The DoH is also investing in increasing the supply of dentists by funding training places and working with PCTs to improve vocational training provision. Dental training provision has already been increased by 25% in 2005 and plans are in place to increase the number of qualified dentists from 2009 (new dental school in the South West, greater provision at the Universities of Liverpool and Central Lancashire and outreach training by the University of Leeds).

3. Impact on the quality of dental services

3.1. The new contract was intended to improve the quality of care provided to patients by allowing dentists to spend more time with patients and promote a more preventative approach. The 3 band pricing system is intended to limit the maximum cost of treatment and simplify the pricing system.

3.2. The Dentistry Watch Survey (October 2007) of 5962 people found that 93% of NHS patients were happy with the treatment they receive. Forty percent of both NHS and private patients surveyed said that NHS charges provide value for money, 40% did not know, and 21% felt that they did not provide value for money.

3.3. The Dentistry Watch survey found that 58% of dentists felt that the quality of care was worse than before the contract was introduced; 2% said it had improved.

3.4. According to the survey of dentists conducted by the British Dental Association:

- 87% felt that the fairness and affordability of dental services had not been improved by the new contract.
- 90% felt that continuity of care for patients had not been improved under the new arrangements.
- 93% did not feel that the new contract allowed them to get a balance between intervention and prevention

3.5. The DoH states that the initial concern in the first year of reforms was the quantity of services available and that the next phase of the reforms will be to support PCTs in improving the quality of services. In addition to expenses and net income, £100m is available to PCTs to improve the quality of premises and equipment. A 'clinical governance' framework has already been introduced which will raise standards in areas such as infection control, child protection and staff development.

3.6. The DoH will support PCTs in developing ways to monitor the performance of dentists including the impact pf preventative work which could be difficult to measure.

4. Impact on dentists

4.1. The new contract intended to address the tendency of the previous arrangements to create a 'tread mill' effect whereby dentists were paid per item of treatment and so their income depended on carrying out as much treatment as possible. Private dentistry was also more lucrative than NHS provision which also helped reduce the availability of NHS services.

4.2. Contracts stipulate how many Units of Dentistry Activity (UDA) dentist are required to perform. The contracts cover the expenses of running a practice and net income for dentists. The arrangements were intended to provide greater long-term security for dentists.

4.3. The DoH believes that new contracts are beginning to benefit dentists' working lives and that workload and expenses have already begun to fall. The DoH also finds that it has not been difficult for PCTs to find dentists wishing to expand their practices and that there has been considerable competition for tenders.

4.4. However, the survey conducted by the British Dental Association, found that:

- 97% did not feel that the contract had removed the treadmill effect.
- 61% said they would not reach their UDA target; 8% said they would exceed their target.
- 91% did not feel that the contract made arrangements between dentists and commissioners clearer.
- 94% did not feel that the new contract provided long-term certainty over the future of the dental practice.
- 81% said the contract had not made their practices more financial viable.

4.5. In the Dentistry Watch survey 41% of dentists felt that their workload was excessive. Many felt that UDA targets were a significant source of stress.

4.6. The DoH however, believes that any additional costs incurred by dentists for treating patients with extensive needs will be offset by those who have good oral health and who rarely need to visit the dentist. Workloads and expenses, the DoH believe, will 'average out' whilst income levels are guaranteed. The DoH finds that dentists are providing on average 5% less treatments for the same guaranteed income.

4.7. The DoH recognises that dentists feel they will be financially penalised for providing more substantial treatments and are working to address this; for example, dentists working in areas with high oral health needs will have a higher value contract or lower contractual requirements.

5. Impact on Primary Care Trusts

5.1. The reforms gave a significant new role to the PCT and demands increasing capacity and skills in planning, commissioning and monitoring services.

5.2. The DoH believes that most PCTs have risen to this challenge and performed well. PCTs completed needs assessments and successfully carried out large tendering exercises to identify providers.

5.3. PCTs are provided with data from the NHS which shows where dentists are providing more or less than agreed services so that PCTs can work with

dentists to address this. Another nationally provided service carries out inspections and consults patients on behalf of PCTs.

5.4. PCTs were allocated a total of £1.8bn in 2006/07, up by £450m the previous year. This budget will be added to the income PCTs make from patient charges. However, the CAB believes that the disappointing impact of the new contract is partly due to insufficient budget allocation to each PCT; allocations were based on previous expenditure and the CAB believes this does not reflect the aims of the reforms and current needs in the community. Indeed, the PCT recognises that in some areas patient charges, and therefore PCT income, has been less than anticipated and some PCTs have spent more in the commissioning process and had to use their main PCT budget. The DoH has increased allocations for 2007/08 as a result.

6. Impact on the relationship between PCTs and dental practitioners

6.1. Primary Care Trusts in the run up to the introduction of the new contract were expected to maintain clear communication with dentists about the new contracts. The success of the contracts is likely to hinge on effective communication and positive relationships between the two sides.

6.2. The DoH finds that there are a number of examples of PCTs and dentists working closely together in the run-up to the new arrangements with successful outcomes including newly designed services and training provision for dental students.

6.3. The survey conducted by the British Dental Association, found that half reported their relationship with the PCT was 'satisfactory', a third found it 'good' or 'excellent', and a quarter said that the relationship had suffered since the introduction of the new contract.

6.4. However, the new arrangements may have damaged the relationship between dentists and the NHS since 95% of dentists in the BDA survey said that they were less confident in the NHS now than before.

7. Significance for the Scrutiny Review

7.1. The information provided above will be useful to the Scrutiny Panel when it comes to compare the Tameside experience with the national picture. The Panel has already received the results of the survey of dental practitioners which were not dissimilar to the findings of the national surveys mentioned above. In January 2008, the Scrutiny Panel will be able to compare feedback from Tameside patients with the national experience. In February 2008, the Panel can discuss the findings of the re-review with the PCT and compare the local and national picture.