Health & Social Services Committee

HSS(2)-11-04(p.8)

Date: Wednesday 6 October 2004
Venue: Committee Room 3, National Assembly for Wales
Title: Dental Services

Purpose

1. My Ministerial Report (HSS(2)-08-04(p.1)) of 23 June 2004 outlined the proposed new contractual arrangements for dentists. Following this the Committee asked for a paper to note on the following issues: action resulting from the Audit Commission report on dentistry with reference to the frequency of check-ups; the review of the Community Dental Service; the oral fissure sealant programme; and the number of people in Wales registered with a dentist.

Background

2. The Audit Commission report *Primary dental care services in England and Wales* was published in September 2002. In addition to examining the use of NHS funds the report looked at access to services, inequalities in health, patient charges, the frequency of examinations and fluoridation. A brief summary of the report and its recommendations are at annex A. The full report is available on the Audit Commission website at: www.audit-commission.gov.uk

3. The issues raised by the Audit Commission in their report and the recommendations it makes have moved on in the 2 years since publication. In particular the publication of new draft National Institute for Clinical Excellence (NICE) guidelines on recommended dental recall intervals, the proposed reform of dental services and new contractual arrangements address many of the concerns.

4. With the exception of fluoridation the issues covered in the Audit Commission report are included in those which the Committee have asked me to cover in this paper. For completeness I also include the latest position regarding fluoridation of water supplies.

Consideration

Fluoridation

5. The Welsh Assembly Government is considering the implications for Wales of the fluoridation provisions in the Water Act 2003. The provisions in the Water Act 2003 require the introduction of secondary legislation by the National Assembly for Wales governing the public consultation process to be followed prior to the establishment of any fluoridation schemes in Wales. At present there are no proposals to introduce new fluoridation schemes in Wales.

6. The first step would be for the National Assembly in plenary to commence Section 58 of the Water Act and to make the public consultation regulations. The earliest that those regulations could be made is April 2005. I have agreed to work being undertaken on the preparation of, and consultation on, draft regulations governing arrangements for public consultation on proposed fluoridation schemes in Wales. A decision has therefore not yet been made on the detail of the public consultation arrangements but I can confirm that the addition of fluoride to the water supply will not go ahead without the appropriate consultation.

Frequency of check-ups

7. The Audit Commission report raised the issue of over-frequent dental examinations. Dentists are expected to follow the advice on recall intervals from NICE. Draft guidance was issued in February and May this year and formal guidance on this subject is expected to be issued to the NHS in England and Wales later this year. It is anticipated that the guidance will follow the principles that modern teaching advocates a minimal intervention approach which will mean that patients at low risk of disease are seen less frequently than now.

8. The principle underlying the draft guidelines is the individualisation of recall intervals. The recommendations contained in the guideline should be seen as an integral part of the evolution of NHS dentistry towards a more preventive-oriented and clinically effective way of meeting patients' needs. The guideline recommendations are designed to assist dentists in using their clinical judgement to assign recall intervals that are appropriate to the needs of individual patients. Patients should be informed that a single 'set' recall interval for their entire lives may not be deemed appropriate and that the recall interval may vary over time to take into account any changes in their level of risk or from oral disease. It is proposed that at each check up the dentist will assess how healthy a patients teeth and gums are, and weigh up the risk of future problems. Based on clinical need the dentist will suggest a date for the next check-up. This could be from 3 months to a maximum of 2 years (one year if the patient is under 18).

Patient charges

9. Successive reports have found that the current system is complex, bureaucratic for dentists and confusing for patients. The Audit Commission recommended that patients should have clearer information about charges and the Office of Fair Trading has found that "patients are frequently unclear whether charges are for NHS or private care".

10. Under current arrangements charge paying patients pay 80% of treatment costs up to a maximum for

a course of treatment, currently £354 in Wales (£372 in England). The cost per treatment is linked to a fee paid to the dentist per item of service. Since new contractual arrangements for dentists providing NHS care are due to come into effect in October 2005, then a new payment system for patients must come into effect at the same time.

11. A Working Group, chaired by Harry Cayton, the Department of Health's Director for Patients and the Public, was asked to propose a simpler, transparent charging system, which would raise the same proportion of total dental expenditure as now. The Working Group included UK patient and consumer representatives, the dental professions including the British Dental Association along with representation from the Assembly Government. The main recommendation of the Group is that there should be a three band payment system for a course of NHS dental treatment:

- Band 1 (maintenance - e.g. check-up, scale and polish)
- Band 2 (treatment - e.g. fillings, extractions)
- Band 3 (complex treatment - e.g. dentures or crowns)

12. I have considered the options available and agreed that a new patient charge regime should be introduced at the same time as a new dental contract in Wales. However, no decisions have yet been made about the Group's report or charge levels and I will consult on any proposed changes in due course.

Review of the Community Dental Service

13. In April this year the Welsh Assembly Government commissioned a review of Community Dental Services (CDS) in Wales. Set in the context of the recent structural reforms of NHS Wales, Routes to Reform and the implications for dentistry of the Health and Social Care Act 2003, the CDS review was established as part of an agreement for a 10% pay deal for all CDS staff spread over a three-year period. Following a formal tendering process Newidiem, a Wales-based UK research and strategy company was awarded the contract to carry out the review.

14. The Welsh Assembly Government established a small Reference Group that through the collective experience and expertise of the external membership, appraised and provided expert advice to the Assembly on key issues developing through the stages of the review.

15. The review considered the arrangement of the CDS, CDS/General Dental Service (GDS) interface and Personal Dental Service (PDS) schemes within the environment of LHB commissioning, addressing issues of service organisation, management, leadership and future roles of the services. The outcome of the review will assist the development of a clear future direction for the CDS in Wales.

16. The review also considered the contribution of salaried dentists within the overall context of primary care dentistry, taking into account the contribution of other members of the dental team. The review assessed functioning of the service, identifying good performance, any under performance associated with systemic defects and areas where system performance can be improved by best practice. I expect to

receive a copy of the final report this month. It is intended that consultation on the review's findings will then be carried out.

17. Although the review is primarily focused on the environment of LHB commissioning, service organisation, management, leadership and future roles of the services the Welsh assembly Government will take account of the context of the emerging principles of *Agenda for Change* and the analysis in the Office of Manpower Economics' Mercer report. The Welsh Assembly Government has observer status on the high level Project Steering Group chaired by the Chief Dental Office England. In general this has allowed the Assembly to be aware of development within the English review process, of issues pertaining to pay, conditions of service and career pathways of progress on these issues. The Assembly Government will consider the English Review when it is published. Issues relevant to pay, terms and conditions and career structures will be considered from a Wales perspective. The Assembly will then deliver its response through the Wales sub-committee of the Joint Negotiating Forum (JNF) and continue to work through the JNF.

Fissure Sealant Programme

18. This programme, which has received £1.5m as part of the Inequalities in Health Fund, commenced in 2001-02 and is now in its fourth year. It is targeted at deprived areas identified by the Communities First programme and is delivered by the CDS at schools in those areas. Principles that underpin the Health Inequalities Fund and the Communities First Programme are comprehensive approaches to tackle inequalities that exist between some of our communities and targeting of the most deprived communities in Wales. Prevalence of dental caries is strongly associated with socio-economic deprivation and so the fissure sealant programme fits well with the overall health and wellbeing strategy of the Welsh Assembly Government.

19. Fissure sealants are applied to teeth to protect the pits and fissures of teeth that are most prone to decay whilst fluorides in toothpaste protect all tooth surfaces. The sealants are provided as part of an overall health promotion package.

Access & number of registrations

20. The latest figures from the Dental Practice Board (at 30 June 04) show that 1,482,666 people (51.1% of the population) were registered with a dentist for NHS treatment in Wales. This compares to 47% in England. This is an increase of some 3,000 over the previous quarter.

21. The Assembly Government has been proactive in addressing the access difficulties and the approach taken is based upon making NHS provision an attractive option for dentists as the Assembly has no powers to direct dentists to operate in a particular area. Despite the successes of the Welsh Dental Initiative and the other schemes in operation I acknowledge that access to NHS dental treatment remains difficult in some areas. These problems are being experienced throughout the UK and there are a number of reasons for this. As the Audit Commission report highlighted, changes to the piecework system which

currently operates have been proposed for nearly 40 years. These are the long-standing problems which this Government has inherited but is determined to tackle.

Reform and new contractual arrangements

22. In May I announced my proposals for a major reform of dental services and the introduction of new contractual arrangements for dentists providing NHS care. This is aimed at providing a new service framework for primary care dentistry which will improve access and help dentists by ending the item of service 'treadmill'. This included £5.3 million over the next 3 years to improve access to NHS dentistry and support implementation of the new contract and associated reforms. I also said that we would follow the same timetable for implementation of the new contract and programme of reform as in England.

23. In August I announced that the implementation date for the base contract for dentists not already in local contracts will be October 2005. I also said that dentists and LHBs who wish to move to local contracts ahead of this date should consider doing so now using PDS schemes. Since my announcement there has been significant interest from individual dentists, practices and LHBs wishing to take advantage of the new contractual arrangements ahead of the formal implementation date. Assembly officials and those from the Dental Practice Board are in the process of talking to interested parties.

24. My announcement also included a 17% increase in dental training places in Wales and how the first £1.5m tranche of the £5.3m additional resources would be allocated. This is as follows:

- £550,000 for dentists, which is equivalent to £1,000 per dental practice, to assist them manage the change and the new ways of working. This will be managed through LHBs.

- £510,000 between the 6 LHBs where access to NHS primary care dentistry is most difficult – Ceredigion; Gwynedd; Merthyr Tydfil; Flintshire; Carmarthenshire; and Pembrokeshire.

- £440,000 to LHBs to support them with the dental change agenda through for example, supporting their dental advisory committees or developing dental leadership skills.

Financial Implications

25. As part of the reforms in England the Department of Health have announced increased funding for NHS dentistry including additional growth monies for PCTs. We are studying the detail of the DH announcement and I hope to make a statement on this shortly.

Cross Cutting Themes

26. A Project Group under the chairmanship of a LHB Chief Executive is being established to oversee implementation of the new contractual arrangements and to provide a source of practical experience and

expertise to inform the way forward. Membership will include representatives of the British Dental Association, Welsh and Local Dental Committees, Local Health Boards, the National Public Health Service, Community Health Councils and other interested parties.

Action for Subject Committee

27. To note the content of this paper. I will provide more detail of the reform and new contractual arrangements as proposals develop further.

Jane Hutt AM
Minister for Health & Social Services

Contact Point: Andrew Powell-Chandler, Primary Care 3, Community, Primary Care and Health Services Policy Directorate, tel: 1689

Annex A

Summary of the Audit Commission report *Primary dental care services in England and Wales*

Family dentists' receive £1.6 billion annually for NHS dental work.

- fees are paid for work done – 'piecework'
- they come direct from the NHS and from people who pay charges for NHS work and although access to urgent and drop-in care has improved since 1999, the Government, dentists and many patients agree that the service does not work well.
- forty per cent of dental practices will not accept adults or children for continuing, preventative care on the NHS
- in some places, no dentists accept NHS patients
- dentists who provide NHS care feel that they are on a 'treadmill', having to work increasingly hard and quickly to keep their businesses going
- this brings risks to quality of NHS care

The current system can be wasteful and confusing.

- unnecessary examinations for people with good dental health, and treatments that bring no proven benefit to health cost at least £150 million in England and £8 million in Wales
- in deprived areas fewer people are registered with a dentist
- patients are frequently unclear about whether charges are for NHS or private care

And little has changed.

- deprived areas have the worst dental health and would benefit most from fluoridation, but there have been no new schemes since 1985
- changes to the piecework system have been proposed for nearly 40 years, yet it remains much the same today
- Options for Change (published in August 2002) is a welcome start because it invites dentists and primary care trusts to test better ways of working in England

Patients should have clearer information.

- about which treatments are necessary, and which cosmetic
- about whether their treatment is available on the NHS or privately
- about charges for treatment

The Government should focus resources on the most beneficial work.

- emphasising prevention, including fluoridation of water supplies
- replacing the piecework system to concentrate funds on prevention and treatments that are of proven value to dental health
- not paying for cosmetic activities on the NHS

Recommendations of the Audit Commission report *Primary dental care services in England and Wales*

The Government in England and Wales should:

1. Replace the current payment system (that is predominantly based on piecework) with a system, or mix of systems, that emphasises prevention and treatment based on evidence of cost-effectiveness, that addresses health need and is implemented by local health commissioning bodies. This will enable local NHS commissioning bodies to secure reductions in the frequency of unnecessary check-ups and cosmetic activities, without driving dentists out of business or forcing more to go private and make necessary care unavailable to the poorer sections of society. The new system should:

a) Define which activities are needed for good health, and allow only these on the NHS. Users and professionals should be involved in developing these definitions. This could form the basis for a system of national standards, backed up by NICE guidance, that are more specific than the current requirement to maintain dental fitness. NHS funding for unnecessary and cosmetic activities, or those that scientific evidence shows do not represent good value for money, should stop. Such activities could still be available to patients who wanted to pay for them, via private arrangements. The definitions of which treatments are necessary for good health, and which are mainly cosmetic could build on the existing

Index for Orthodontic Treatment Need, leading to the introduction of similar indices for other types of activity (for example, crowns) where guidance is needed.

b) Implement the recommendations of the NICE review on risk-based recall intervals to allow dentists to offer more individual recall intervals for patients and consider taking this further by using the risk categories to vary capitation payments, allowing longer registration periods while still providing value for money. This would enable the 15-month rule to be scrapped, whereby patients are automatically de-registered if they do not attend within that period, which causes distress, especially to older patients with dentures, who may not see a need to attend with such frequency.

c) Enable local commissioning bodies to negotiate local contracts implementing national standards for NHS dental healthcare and national access standards. Instead of piecework, local contracts should be predominantly based on capitation, 'cost and volume' agreements or sessional and/or salaried payments, with safeguards built in that limit expenditure and discourage 'supervised neglect'.

d) Give local commissioning bodies discretion to support investment to modernise infrastructure (premises, equipment) and reduce overheads, allowing some degree of direct reimbursement for the cost of premises, staff payments, equipment and consumables, avoiding public investment in outdated and inappropriate premises. Local NHS commissioning bodies should be able to influence the distribution of, and services offered by, GDPs, for example, by payment for premises in targeted locations.

2. Review the charging system for activities that improve patients' health, in the light of evidence that some (for example, pensioners with low incomes and lower paid people) are deterred from dental healthcare because of its cost. The current exemptions do not match those in other areas (for example, prescription charges) and the review of charges, recommended in the 'Wanless' report, should be an opportunity to devise a consistent approach, where those who can afford to contribute do so, but so charges do not prevent access to necessary health care.

3. Begin a campaign to help patients to become informed consumers. They need understandable information that allows them to know what is necessary for their health, and what is for cosmetic purposes only. They also need clear information in advance about charges.

4. Act to secure fluoridation of water supplies.

Local NHS bodies (PCTs in England and from 2003 LHBs in Wales) should:

5. Ensure that they have the expertise and capacity to plan for, and shape, primary dental care services and to involve local GDPs in this work.

6. Focus effort on improving dental health, and access to continuing care for those with the worst health, in the most deprived communities.

7. In addition to pursuing the fluoridation of water supplies, explore other ways to improve dental health, for example by getting fluoride toothpaste used by those most at risk, promoting fissure sealant programmes, sponsoring schemes that make good food available in local communities and investigating the targeted use of fluoride in school milk, bottled water or diluted sugar-free fruit drinks.

Individual dentists should:

8. Review the frequency of check-ups, and whether treatments offered have been shown to be effective in improving dental health and not just cosmetic appearance.

9. Ensure that Government guidance on providing written estimates and a treatment plan in advance are followed, and that there is a good range of other information available to patients on how to care for their teeth and gums.