A Review Of The National Dental Contract In Wales - TASK AND FINISH GROUP

Final Report agreed by Task and Finish Group
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1. **Executive Summary**

- The Welsh Assembly Government record on investing in NHS dentistry has been good at times, but inconsistent in approach.
- The system introduced in April 2006 is commissioner driven to respond to community need in the 21st century.
- Overall, oral health has improved in the community but deprived sub-groups continue to experience relatively high levels of disease. The challenge is to improve oral health and address inequalities by improving the oral health of those with the poorest to that of the best, at the same time ensuring adequate access for the community to dental services.
- The contractual change has resulted in tensions within all stakeholders – patients, dentists, Local Health Boards (LHBs) and the Welsh Assembly Government.
- Greater clarity is needed for patients on available treatments, patient charges and the interface between private and NHS provision and improved patient access to dental advice services.
- Even though the transition from old to new has been challenging for the dental profession, the two years that have elapsed have shown that most dentists are supporters of the NHS.
- There are diverse views regarding the new situation within the profession. The balance is moving toward the view that the new system is a ‘workable system’. LHBs are not finding difficulty attracting new dentists or expanding the services provided by established practitioners.
- LHBs need to drive oral health improvements and access as they move from contracting to commissioning. In so doing LHBs need to be mindful that NHS dentistry should be an attractive option for dentists.
- The Unit of Dental Activity (UDA) as a sole outcome measure is inadequate. Work continues within a sub-group of the Task and Finish Group to develop a ‘basket of indicators’ to facilitate these improvements.
- In order to achieve stability in the dental workforce extending the timeframe for specific dental allocations of LHBs beyond April 2009 is recommended.
- It is essential to ‘grow’ year on year allocations if we are to ensure oral health/access aims and objectives are met and to address demographic and epidemiological change.
- The Community Dental Service (CDS) has the potential to support the work of General Dental Practitioners (GDPs) and enhance community oral health.

2. **Introduction and Background**

2.1 In April 2006 the Welsh Assembly Government introduced a new set of regulations for general dental services, personal dental services, the dental performers list, patients’ charges and functions of Local Health Boards.
2.2 The Key points of the new contract and the supporting regulations were that:

- All dentists providing general dental services on 30 September 2005 (practice owners and associates) had a legal right to be offered a new base contract with the LHB when the new arrangements come into effect;
- Dentists’ most recent earnings being protected for three years (uplifted to take account of agreed Review Body increases each year) provided that their NHS commitment is maintained;
- Dental contractors were no longer required to provide out-of-hours services unless they wish to do so as contracted with the LHB;
- The list of treatments available and which would be paid for by the NHS was discontinued;
- A simplified patient charging system was introduced; and
- Local commissioning of dental services by LHBs.

2.3 Under the new arrangements, dentists are required to provide all proper and necessary dental care and treatment which a dentist usually provides for a patient and which the patient is willing to undergo. This is the same requirement as under the old contractual arrangements but removal of the list of treatments has removed the clarity of what is available.

2.4 The reforms of 2006 have created an environment in which tensions have emerged within all stakeholder groups – dentists, patients, Local Health Boards and Welsh Assembly Government. In November of 2007, the Minister of Health and Social Services of the Welsh Assembly Government asked Professor Wayne Richards to chair a task and finish group to review the new dental contractual arrangements in Wales.

3. Terms of Reference

3.1 The terms of reference under which the Task and Finish group was asked to operate were:

- To identify and discuss the key issues associated with the NHS dental contract introduced in April 2006;
To make recommendations regarding significant issues which need to be addressed by the Welsh Assembly Government, LHBs or the dental profession;

To lay the ground for fulfilling the Welsh Assembly Government’s published goal of consolidating and developing the CDS in Wales following its response to the publication of *Bridges to the Future – A Review of the Community Dental Services in Wales*; and

To contribute toward meeting the *One Wales* agenda on the provision of NHS dental services.

3.2 In writing to convey these terms of reference, the Chair was asked to bear in mind that recommendations should be capable of being implemented with maximum efficiency and with safeguards for the public purse. The Chair was also asked to ensure that the group:

- Consider implications from the commissioner, patient and provider perspective;
- Consider the funding implications of implementing any recommendations and the on-going costs;
- Share best practice from national and local implementation; and
- Keep the Minister and the Health and Social Care Management Board advised on progress.

3.3 The Community Primary Care and Health Services Policy Directorate of the Welsh Assembly Government established membership of the Task and Finish group to include interested representative bodies (see Appendix 1).

4. **The Review Process**

4.1 **Conduct of the review**

4.1.1 On the basis of the terms of reference it was agreed to conduct the review in five phases:

- initial scene setting so as to define fundamental problems;
- the request for current up-to-date evidence from the group;
- analysis of the evidence by the group, including contributions from invited ‘case studies’ so as to demonstrate ‘real’ operational problems;
- preliminary considerations, discussions and recommendations; and
- preparation of this report.

4.1.2 The Task and Finish Group first conducted a general overview to establish the fundamental context of the changes.
4.2 Summary of the Overview.

4.2.1 Historical context

(a) The NHS system set up in 1948 faced challenges in oral health that were very different from those faced by the NHS today. NHS dentistry served a nation with poor oral health with large amounts of untreated disease. The fee per item system of payment for dentists was introduced to deal with these challenges. This system was driven by the providers of care (dentists) and treatment items that could be provided and paid for by the NHS.

(b) The rationale for the introduction of the present NHS dental care arrangements is based on a long history of reported failings of the old system. All have suggested problems with the previous delivery arrangements but from differing perspectives. The reports include: the Schanschieff Report (1986), examining the possibility of over prescription; the Bloomfield Review (1992), regarding payment mechanisms; the Audit Commission (2002) and the Office of Fair Trading (2003), exploring the manner in which the dental “market” operated, and; the National Audit Office (2004), dealing with the risks of the current arrangements. The new system became a system driven by commissioners (LHBs) so as to meet the needs of local communities.

(c) From the early 1970s as a result of the introduction and widespread use of fluoride toothpastes and improvements in dental services the incidence of tooth decay and resultant tooth-loss dramatically reduced. Between 1973 and 1998 the number of adults with no teeth fell from 40% to 13%. Decay rates in children have also been reduced. The DMFT (decayed, missing or filled teeth) for 11 year olds in Wales in 2004 was 1.09 with over 50% of 11 year olds caries free. The average number of carious teeth (dmft) in five year old children, surveyed in the winter of 2005/06 for Wales was 2.38 with 47.2% caries free. Blaenau Gwent experienced the highest average dmft (3.96) but not the lowest number of caries free children (29.8%). Merthyr Tydfil (dmft 3.91, caries free 23.7%), Torfaen (dmft 3.4, caries free 31.2%) and Neath Port Talbot (dmft 3.04, caries free 35.5%) recorded higher levels compared with the Welsh average. Conversely, Conwy experienced the lowest average dmft (dmft 1.62, caries free 58.7%). Deprived sub-groups in Wales continue to experience relatively high levels of tooth decay (Figure 1).

(d) In order to achieve the policy goals of reducing social inequalities in oral health the main challenge for commissioners (LHBs) is therefore to impact on the oral health of the deprived sub-groups experiencing higher levels of disease while maintaining access to dental services for the whole population.
(e) In November 2007 the Minister for Health and Social Services announced the development of a National Oral Health Plan which aims to improve oral health in Wales. This includes a targeted national fluoride supplementation programme and an expansion of multi-sectoral oral health promotion initiatives by all involved stakeholders, including general dental practitioners. The external pressures of advertising and the media have raised public awareness of a nice smile - one which is cosmetically pleasing. This sometimes creates a problem for both providers and commissioners in defining the boundary between what is clinical need and patient wants. Some dentists have chosen to resolve this dilemma by concentrating on providing the latter service and operating outside the NHS within a private contract with patients. Data on private sector coverage is poor. It has been estimated that 14% of the population of the UK has received private care over the last year.

(f) The majority of dentists in dental practice are independent self-employed practitioners. As such they are at liberty to choose whether they contract a proportion of their time to providing NHS treatment on behalf of LHBs.

### 4.2.2 Workforce

(a) 80% of the UK dental workforce is in Primary Dental Care. Primary Dental Care in Wales is provided, in the main, by GDPs operating from High Street locations. Also the CDS provides Primary Care Services.

(b) In July 2004, the Department of Health published a Review of the Primary Care Dental Workforce Review. This review identified a shortfall of 1,850 dentists (10% over a baseline of 18,000 dentists) and stated that (if no remedial action were taken) this figure would rise by a further 16-25% (3,600-5,050) by 2011 and would remain at that level until 2021.
In November 2005, the Department announced that both targets had been met (and exceeded). Between April 2004 and September 2005, the Department recruited the equivalent of more than 1,450 extra whole time dentists. In October 2005, there was an increase of 189 dental training places across England and Wales. In 2002, the Welsh Assembly Government commissioned a review of the Dental Workforce in Wales. The Dental Workforce Development and Advisory Group made a series of recommendations that included the increasing the number of dentists and dental care professionals working in Wales. Along with increased workforce levels, in 2006/07 the number of dental undergraduates was increased and additional vocational training places were funded.

(c) As of 31 March 2007, there were 1,186 dentists on open NHS contracts (performers) recorded on the NHS Business Services Authority Dental Services Division ‘Payments Online’ system. This is the mechanism used by LHBs to pay dentists. There were 4.0 dentists per 10,000 population (www.statswales.gov.uk). Variance can be observed in dentist: population ratios between LHBs. Some have more favourable workforce figures than others. This ranges from 7.0 in Merthyr Tydfil and Conwy to 2.9 in Pembrokeshire (31 March 2007).

(d) The number of dentists employed by the CDS in Wales is relatively few compared to the number of dentists in the General Dental Service accounting for around 1 in 9 of all dentists in 2005/06. Traditionally the CDS has embraced a Dental Public Health approach to the care it delivers. In addition to its safety net role it has undertaken community screening, oral health promotion and the care of special needs groups. It has also been involved in epidemiological surveys under the umbrella of the British Association for the Study of Community Dentistry (BASCD).

4.2.3 Activity

(a) As of 31 March 2006 the number of patients registered with dentists working in Wales was as follows:

<table>
<thead>
<tr>
<th>Total number of patients registered</th>
<th>1,407,751</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of total population</td>
<td>47.7%</td>
</tr>
<tr>
<td>Number of children registered</td>
<td>385,500</td>
</tr>
<tr>
<td>% of children registered</td>
<td>59.1%</td>
</tr>
<tr>
<td>Number of adults registered</td>
<td>1,022,251</td>
</tr>
<tr>
<td>% of adults registered</td>
<td>44.4%</td>
</tr>
</tbody>
</table>
Variance can be observed between LHBs in the level of patients receiving NHS dental treatment. Some have more favourable treatment levels than others, ranging from Denbighshire 72.8% to Pembrokeshire 24.9% (31 December 2007).

(b) A total of 4,378,200 Units of Dental Activity were recorded in the first year of the new contract, representing 2,055,000 courses of treatment. A total of 1,642,988 patients were recorded as having been treated in the 24 months up to 31 March 2007, amounting to 56 per cent of the population (www.statswales.gov.uk). Patient charges between 1 April 2006 and 31 March 2007 amounted to £22.7 million. Forecast outturn for 2007/08 is £25.9 million. Forty four per cent of all claims for treatment were for paying adults. Data from pre-contract periods are not statistically comparable with post contract data.

(c) Figures available in December 2007 showed a small drop in the number of patients seen in the previous 24 month period.

(d) During 2006/07, the CDS in Wales saw over 72,000 people and 196,000 total contacts (courses of treatment/screening episodes). Children aged 5-15 accounted for over half of both first and total contacts. Almost 20,000 children were screened by the CDS in Wales during 2006/07, representing 80 per cent of the total people screened.

(e) It is difficult to estimate population coverage from the available Primary Dental Care data.

4.3 Meetings of the Group

4.3.1 The group met on seven occasions. A record of each meeting was placed on the website of the Chief Dental Officer for Wales. It reviewed an array of evidence from many sources, including direct evidence from group members, statistical returns from Welsh Assembly Government, academic studies, good practice reports from commissioners, and examples of new policy from the Department of Health in England. Sources of all evidence contributed can be found in Appendix 2.

5. Issues relating to the new contract identified by the Task and Finish group

5.1 Many issues have been identified during the review process. The information below is a consolidated view of the discussions that took place and the evidence presented to the group. Some of the issues have been raised by all group members. Some positive elements of the new system that were anticipated when the new contract was introduced have been reported, including:

(a) Regular payments for dental services - this improved budgeting for dentists, LHBs and the Welsh Assembly Government;
(b) LHBs taking responsibility for organising and providing ‘out of hours’ emergency dental care;

(c) Simpler patient payment system for NHS dental treatment;

(d) LHBs report improved access to NHS dental services; and

(e) A strategic approach to the commissioning of dental services by LHBs.

5.2 Patients

5.2.1 The main issues expressed in relation to patients are as follows and have been categorised under the following sub-headings of:

Quality of care

(a) Quality of care – It has been reported to the Community Health Councils (CHCs) that some patients are being told by their dentists that private work is carried out to a better standard than NHS treatment. This may lead patients to perceive that NHS treatment is of a poor or inadequate standard. Confusion arises when there is no clear distinction between what is meant by quality of treatment and the quality of service.

Access

(b) Patients complain that access to dental practices accepting NHS patients are often far away from their homes or places of work, making it difficult and expensive to access these services.

(c) Patients regularly make contact with CHCs about the increase in visits to the dental practice for their course of treatment with temporary fillings placed rather than permanent restorations – making it difficult for patients to schedule time off work.

Cost

(d) Private Capitation/Insurance schemes- The most common concern raised with CHCs and Citizens Advice Bureau Cymru (CAB) are the demands put on patients to join private insurance schemes. Some patients report feeling pressurised to buy dental insurance because they fear that they will not be able to access dental care in the future.

(e) Confusion over payments – patients that contact the CHC and/or CAB report confusion over NHS and private payments because they are not given a copy of a treatment plan, neither NHS nor private, and they do not realise, or are not told the nature of the contract. The patient often discovers this when they are presented with a large and unexpected bill at treatment completion.
(f) Another area of confusion that patients report is that private treatment charges are sometimes less than the NHS charge for simple courses of treatment - “the dentist offers to do treatment for less than the NHS fee”.

(g) It is important that patients receive appropriate information to allow an informed choice of treatments. If patients do not understand the difference between a clinical ‘need’ and a patient ‘want’ this should be explained, especially when patients are charged privately for treatments that are wants rather than needs. The most common examples are the scale and polish treatment where patients are informed that a “scale and polish is not clinically necessary so can not be provided on the NHS”.

(h) Although the CHCs have no formal evidence that the cost of treatment was a barrier to NHS dental care, evidence from a public survey and some dentists confirmed that the cost of treatment did affect treatment choices by patients.

Information

(i) Ease of accessing information regarding the availability of dental services. This is particularly a problem for non-computer literate/available individuals when faced with computer based services.

(j) CHCs note that reports of enquiries from patients are not common to all practice sites. Some practice sites are associated with more enquiries from patients than others.

5.3 Local Health Boards

5.3.1 The main issues in relation to LHBs are:

(a) LHBs are key to the success of the new contract in developing services to improve oral health while maintaining access to dental services for the community. LHBs will have the opportunity to strategically commission dental services based on the oral health needs of their population and there are opportunities to build good working relationships with dental contractors.

(b) The availability of resources in terms of personnel, management time, professional advice and funding in order to commission dental services effectively. In particular, some LHBs felt bombarded by information and were unable to analyse all of the data sent to them on a monthly basis because of a lack of these resources.

(c) LHB dental budgets are based on a test period, and took account of patient charges. Underwriting anticipated patient charge revenue will effectively reduce commissioning budgets if it reduces (the converse is also applicable). In 2006/7 patient charge revenue was 20.9% lower than expected by the Welsh Assembly Government. This reflects the transition from one contract to another. More recent figures suggest that
patient charge revenue is returning to anticipated levels (2007/08 forecast outturn is 9% lower).

(d) The Payments Online system is perceived to be complex to use even though the NHS Business Services Authority Dental Services Division provides comprehensive training. Difficulties seem to arise when changes are made to the data by the LHB and the Business Services Centres which conflict.

(e) The commissioning of services solely in terms of UDAs is limiting.

(f) There is a lack of information regarding Whole Time Equivalent (WTE) dentists per population per borough which may reduce the ability to plan workforce effectively in the future.

(g) Access difficulties have improved following the introduction of the new contract. Access problems are now focused on patients with high treatment need.

(h) Current funding mechanisms that rely on the re-deployment of funding create problems for commissioners e.g. low UDA values in practices where the dentist is looking to retire make it difficult to generate interest when trying to re-commission as a new contract. This is particularly pertinent when setting up new practices in areas where poor NHS access had been an issue. The commissioning of additional services through re-deployment could prove difficult.

(i) The provision of domiciliary and sedation services have seen increased waiting lists in both specialist practices and also the CDS and secondary dental care.

(j) LHBs note that in 2006/07 their dental budgets were based on a test period and (apart from inflation increases) have not grown in real terms. Some LHBs received varying amounts of additional funding to assist and address access problems. The long lead in times required in opening a new practice to the public has meant that during the past 2 financial years, some LHBs have not been able to spend the moneys within the required timescales and have had to return some of this funding to the Welsh Assembly Government. However, these under-spends will cease as more of new practices attracted into Wales are opened. It is expected that by 2009 LHBs will have fully committed dental budgets. An element of growth funding will be required to meet demand from pressures such as continuing access problems, Vocational Training (VT) +1 and from a growing and ageing population.

5.4 General Dental Practitioners

5.4.1 The main issues expressed in relation to general dental practitioners’ are:
(a) A loss of autonomy when managing dental practices. Practitioners take all the business responsibilities and associated risks but feel that they no longer have control over the most important parts, clinical freedom and the funding.

(b) While understanding that LHBs are ‘new’ to contractual responsibilities dentists voiced concern with the inconsistent approach taken by some LHBs on contractual issues and the effect this has on the morale and confidence of independent contractors. As a result some practitioners have already terminated their NHS commitment. Evidence suggests that overall manpower retention to the NHS remains static.

(c) Dentists are unhappy with the lack of information about the future, especially about what may happen after April 2009.

(d) Practice goodwill and transfer of contract are major issues for practitioners who are looking to sell their practices for whatever reason. For some types of practice, and in some areas of Wales, practice goodwill value is now non existent.

(e) The new contract has not addressed workload issues with dentists complaining that one treadmill has been replaced by another. Dentists have expressed concerns that it fails to reward genuine patient care and has done nothing to enable time to focus on prevention rather than repair.

(f) The test period used to allocate Annual Contract Values did not take into consideration charges made to patients for failed appointments. Dentists are no longer allowed to charge for failed appointments so no remuneration is received to cover the continuing expenses of a practice during lost time when patients fail to turn up for appointments.

(g) An inequality in UDA values is seen between different providers even in the same area. Whilst this relates to the individual’s pattern of practice during the test period, this understandably has given rise to discontent within some members of the dental profession.

(h) Dentists in some parts of Wales complain that there are not enough sedation and orthodontic services, leading to long waiting lists. Changes made to the eligibility of patients for orthodontic care Index of Orthodontic Need (IOTN) assessment have also caused some patients to complain about availability.

(i) Dentists report that there is less incentive to take on new patients with high treatment need as the reward (3 UDAs) for caring for any patient requiring Band 2 treatments is the same in all cases.

(j) The banding system of UDA generation is generally disliked by dentists. Band 2 is considered too all encompassing and should be split into more well-defined categories.
(k) Performance monitoring is inadequate if the only contract currency is the UDA. End of year over/under performance is surrounded by uncertainty and concern.

(l) Whilst guidelines exist on issues such as maternity, paternity and long term sickness payments, LHBs have varying interpretation of these which has caused unnecessary stress to some practitioners.

(m) Recruitment of new practitioners to expand a practice, for example Vocational Dental Practitioners (VDPs) wishing to stay with their training practice is a problem. Unless the LHB has freely available funds then a new dentist can only be employed if the total UDA allocation is diluted amongst all the dentists and the practice increases the amount of treatment being provided privately. This compounds the feeling of loss of autonomy for dentists, especially amongst those who have a commitment to providing NHS care.

(n) There has been a reduction in the number of VDP trainers in Wales. Most leaving the scheme cite the difficulties resolving the payments via Payments Online as the major issue for leaving.

(o) Inability to apply modern principles of caries management because of the lack of historical notes when patients attend as new patients.

(p) Referrals to secondary care services have increased by 20% since the implementation of the new contract.

6. Discussion of key issues

6.1 The overriding aim of a publicly funded dental service must be the improvement of the population’s oral health. Ideally this should be achieved in an efficient and equitable manner. The pursuit of this objective using the new contractual arrangements is complicated by a number of issues identified by dentists, patients and LHBs that require discussion. An effective public system should be able to overcome the difficulties, and provide prompt and cost effective access based on clinical need.

6.2 The issues can be grouped broadly under the following headings:

- Financial issues (National benchmarking, understanding and deciding on contract currency)
- Contract management and overall contract performance to meet oral health aims
- Information (measuring oral health and information on population needs/defining valid outcome measures, patient information needs)
- Workforce issues
6.3 The group also identified factors that might limit or delay change:

- Current Regulations
- The Welsh Assembly Government has a minority role in the funding of the NHS Business Services Authority and hence the Dental Services Division of that organisation
- Department of Health is in a strong position to influence the direction of dental policy for England and Wales
- The lead in time for amending existing and developing new IT systems including the more complex elements of the payments system

7. **Recommendations**

7.1 No one system for the delivery of oral health care is going to satisfy all people all the time. However, the new contract of 2006 provides Wales with a system that has the potential to improve oral health and the first two years have shown it to be a workable system.

7.2 **Recommendations agreed**

7.2.1 To enhance contract effectiveness and deliver improvements in oral health the group recommends that the Minister considers:

(a) Implementing on 1 April 2008 an enhanced clinical data set contained within FP17W to enable LHBs and dentists to understand and manage contract performance more effectively.

(b) Extending the timeframe for specific dental allocations of LHBs beyond April 2009 by a further three years.

(c) Changing the legislation order to allow dental providers to introduce a discretionary charge for patients who fail to attend appointments – Do Not Attends (DNAs). Charges to be based on agreed criteria developed in conjunction with patient groups.

(d) Ensuring Year on year growth of LHB primary dental care dental funding allocations (see Para 5.3 (j)).

(e) Changing the regulations so that the FP17DC is available to all patients on request but is produced on a mandatory basis for all new patients, patients receiving band 3 treatments and all patients offered private treatment options.

(f) Urgently developing clear national guidance that clarifies the policy on termination and transfer of contract.

(g) Reviewing patient charge revenue levels in LHB allocations.
(h) Issuing a new framework to LHBs on the planning, delivery and performance monitoring (including quality) for NHS primary dental care. The framework should include guidelines on the management of the 2009 transition. In addition access to primary care dentistry should be identified as an LHB performance issue in the Welsh Assembly Government’s Annual Operating Framework.

(i) Directing LHBs to produce local dental strategies as part of the framework that will include a rolling local oral health action plan with annual updates on achievements.

(j) Directing LHBs to observe the statutory requirement to consult with and support Local Dental Committees, and take account of other professional advisory structures.

(k) Directing LHBs to adopt an enhanced partnership approach with their contracting practices to aid the development of long term relationships with key providers.

(l) Directing LHBs to work together across Regional and other geographical areas as necessary for effective planning and contracting of specialised services and emergency dental care.

(m) Ensuring that Wales has the capacity to develop distinct arrangements for dental services in the principality should the Department of Health further diverge from the policy direction for Wales. In addition increasing the availability of professional dental advice to the Welsh Assembly Government as a matter of urgent priority and strengthening the dental policy unit in Welsh Assembly Government to enable it to meet the increasing demands from all stakeholders.

(n) Increasing the dental public health capacity within the National Public Health Service to provide LHBs with the appropriate access to high quality support to meet the expanding agenda.

(o) Enacting legislation to allow consultation on fluoridation of the water supply in Wales or if not, provide further investment in a fluoride supplementation programme.

(p) Ensuring that the dental implications of research being carried out into workforce planning by the National Leadership and Innovation Agency for Healthcare (NLIAH) are fully considered.

(q) Directing LHBs to ensure that accurate information about dental services is available and can be easily accessed by patients. It is recommend that as a part of a general health advice service, that each LHB area be required to provide specific provision for dental queries by patients and patient representatives. LHBs must ensure proper consultation with CHCs is carried out on this issue.
(r) Carrying out a review of the function performed by NHS Direct in relation to dental services.

(s) Redefining of the roles of LHBs and shared services with respect to the NHS BSA Dental Services Division Payments Online system.

(t) Creating a central fund to allow the upgrade and/or maintenance of surgery equipment which would enable Providers to meet any new statutory or governance requirements quickly and effectively.

(u) Directing the Committee for Vocational Training for Wales to carry out a review of vocational training which also addresses the issue of VT+1 and General Professional Training. The review to include an evaluation of the remuneration system for the provision of vocational training in Wales seeking to simplify the process and delineate it from the main payment system for the main contract.

(v) Developing an All Wales ICT strategy for dentistry.

(w) Additional work should be commissioned to investigate issues surrounding dental patient records including the transferability of the record between dentists (and orthodontists).

7.3 Recommendations still under consideration

7.3.1 A sub group is carrying out a further review of specific issues. These are:

(x) Conducting a review of UDA currency including investigating the issues of standardising and/or adjusting UDA values towards a national norm.

(y) Investigating how the system can better cater for the high need patient.

(z) Developing a recommendation for a basket of indicators to improve the performance management of the contract (including quality issues).

(aa) Developing a concise statement on inclusion and exclusions of NHS treatments.

(bb) Addressing the issue of inequity identified in the patients charging systems.

8. Community Dental Service Issues

8.1 The Task and Finish Group has fulfilled the terms of reference regarding the above issue by setting up a subgroup to discuss and analyse the relevant issues. The Community Dental Service sub group will be producing a separate set of recommendations and will be presenting a separate report.
Appendix 1: Membership of Task and Finish Group

The Task and Finish group was constituted as follows:

Wayne Richards [Chair]  Visiting Professor of Community General Dental Practice, University of Glamorgan
Sue Stokes [Vice Chair]  Chair, Welsh Committee for Community and Public Health Dentistry
Alan Griffiths  General Dental Practitioner
Alun Gruffudd  Public Affairs Officer, Citizens Advice Bureau, Cymru (meetings 1-4)
Barbara Dixon  General Dental Practitioner
Bernadine Rees  Chief Executive, Pembrokeshire Local Health Board
Catherine O’Sullivan  Federation Chief Officer, Gwent Community Health Council (Board of Community Health Councils in Wales)
Chris Edmonds  Managing Director, Dental Services Division of the NHS Business Services Authority
David Thomas  Consultant in Dental Public Health, National Public Health Service
Gareth Lloyd  Chair, Welsh General Dental Practitioners Committee
Helen Goodey  Service Development Manager, Caerphilly Local Health Board
Jonathan Edwards  Wales Public Affairs Officer, Citizens Advice Bureau, Cymru (meetings 5-7)
Richard Herbert  Associate Dean of General Professional Training in Wales, School of Postgraduate Medical and Dental Education, Cardiff University
Stuart Geddes  Director, British Dental Association (Wales)
Wyn Thomas  Chief Executive, Conway Local Health Board

Welsh Assembly Government
Andrew Powell-Chandler  Head of Dental Policy, Welsh Assembly Government
Hugh Bennett  Deputy Chief Dental Officer for Wales
John Sweeney  Head of Community, Primary Care and Health Services Directorate, Welsh Assembly Government (meetings 1&2)
Julie Broughton  Deputy Head of Primary Care Finance, Welsh Assembly Government
Paul Langmaid  Chief Dental Officer for Wales

In attendance
Neil James  Dental Policy, Welsh Assembly Government
Melinda Willington  Dental Policy, Welsh Assembly Government
Robert Tyler  Dental Policy, Welsh Assembly Government
Appendix 2  Sources of evidence used by Task and Finish Group

Publications


Citizens Advice Bureau (2007) Gaps to Fill CAB evidence on the first year of the NHS dentistry reforms


Dental Tribune November 2-8, 2007 Dentists asked for views on plans to extend branding to practices ‘committed’ to NHS dentistry

DH (2008) Commissioning NHS Primary Care Dental Services: Meeting the NHS Operating Framework Objectives London:DH


Downer M C  Drugan C S  Blinkhorn A S  (2005) Dental caries experience of British children in an international context Community Dental Health 22,86-93

Hart J T (1971) The Inverse Care Law Lancet 1:405-412


NICE public health guidance 6 (2007) *Behaviour change at population, community and individual level* National Institute for Health and Clinical Excellence


The Scottish Government (2007) *Amendment No 109 to the statement of Dental Remuneration: Reimbursement of Practice Rental Costs*

The Scottish Government (2007) *Updated grants and allowances leaflet*


Welsh Assembly Government (2007) *One Wales A progressive agenda for the government of Wales*
Welsh Assembly Government (2002) *Routes to Reform A Strategy for Primary Dental Care in Wales*

**Websites**

[www.dpb.nhs.uk](http://www.dpb.nhs.uk) - NHS Dental Statistics UK

[www.dundee.ac.uk/truth/search/tables](http://www.dundee.ac.uk/truth/search/tables) - BASCD search results

[www.ofc.gov.uk](http://www.ofc.gov.uk) - Office of Fair Trading

[www.statswales.gov.uk](http://www.statswales.gov.uk) – NHS Dental Statistics Wales

[www.scotland.gov.uk](http://www.scotland.gov.uk)


**Other Sources of Evidence**

All Wales Dental Quality Assurance and Practice Assessment Document 2006/7.

BDA Case Mix Model Training Pack.

Bridgend LHB Draft Policy for Dental Contract Changes and Termination of Contracts.

Chestnut I G (12.2.08) Attitudes to, and perceptions of, NHS General Dental Services in Wales.


Davies L Thomas D R Sandham S J Treasure E T Chestnutt I G Factors influencing career aspirations and preferred modes of working in recent dental graduates. Primary Dental Care (In press)

Doncaster PCT Dental QOF Dental Policy Branch CPCHSPD 2.5.08

Gwent Community Health Council (March 2008) A selection of Case Studies of Complaints and enquiries received by CHCs in Wales since June 2007 – Six case studies.

Health Needs Assessment 2006 Dental Health NPHS

NHS Dentistry Balanced Score Card.

Correspondence received

Jane Lewis (Service Development Manager, Cardiff LHB) via Paul Parker
Welsh Assembly Government 10.10.07

David Howells (Orthodontist, Llanelli) 15.11.07

Keith Sylvester (Oral Surgeon, Morriston Hospital) 30.11.07

Bro Taf Local Dental Committee 26.01.08

Rhys Ap Delwyn Phillips (GDP, Llandeilo) 4.02.08

Alan James Raddon (Patient, Ceredigion) 5.6.08