NHS Dentistry: Options for Change

August 2002
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1 Last summer I was invited to lead a working group, comprising of representatives from the profession, of patient groups and of various sections of the department, to look at options to modernise NHS dentistry, building on the Government’s strategy document Modernising NHS dentistry: Implementing the NHS Plan, published in September 2000.

2 The Terms of reference of the NHS Dentistry: Options for Change Working group and details of its membership are at Annex A and B.

3 The NHS Dentistry: Options for Change working group drew on the Dentistry Modernisation Steering Group reports, which had already delivered some important advice on modernisation. The current project was also informed by a workshop held in June 2001 between the Department of Health and the British Dental Association, when the problems of the present system of NHS dentistry were examined, likely drivers for change were considered and ideas discussed about possible future models of oral care.

4 The NHS Dentistry: Options for Change working group was also mindful of the Report of the House of Commons Health Select Committee last Spring which concluded that the system of remuneration in the general dental services was a main factor for dissatisfaction amongst both professionals and patients and called for a workforce review of primary dental care and a long term strategy for NHS dentistry. The primary dental care workforce review has been proceeding in tandem with the NHS Dentistry: Options for Change project. Now in its final stages, the workforce review can be informed by our findings provided they are acceptable to you.

5 Within the working group, I set up three task groups to develop NHS Dentistry: Options for Change on:

- A new deal for patients – national standards
- Systems of delivery of dental care
- Education, training and development of the dental team.
The final reports of those three task groups form chapters 3, 4 and 5 of this report. Chapter 1 outlines a vision for NHS dentistry in the future. Chapter 2 brings together the key themes and issues and suggests priorities for action.

In brief these are:

- **Local commissioning and funding**
  Primary Care Trusts should commission such services as are necessary to secure access to a high quality NHS dental service and to improve oral health and address inequalities. Funding will need to be devolved to a local level, with accompanying safeguards to protect provision for independent contractors and the salaried services if necessary.

- **Methods of remuneration for general dental practitioners**
  A menu of ways of paying dentists should be tested, including salary, capitation and simplified, modernised fee scale options. The possibility of a basic practice allowance should also be considered. There should be no sudden change but models should be tried out in demonstration sites and, if successful, made available across the service, building on experience of Personal Dental Service pilots. There is unlikely to be one method which will fit all circumstances.

- **Prevention and an oral health assessment for patients**
  A central recommendation is for the patient gateway to NHS dentistry to be through an oral health assessment. Unlike the present GDS examination, the assessment should focus on prevention of disease, lifestyle advice, the discussion of any necessary treatment options and date of the next assessment.

- **Clinical pathways**
  The direct association between payments to dentists and the types of treatment offered to patients needs to be removed where possible. Treatment should be offered which is clinically appropriate, according to agreed protocols. A clinical pathway approach should be developed, based on best practice and the available evidence base.

- **Information and Communication Technology**
  Better use of Information and communication technology (ICT) will assist the clinical pathway approach, as well as improving information for patients and encouraging better quality through clinical governance. Building an effective information infrastructure for dentistry is also essential for better integration with the rest of the NHS.

- **Practice structure**
  In the future there should be larger practices, using the skills of a range of staff including professionals complementary to dentistry and those dentists with specialist skills. The disincentives to such growth in the present system must be removed, through capital support, possibly through NHS Local Improvement Finance Trusts (NHS LIFT). A range of models is likely to be necessary and further work should be carried out on the optimal sizes and configurations of practices to balance easy access with cost-effectiveness.
● **Development of the dental team**

The report includes ways in which the education, training and development of all members of the dental team can be improved to help the quality of patient care, and enhance job satisfaction for everyone. I would plan to develop these further in consultation with the profession and the relevant regulatory authorities, educational institutions, dental faculties of royal colleges and commissioners of workforce development.

● **Patient experience**

Dependent on testing, a new deal for patients with national standards is proposed. Priorities would be access to care, providing a quality service, better information for patients and oral health promotion.

8 I propose we should implement the above through:

● demonstration sites organised with the NHS Modernisation Agency

● working with volunteer PCTs to develop commissioning options and new forms of contracting

● developing an ICT infrastructure for dentistry which supports clinical pathways and encourages quality.

9 I would propose to lead a small top level steering group of departmental officials, members of the profession, NHS managers and patient organisations to oversee implementation and to report to you regularly on progress.

10 I would like sincerely to thank all those who participated in the *NHS Dentistry: Options for Change* working group and particularly those who chaired and were members of the Task groups.

11 I have pleasure in submitting this Report, which does not follow the normal format but is rather a collection of proposals and clear suggestions for further work and implementation. Members of the working group believe this to be a pragmatic, practical and incremental way forward for improving NHS dentistry for patients, practitioners and the wider NHS. I hope you will be able to support our proposals and suggestions.

Dame Margaret Seward  
Chief Dental Officer  
August 2002
A modernised service for patients in the 21st century

A new service

1 The *NHS Dentistry: Options for Change* Report proposes a new NHS dental service for England. Fifty-four years after the foundation of the NHS, this report contains recommendations to begin radical changes, designed to provide a first class NHS dental service, responsive to local needs.

2 Health policy on dental services has lagged decades behind other health sectors. Over the decade since 1992, dentists’ commitment to the NHS has reduced, leading to access difficulties. The recommendations in the *NHS Dentistry: Options for Change* report are designed to build on recent initiatives aimed at modernising NHS dentistry. They establish a new foundation for taking forward an NHS dental service for all. Dentists and dental professionals have been discontented for a long time with the framework for delivering care within the NHS. These proposals will enable them to provide high quality NHS care, shaped for the needs of patients in the 21st century.

3 A new NHS dental service should be a universal system, but it should also meet the needs of particular groups in the population, with referral to specialist NHS dental services as necessary. Furthermore, the new service should allow the dental team, for the first time, to focus on preventive measures to combat dental disease, and to tackle the serious oral health inequalities, particularly in children.

Meeting Patients’ Needs

4 *NHS Dentistry: Options for Change* proposes a new foundation for NHS dental services, working with NHS structures; new standards of care; supported by a new payment system; and proposals for a modern workforce to meet the needs of today and tomorrow. The Report proposes that its recommendations are first tested and evaluated carefully in demonstration sites by dentists and Primary Care Trusts in selected areas, using PDS flexibilities. This will allow change to be introduced and tested carefully and with the consent of all concerned. Over time, a new NHS dental service should be available to everyone.

Putting Patients’ Interests First

5 In line with the *NHS Plan* and *Modernising NHS Dentistry*, the *NHS Dentistry: Options for Change* proposals put patients, and the patient experience, at the heart of the new NHS dental service. Currently, patients find care options confusing and dentists have the task of explaining to patients their choices. There is an over-complex NHS regime, and then a mixture of private and NHS care available in many practices. The experience of grappling with the current systems often leaves patients feeling disempowered and dentists disengaged.
Under the new proposals, NHS treatment options to maintain dental health – for children, for adults of working age, for older people, and for those with particular needs – would be evidence-based and regulated by service agreements with the dental professions. Patient-focused standards of care would be introduced into all NHS primary dental services. NHS patient charges, currently numbering over 300 individual items, would be simplified. The responsibilities of each member of the dental team and their professional duties of care would be clarified. Where patients require further specialist care, referrals would be made to appropriate specialists.

NHS and Private Dental Care

In a new NHS dental service, the range of treatments provided by the NHS would be clear to patients. Some patients will want to choose treatments, which are effective and valuable to them, but which fall outside NHS care because they do not follow agreed NHS clinical pathways. In a modern society, such choices should be available, and many or most general dental practitioners offer these treatments already. In the proposed new NHS primary care service, dentists would often offer both NHS and private dental care. Dentists who provided these additional private services would give information and advice on private treatment choices and methods of payment. The choices for patients should be much more transparent than at present.

Developing the Dental Team

The proposed NHS dental service would be governed by a set of standards, drawn up between patients groups, the dental professions, the NHS and Government and these would be available to all patients. The new dental service would involve all members of the dental team, which would allow new roles and responsibilities to emerge. Over time, with investment in new premises and in team development, dentists would be encouraged to become clinical leaders, assessing need, co-ordinating the different skills of the team, and actively supporting the oral health wishes of their patients. In this way there would be new opportunities for all parts of the dental team to meet the challenges of tomorrow.

Seven elements of a new NHS dental service

- The service would be available to everyone who wants it, including people with special needs, however they contact the NHS
- It would be based on a range of services to achieve dental health and, by preventing illness, to maintain dental health and address oral health inequalities
- It would be governed by service agreements for children’s health, adults’ health, and older people’s health as well as specialist services
- NHS services and standards of care would be clear to all users
- NHS charges and payments would be simplified
- Referrals would be made to specialist NHS services as appropriate
- Private dental services, not available on the NHS, would be clearly identified in practice prospectuses and within treatment plans.
How it would look

9  About two thirds of adults visit their dentist on a regular basis; the remainder attend only when they have trouble. In addition some patients have special needs, or require specialist care, for example in the fields of oral surgery and orthodontics. NHS dentistry will be modernised, over a period of time, to provide a high-class service for all these patients.

10  Primary Care Trusts will have the responsibility to ensure that NHS dental care is available on a regular basis for all those who want it and who live within the PCT area. There needs to be a more inclusive approach to patient registration with a general dental practitioner. Patients will often be seen at less frequent intervals than at present, according to clinical needs. When seen, however, they will be offered an oral health assessment, which will include a significant element of disease prevention. The need for treatment will be decided through clinical pathways. Such treatment as is necessary and clinically effective will be offered under the NHS.

11  PCTs will also have the responsibility to ensure that care is provided for those who wish to access treatment when they have trouble, irrespective of where they live. Urgent NHS dental care will be commissioned with general dental practitioners in their practices or through the salaried services, including Dental Access Centres. Arrangements will be made to ensure that out-of-hours treatment is available when it is needed, consistent with arrangements made for treatment out-of-hours across the rest of the NHS. As with patients attending on a regular basis, necessary treatment will be provided according to agreed clinical pathways. Such services would accept referrals from NHS Direct, medical practitioners and other healthcare professionals.

12  Specialist care will be available through services commissioned by PCTs from hospital specialists and dentists who are working in primary care.

13  Through such a system access will be secured for those, including patients with special needs, wanting

- regular dental care with a dentist of their choice
- dental care when having trouble (including out of hours and care needed urgently)
- specialist care.

14  The quality of NHS dental services will be improved through:

- a better experience for patients
- a well educated and trained workforce
- clinical pathways underpinned by clinical governance
- installation of Information and Communication Technology (ICT) in practices and clinics.

15  PCTs through their Health Improvement and Modernisation Plans (HIMPs) will be making significant improvements in oral health and the reduction of oral health inequalities.
Introduction

1.1 The NHS Dentistry: Options for Change (OfC) process has set out key issues that need to be addressed in order to reform NHS dentistry. These include education and training, the way NHS dentistry is commissioned and how oral health inequalities are tackled. Although complex, this report clarifies some of the key issues and real change is now possible.

1.2 In this chapter key themes are considered and how they relate to each other. In doing this, we draw on the reports of three NHS Dentistry: Options for Change task groups and take into account recent changes to the NHS, especially the NHS Plan, Modernising NHS Dentistry and Shifting the Balance of Power in the NHS.4

1.3 A scenario for the service patients can expect is then outlined. In it there is a stronger emphasis on maintenance of good oral health, reflecting in part the improved oral health of the population over recent years. The NHS’ role will need to change to secure a service focused on the needs and wishes of patients, with room for local flexibility. This may require changes in legislation. Information and communication technology (ICT), including connections with other parts of the NHS, will play a central part.

1.4 Also in this chapter suggestions are set out as to what might be done to address the key issues, in order to achieve a high-class service and to meet the needs and wishes of patients, dentists, the Government and the wider NHS. Finally, an outline programme of work is proposed based on demonstration sites to be run through the NHS Modernisation Agency.

Issues and Themes

Securing the service – how to commission it

2.1 The current national dental contract does not allow the NHS to secure services in the mid- or long-term. Nor can services be targeted on oral health inequalities. These issues could be more easily addressed if NHS dental services were locally commissioned. Dentistry would also be enabled, through a full engagement with Primary Care Trusts, to play a bigger part in the wider NHS, thus fulfilling one of the key objectives of Modernising NHS Dentistry – Implementing the NHS Plan.

2.2 By working closely with dentists locally within Health Improvement and Modernisation Plans, Primary Care Trusts (PCTs) could achieve better outcomes from the resources available. Within such a framework, PCTs could directly commission the services that are needed to address poor oral health rather than, as now, having to rely on the national contract to effect improvements. Such local commissioning could, however, take place within a national...
framework so it would not be necessary to ‘re-invent the wheel’ locally. Mechanisms for joint working with the dental profession locally are already being established under *Shifting the Balance of Power in the NHS*. Dentists and patients, as well as PCTs, could expect to see benefits from such local commissioning.

2.3 These changes would require a major change of culture which in the long run would mean:

- devolving funding to a local level and using it in a more targeted way to achieve locally-determined objectives, with accompanying safeguards, as necessary, so that it remains focused on dentistry
- ensuring that no NHS dentist loses out financially from any change
- ensuring that the salaried services too can contribute to the objective of an NHS dental service which serves a population fully and is part of an integrated clinical network
- reviewing the concept of registration with a general dental practitioner and any consequent time limits, in the light of the new locally-based framework
- addressing the issue of equity of distribution of funding and, for the future, control of entry to NHS contracting arrangements.

2.4 A major consequence of this approach would be to re-integrate dentistry within the NHS. ICT links would be necessary to support this.

2.5 It is not desirable to seek to implement changes of this scale across the whole NHS dental service at one time. A tested, incremental and voluntary approach is the best way forward. This should be based on an intense programme of work through the NHS Modernisation Agency, to demonstrate ways of making rapid progress and of disseminating the results to the rest of the NHS.

How to remunerate dentists – quality rather than quantity

2.6 Independent contractors who deliver NHS dental services will have to be paid differently if change is to be effected. For general dental practitioners there should be a menu of options in which they can contract with the NHS. This would apply also to groups of dentists, including dental bodies corporate, as they are now or following possible future changes. Options might include long term cost and volume contracting with case mix taken into account, sessional payments, or a greater element of salaried employment, as well as combinations of these. PCT directly provided services, such as CDS, should benefit from a more secure organisational and planning basis.

2.7 If there is to be a new way for GDPs to contract with the NHS, we do not expect this to be achieved through sudden change – reform should be evolutionary. However, once models have been identified, tested and proven, the NHS might in due course want to offer general dental practitioners the options of choosing from a new menu of arrangements. This could allow movement between options at different points in their careers rather than continuing with the current ‘one size fits all’ approach.

2.8 New forms of contracting should remove existing perverse incentives for the payment system to influence the type of treatment. A better approach should be developed, based on the clinical needs and wishes of the patient. Treatment should then only be offered if it is both clinically desirable and clinically
effective. Any incentives should be aligned towards these ends, which implies a different approach to the issue of patient registration and payment. Clinical pathways, as are now adopted across much of medical practice, should be developed and applied in dentistry. They should build on available evidence and best practice. Dentists would then record their clinical interventions and note the outcomes, rather than receiving a fee for each intervention.

2.9 As well as ensuring that dentists provide treatment which is driven by need and supported by evidence, nationally agreed clinical pathways would provide a better deal for patients by ensuring a degree of standardisation of treatment across the country. By achieving this, a key concern of the task group on A new deal for patients – national standards would be met. Furthermore the clinical protocols established by these pathways would act as a powerful tool to support the implementation of clinical governance, as well as giving patients a better understanding of the treatment process.

2.10 This approach would have major implications for the use of ICT. Clinical pathways could link to and build on the existing framework of monitoring as currently undertaken by the Dental Practice Board, and provide a basis for clinical governance information to practices and PCTs.

2.11 The existing pay system discourages practice growth and may restrict cost-effectiveness in that the employment of a diverse staff group and the full integration of Professionals Complementary to Dentistry (PCDs) are both limited by the small size of practices. The NHS offers no recurring, direct support for capital development, other than through the feescale, so expansion of practices is entirely financed though private capital, in which there is little place for ‘public-private partnership’. NHS Local Improvement Finance Trusts (NHS LIFT) however, could change this.

2.12 The benefits of larger practices are that they can have more diverse staff groups and a greater potential for efficiency. They can have a greater differentiation of roles between PCDs, dentists and – potentially – for specialists within primary dental care. The NHS needs to encourage and test these developments. Such change could be achieved partly through capital support, whether through NHS LIFT or other means. However, a key theme for early exploration would be the option of testing a basic practice allowance to offset some of the fixed costs of running a dental practice. Elements of capitation, item of service payments or other means of local commissioning could then be related to clinical outcomes.

2.13 Reform along these lines could support development of the dental team, covered by the Task Group’s report on education, training and development of the dental team.

Big challenges

2.14 For the patient, there are some particular historical problems with the way NHS dentistry is provided.

The NHS/private boundary – mixing

2.15 The current position, whereby dentists can mix private and NHS items of treatment within the same course, is known to cause confusion amongst patients. The situation is further complicated by some dentists not being
2.16 If it were possible to disengage the provision of treatment from the fee per item remuneration system – as suggested above – then it would be possible to develop contractual arrangements directly between the NHS and dentists. If the treatment is clinically necessary – for example within the clinical pathway – and if a suitable monitoring system assures quality as part of clinical governance, then it should be possible to reduce the reliance on item of service within the fee scale. However it will probably be desirable to retain this option for some items of treatment and for dentists who prefer this model of remuneration. The effect of such changes could be to make the decision processes leading to treatment by ‘NHS dentists’ more like those of NHS clinicians in other fields.

2.17 If payment were broadly separated from the detail of treatment in this way, then private treatment would be defined by reference to what falls outside the NHS clinical pathway for instance cosmetic, optional items. In this context an ‘NHS dentist’ would be a dentist who had contracted to provide a defined range of services to an agreed population within a range of clinical protocols defined by a clinical pathway, with other arrangements for dealing with exceptionally high cost treatments. This would need to be monitored at PCT rather than national level to reflect local needs and priorities.

2.18 Any dentist working within these arrangements would retain their right to provide private treatment. The protocols within the clinical pathway would define the NHS/private boundary. The objective would be to introduce clarity into the system for patients and clear demarcation boundaries for clinicians.

2.19 Given the complexity of the present fee scale and the radical nature of the proposed changes, it would seem prudent to tackle change by addressing the feescale in sections. Any reform or revision to the present system would need to ensure that dentists received comparable remuneration for comparable volumes of NHS work taking account of treatment complexity, special needs and case mix. However, the block or cost and volume contracting models, for example, have the capacity to accommodate variations.

**Patient charges**

2.20 Concerns about charges centre on charging structures and lack of transparency, a view consistently reported by patient representatives and surveys. Any change to the existing system is challenging in that:

- there is currently a direct legislative link between remuneration and charges
- a proportion of remuneration comes from charges and there are risks in altering the arrangements.

It may however be possible to overcome both these hurdles.

2.21 The profession would prefer to separate the direct link between patients’ visits to the dentist and charge collection. Their view is that the present system has the potential to dilute the trust that underpins the professional relationship between practitioner and patient. This might suggest a system of regular payments. It should also be possible to simplify the present system so that charges fall into a range of bands reflecting the complexity of the treatment,
in preference to the precise calculations required where charges are an exact proportion of fees per item. A change of this sort would in any case be essential if item of service ceased to be the sole method of remuneration. Further work needs to be done on this in the light of the piloting of new approaches to payment outlined above.

Workforce, education and training and the dental team

2.22 A separate primary dental care workforce review has been underway in parallel to NHS Dentistry: Options for Change. Therefore, this latter group has not directly considered workforce numbers nor the issues for supply and demand in the workforce. This report, however, makes proposals about how the service should be delivered in the future, which could feed into the later stages of the workforce review and into ongoing workforce planning initiatives, in respect of workforce supply and demand issues: numbers, skill-mix, recruitment and retention.

2.23 The Education, training and development of the dental team task group has made a number of recommendations that will contribute to actions following the workforce review. These include team development, to ensure that more dentists are able to work at the higher end of their skill level, rather than doing work which could be done by PCDs. This would, for example, enable more effective deployment of dentists’ specialist skills, where applicable.

How will patients experience NHS dentistry?

3.1 The task group looking into a New deal for patients made a number of positive recommendations which will need to be developed further in consultation with the profession and patient organisations. Two particular points are highlighted.

3.2 First, the experience of the patient in trying to enter the NHS ‘system’ can be chaotic and varies from locality to locality, for historical reasons. The Prime Minister’s pledge – by October 2001 anyone who wanted to could find an NHS dentist by phoning NHS Direct – has introduced rationality into this for the first time and provides impetus for further development. All the ideas above will build on the premise that dentistry should be an integral part of the NHS and delivered in similar ways.

3.3 A second point is to describe how the service might look and feel to the patient in future. A scenario for a key element of this, the oral health assessment, is set out below. The scenario is intended to be generic and does not reflect the variations that would be necessary for children, working-age adults or older people.

The oral health assessment

3.4 For regular attenders with an established relationship with an NHS dentist, the gateway to NHS dentistry could be through a standard oral health assessment, available to all. For patients requiring treatment on an occasional rather than regular basis, there would also need to be clear and well defined pathways to treatment. It would be a PCT’s duty in the future to ensure patients can access NHS dentistry in ways which meet local need.
The standard oral health assessment would comprise three elements: diagnosis, prevention and treatment planning.

The diagnostic element would provide recommendations for treatment where necessary and set out clearly and in a standard NHS format what the patient’s state of oral health is and what treatment options, if necessary, were available under NHS arrangements.

The prevention element could include lifestyle advice such as smoking cessation, oral health education, oral cancer screening and discussion of treatment options.

If no treatment were necessary, the patient would be invited to return for a further assessment at an agreed future date and sent a reminder. The time between assessments would be determined by the dentist in consultation with the patient, taking into account the clinical needs of the individual concerned. This would necessarily take into account the results of the systematic review of the six-month recall to be considered by the National Institute for Clinical Excellence (NICE) in the near future.

The assessment would carry an NHS charge, as do examinations now. Payment methods should be simple and free from excessive bureaucracy.

There would be no scope for mixing NHS with private treatment at this stage, so the patient would know exactly what they were getting and paying an NHS charge for. There would be no intention, however, of preventing dentists from offering private assessment and treatment options separately.

Quality of the assessment would be tracked through a system of clinical governance linked to the payment systems at the Dental Practice Board. The practice and PCT would receive results at appropriate intervals for effective monitoring of the service.

Contracts for providing this assessment would be held by PCTs, where supply could best be matched to demand.

As part of a wider commitment to integration of services across the NHS, the future patient might be seen at a multi-facility health centre (NHS Plan, One Stop Centres). An aim should be to facilitate on-line booking of appointments and payment of charges by the widespread use of ICT in dental practices. Ideally, the dental record would link to wider NHS electronic health recording systems.

Recall intervals

While it is accepted that oral examinations at appropriate intervals are of value in maintaining oral health, there is little direct evidence to support a specific interval nor to quantify the benefit. There is therefore a requirement for the practitioner to undertake a needs assessment exercise for each individual patient.

Although it is not evidence-based, the six-month recall interval is sufficiently long-established that change can be most credibly introduced if advocated by an authoritative body – NICE – in the light of an appraisal of the evidence. The following remit has been agreed and has now been referred to NICE as part of its 7th wave work programme.
To prepare guidance for the NHS in England and Wales, on the clinical and cost effectiveness of a dental recall examination for all patients at an interval based on the risk from oral disease.'

What needs to be done?

4.1 Progress is required in the following areas:

- PCT commissioning of NHS dentistry
- remuneration – concentrating on quality
- development of clinical pathways
- workforce
- ICT infrastructure
- the ‘mixing’ issue
- patient charges.

4.2 The priorities, however, are:

- to test new, local models of commissioning dentistry and, funding and remunerating practices, through volunteer sites using current Personal Dental Services flexibilities
- to complete the primary dental care workforce review and initiate any necessary follow-up action.

Demonstrable progress in both these areas should be possible within the current financial year.

4.3 The next set of issues should be:

- development of clinical pathways
- to explore options for linking dentists to the NHSnet
- to build dentistry firmly into the future NHS LIFT programme.

4.4 Finally, tackling the issues of NHS/private mixing and patient charges probably needs to await the outcome of work with demonstration sites.

How to test?

5.1 To test these proposals it is proposed to initiate demonstration projects in 2002/3. These would be managed through the Modernisation Agency with support from the Department of Health dental policy team and the BDA. The clinical pathways programme will also be a major piece of work. We would propose starting this too in 2002/3, linking to the programme of work on ICT already underway.

5.2 Demonstration projects should involve close working with volunteer PCTs (singly or in groups) to develop commissioning options and new forms of contracting. These will be able to build on the experience of Personal Dental Services pilots with the view to producing models with the potential for wider rollout in future. The aim will be to make investment in dentistry deliver better outcomes for patients, dentists and their staff, including those in the salaried services, and the NHS overall.
The terms of reference for this task group were:

‘to develop possible standards for NHS dentistry to meet the needs and wishes of patients’.

The group’s main conclusions were:

● The task force determined upon standards that would provide the basis for an NHS dental service committed to providing patients with access, a quality service and full, clear information. The standards also aimed to create a service focused upon oral health promotion and the prevention of disease, underpinned by cohesive support for the dental team and a modernised infrastructure.

● A key theme of the standards is that of an increased priority for dentistry at both a national and local level. Primary Care Trusts should be mandated to maintain an interest in the provision of dentistry for their communities through annually drawing up dentistry action plans. The standards also provide for dentistry to be included in initiatives such as Healthy Lifestyles Programmes and the Health Improvement and Modernisation Programme. The group also thought that the Department of Health and Primary Care Trusts should be mandated to achieve and maintain certain oral health standards among the population.

● Other innovative suggestions made by the group include: Monitoring of oral health and population trends as an aide to planning workforce levels; All dentists to undergo customer service training in order that they can better empathise with patients; introduction of an integrated primary care complaints procedure system, operating across all branches of the NHS; NHS dentistry to expand its role and take advantage of its position as part of the health service that is routinely accessed by people who are well, to cover tasks such as smoking cessation programmes and blood pressure checks.

Membership of Task Group

Dr Roger Matthews (Chairman)
Ms Vanessa Bourne
Dr John Boyles
Ms Sally Goss
Ms Ros Keeton
Dr Raj Rattan
Dr David Smith
Professor Nairn Wilson
Helena Edwards (Secretariat)
Penny Stayte (Secretariat)
Introduction

1.1 The terms of reference of this Task Group were to propose achievable standards for NHS dentistry to meet the needs and wishes of patients.

1.2 The task group report has been further developed around:

- the concepts set out in our Interim Report
- the comments from the wider Options for Change group
- a model template supplied for task groups’ reports.

Identify Issues – Areas for change

2.1 As Lord Hunt said at the BDA Conference in May 2001, ‘dentistry needs to be a core NHS Service, it must be a service shaped around patients.’

2.2 Themes initially identified by the task group are supported by evidence received from patient representative groups and correspondence to the Department of Health and the British Dental Association.

Empowerment of patients

2.3 Patients should be central to dental care and practice. Patients – and especially children, older people and people with disabilities – require access to care which meets their needs and to be enabled to enter into a partnership in the provision of their dental care and treatment.

Patients say:

- it can be virtually impossible for adults especially to access NHS dental care, the only way to see a dentist is to pay privately
- finding a dentist can be difficult, time-consuming and off-putting, with a “postcode lottery” sometimes evident.

Commitment to quality

2.4 Wherever they live, patients expect to receive appropriate, necessary and timely oral and dental care that is of consistently high quality, delivered with technical competence by trained, motivated and engaged dental teams who put their patients’ interests first. Care must be built around prevention and based where possible on lifelong care rather than episodic or reactive. Quality of care depends not just on the patient/clinician transaction, but is also about the quality of the organisation and the environment in which care takes place.

Patients say:

- dentistry can look very different to the new, modern, IT-based image of the NHS which is emerging.

Information

2.5 Accurate, relevant and clear information is the basis of safe and effective clinical care and shared decision-making, and it is a pre-requisite for patient choices about personal health and treatment. Patients should be confident that they are giving informed consent to treatment on the basis of accurate information. Clarity about NHS dental charges and a charging system which
is sensibly linked to the overall objectives of promoting oral health and minimising barriers to care are also essential.

Patients say:
- charges are unclear and raise concerns over the cost of care
- there is insufficient time to ask questions or to discuss treatment or techniques.

Integration
2.6 Dentistry must be fully integrated within the NHS family and the key relationship between good oral health and good general health must be recognised. The inclusion of dentistry in future National Standards Frameworks is central to this aim. Seamless co-operation and systems across dental practices, clinics, Walk-In Centres, PCTs and other NHS organisations should ensure that the service has a unified customer proposition, whatever the infrastructure.

Patients say:
- there is inconsistency in the nature and manner in which dental care is delivered
- the alternative types of dental services available are confusing to the public.

Trust
2.7 Building trust in health care requires that there should be improved diagnostic and therapeutic consistency, based on transparent and accurate information. Evidence based care and treatment should be provided where possible. There should be wide professional awareness both of the effectiveness and cost-benefit of procedures, and also of those for which there is a widespread scientific consensus. Minimally interventive procedures should be adopted where possible and appropriate.

Patients say:
- there is widespread media coverage about inconsistency in dental treatment
- making complaints is difficult because the first step is often to deal directly with the provider being complained about.

2.8 In summary, the issues identified present a clear picture that NHS dentistry is far from meeting the needs and wishes of patients – it is not patient centered. To rectify this state, achievable standards need to be created and this report contains the Group's considered views on what these standards should look like.

Options for change
3.1 We have considered the development of standards around the themes and related barriers to achieving a patient focused service identified in our evidence at point 2.2. We readily identify that there are relationships between these themes and we recognise that any proposed standards will, in turn, be inter-related. However, we feel that priorities should be attached and our major headings, which are recurrently used throughout the remainder of the paper, are given in order of importance.
3.2 ● Access to Care
● Quality Service
● Information
● Oral Health Promotion
● Support and Infrastructure.

3.3 We have endeavoured to use SMART principles in defining these standards in line with the priorities established above:

● Specific: Who is responsible?
● Measurable: How will it be measured?
● Achievable: How will we know that it has been achieved?
● Relevant: How is it relevant?
● Time-limited: When does it have to be implemented by?

Whilst indicative timings were considered by the group, these are ultimately a matter for consideration and prioritising in the context of all the task group reports.

3.4 **It can be virtually impossible for adults especially to get NHS dental care, the only way to see a dentist is to pay for private treatment.**

3.5 Patients lack confidence in the profession because there is media coverage about inconsistency. Making complaints is difficult because the first step is often to deal directly with the provider being complained about.

<table>
<thead>
<tr>
<th>Access to care</th>
<th>Assigned to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td></td>
</tr>
<tr>
<td>1. a) It shall be a continuing priority to ensure that all patients can access the NHS dental service they require easily whether it be for long term care or emergency treatment.</td>
<td>Department of Health/Primary Care Trusts</td>
</tr>
<tr>
<td>b) Systems will be developed which can provide NHS Direct with information on the availability of NHS dentistry and are able to monitor and performance manage results in order that any shortfalls can be filled.</td>
<td>Department of Health/(to NHS Direct)/PCTs</td>
</tr>
<tr>
<td>2. NHS dentistry should be provided under one umbrella, that of “Primary Care NHS Dentistry” linked to other Primary Care Services. Under this umbrella: a) PCTs would form managed, resourced and organised dental referral networks; b) Funding and resources would be designed to provide consistency of care and treatment from the viewpoint of the patient. c) Rules on the mixing of NHS and private treatment would be revisited to ensure clarity to patients and professionals.</td>
<td>Department of Health/British Dental Association through the Shifting the Balance of Power process NHS locally (including Salaried Services) forming primary care networks that include dentistry as a driving force</td>
</tr>
<tr>
<td>3. A new and acceptable system of triaged out-of-hours emergency care provision will be designed and implemented.</td>
<td>Department of Health/BDA</td>
</tr>
</tbody>
</table>
3.6 There is insufficient time to ask questions or to discuss treatment or techniques. Charges are unclear and raise concern over the cost of care.

### Access to care continued

<table>
<thead>
<tr>
<th>Standard</th>
<th>Assigned to</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Effective performance management of PCTs will be introduced.</td>
<td>Department of Health/PCTs/STHAs</td>
</tr>
<tr>
<td>5. PCTs, with input from the Patients' Forum will generate Dentistry Action Plans (DAPs) for 2002/03, to identify and to target problem areas on the basis of monitoring data from 2001/02.</td>
<td>PCTs</td>
</tr>
<tr>
<td>6. Workforce levels will be identified and planned by regular monitoring to depict future trends, with advice from the dental professions.</td>
<td>Department of Health Workforce Review/The Profession/PCTs</td>
</tr>
</tbody>
</table>

### Quality service

<table>
<thead>
<tr>
<th>Standard</th>
<th>Assigned to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dental teams will be enabled to spend sufficient time diagnosing, treatment planning, assessing risks, and discussing options with patients on their individual needs in accordance with the general requirements of clinical governance.</td>
<td>Department of Health to look at current delivery &amp; handling systems.</td>
</tr>
<tr>
<td>2. Continuous Quality Improvement should be at the heart of all dental practice. The principles of clinical governance, including CPD, audit and peer review, together with the collation, dissemination and uptake of evidence-based treatment, and that supported by wide and responsible bodies of professional opinion are minimum objectives to be acknowledged and implemented.</td>
<td>The dental profession/Department of Health</td>
</tr>
<tr>
<td>3. The dental team will receive regular customer service training (for instance through the NHS University) so that they are able to relate in a positive and empathetic way to patients under treatment or during complaint procedures. There should be improved access to NHS occupational health services and stress counselling.</td>
<td>Department of Health/NHS locally (including the salaried service)</td>
</tr>
<tr>
<td>4. A Dental Action Plan shall contain agreed standards of customer care and a clear quality service agreed as a result of patient experience and reviewed quarterly through Patients’ Forums. They might include: a) Maximum waiting time for a routine and emergency appointment including secondary care b) Waiting time to be seen on arrival for a booked appointment/Out of Hours provision/walk in service c) Appropriate facilities for patients with anxieties about dental care and treatment.</td>
<td>PCTs/STHAs</td>
</tr>
<tr>
<td>5. Primary Care NHS Dentistry will be included in Healthy Lifestyles Programmes.</td>
<td>NHS locally</td>
</tr>
</tbody>
</table>
3.7  Dental disease is almost entirely preventable.

### Information

<table>
<thead>
<tr>
<th>Standard</th>
<th>Assigned to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There shall be accurate and reliable information on NHS dentistry, communicated through NHS Direct, NHS.uk and alternative gateways of information such as other primary care services, patient representative groups, supermarkets, libraries and post offices.</td>
<td>Department of Health (to NHS Direct)/PCTs/StHAs</td>
</tr>
<tr>
<td>2. There will be clear communication to patients about dental care and treatment which is being carried out or necessary, whether it is private or NHS. Treatment options should be explained and written information on costs given on estimates, treatment plans and receipts. There should be a readily available and clear guide to treatment costs widely publicised, and clearly displayed at all relevant dental premises.</td>
<td>Department of Health/ The Profession</td>
</tr>
<tr>
<td>3. Patients’ clinical records will be transferable between dentists and there should be common notation for dental records.</td>
<td>Department of Health/ The Profession</td>
</tr>
</tbody>
</table>

### Oral health promotion

<table>
<thead>
<tr>
<th>Standard</th>
<th>Assigned to</th>
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</thead>
<tbody>
<tr>
<td>1. There will be an oral health component supported by an Advisory Committee as part of every local (PCT) Health Improvement Modernisation Programme.</td>
<td>PCTs</td>
</tr>
<tr>
<td>2. A co-ordinated programme of primary care based research undertaken to identify forms of treatment which result in a demonstrable health gain.</td>
<td>BDA/Department of Health</td>
</tr>
<tr>
<td>3. NHS Primary Care Dental Services must undertake smoking cessation programmes and consider other initiatives such as blood pressure checks.</td>
<td>NHS locally</td>
</tr>
<tr>
<td>4. By 2003, five-year-old children will have on average no more than one decayed, missing or filled primary tooth and seventy per cent of five year olds should have no experience of tooth decay.</td>
<td>NHS locally</td>
</tr>
</tbody>
</table>
3.8  Dentistry can look and very different to the new, modern, IT based image of the NHS which is emerging.

Support and infrastructure

<table>
<thead>
<tr>
<th>Standard</th>
<th>Assigned to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary Care Dental Services will be included within the NHSnet/Primary Care IM&amp;T Strategy.</td>
<td>Department of Health</td>
</tr>
<tr>
<td>2. Primary Care Dentistry will be included in planning for premises improvement (NHS LIFT) and relocated appropriately within other NHS services such as Walk In Centres.</td>
<td>NHS locally (including the salaried service)</td>
</tr>
<tr>
<td>3. Dental premises will be enabled to participate in programmes of equipment modernisation to comply with current accepted standards of care, regulations and access.</td>
<td>Department of Health</td>
</tr>
<tr>
<td>4. An acceptable and standardised format for patient electronic dental records will be developed and piloted in conjunction with dental commercial software.</td>
<td>Department of Health</td>
</tr>
</tbody>
</table>

Consider outcomes – Develop scenarios

4.1  The combined result of implementing these standards would be national consistency and patient empowerment. If we look at each of the themes in turn and what the outcomes would be.

Access to care

There are many myths about dental services. Providing one integrated service – “NHS Primary Care Dentistry Service” – would be a first step towards:

- making the service structure less complicated to patients at the outset – all patients pass through a gateway and there is a unified perception of dental care services
- a faster and more convenient service – one call, to one place, at one time with the output being two-fold
- referral based on a patient’s needs, both clinical (routine, emergency, specialist), and social (age, disability, culture) to the appropriate part of the service within the agreed time and distance standards
patient’s wishes being taken into account through choices about how they want the service to be provided i.e. some patients’ priorities would be to build a patient-dentist relationship with one dentist whilst others might be more concerned with accessing the service to suit their own work/family commitments.

Scenario A

Find A Dentist

For some time 23 year old Jason has been unhappy with his teeth. He feels they are not in good condition (he had a number of fillings as a child which he feels need to be replaced) and his gums bleed when he cleans them. He last went to the dentist when he was 17 whilst he was living at home and since then he has moved away to Surrey to work. He wants to find an NHS dentist but doesn’t know where to start and he also doesn’t have much time available. He believes they are hard to find in the vicinity of his workplace.

Jason is in his local large supermarket after work one evening. In the entrance he sees a leaflet holder with some leaflets among which is one titled “NHS Dental Care”. The leaflet describes what is covered by NHS care, gives some examples of charges and NHS Direct’s telephone number and website address. On his way home he calls NHS Direct who identify a dentist accepting NHS patients within a mile of his workplace and they book an appointment with the practice for three weeks’ time. They offer to confirm the appointment in writing. Jason has solved his dental problem with one phone call.

4.2 PCTs can in future through their Dental Action Plans look at local demands and new ways of providing access. For example:

- tele-dentistry could be piloted to give dentists and patients fast and easy access to consultant opinion and telephone booking across the service
- there could be pilot schemes where consultants are contracted to provide sessions in localities where there is no local hospital provision.

4.3 Such integration would mean that local health economies would need to develop strategies to move currently isolated groups such as the salaried services and single-handed dentists into the same framework.

Information

4.4 Providing accurate and relevant information and improving communication between the service and its patients would mean that they could be equal partners in the provision of their care.

4.5 Transferring patient records and using common notation would, for instance, minimise the number of radiographs taken and if records were electronic it would not matter how the patient accesses the service, since the clinician would have access to comprehensive information about the patient.
Scenario B

Providing Information
Retired teacher Sandy needs to have a replacement bridge. She has to budget carefully and expects to have full information on the cost of proposed treatment. During the examination her dentist explains the treatment options both for NHS and private treatment and gives an estimate of their relative costs and outcomes. She has already seen the written guide to NHS/private charges in the waiting area. At the end of the conversation she agrees with the dentist that she will think about it and he suggests a neighbouring practice which would be able to provide a second opinion and to whom her x-rays would be digitally copied.

On returning to reception, she is given a proposed treatment plan and estimate and the receptionist answers questions and explains that prior approval will have to be sought before the treatment can begin. After thinking it through, Sandy telephones the practice and says that she would like to have the treatment done under the NHS and the receptionist then makes an appointment for her in two weeks’ time.

Quality
4.6 If the whole dental team receives ‘across the board’ customer service training via institutions such as the NHS University this would result in their identifying more with the mainstream NHS, aiding their motivation which would then be apparent to patients through consistent treatment to the same profession/client standards.

4.7 Having a simpler complaints procedure with an independent facilitator, linking to other primary care services would mean that disputes or concerns are resolved with speed and to the patient’s satisfaction.

4.8 An increase in the time that a patient has with a dentist will improve confidence in the service and increase patients’ perception of their status.

4.9 With no isolated groups in the new integrated structure, clinical audit and clinical governance would be encouraged and easier to performance manage: poor performance is often a result of feeling isolation and perceived lack of support.

Oral Health Promotion
4.10 By linking NHS dentistry into health improvement modernisation plans, patients living in areas with the greatest inequalities in health will benefit from the greatest investment and improvement in their oral health service. The objectives should be: less pain or acute episodes, fewer visits to the dentist and more confidence in the service.
Scenario C

Oral health promotion

Dental practices in an inner City PCT took part in a smoking cessation pilot using PCDs. The BDA/ASH leaflet was used as a starting point into a discussion about the benefits and at-risk patients were identified during dental examinations and encouraged to take up the opportunity to book into the PCT run smoking cessation scheme.

Tackling oral health inequalities

4.11 Improving access to NHS dentistry, so that preventive dental advice and treatment is available in every community will reduce oral health inequalities. Making it easier to find out about local dental services via NHS Direct and nhs.uk as well as making information about treatment in individual care settings fuller and clearer will reduce barriers to care.

4.12 The standards relating to oral health promotion include setting targets for child registration, reproducing the DMF target set in Modernising NHS Dentistry and making a requirement for an oral health component in every HIMP. Collectively these will enable PCTs to look practically at how dental disease levels can be reduced on a targeted basis. The major potential for using dental care settings for smoking cessation advice as well as other health checks, targeted to localities where they are most needed, will be a result of implementing the standards.

4.13 Oral health is not part of the Older People’s NSF and the standards rectify this serious omission by including a requirement to improve oral health for older patients. The standards also require that vulnerable groups such as adults and children with special needs are included in each DAP.

Benefits for PCTs, the profession and involving patients

4.14 These standards provide a framework within which PCTs can focus on dental activity which reflect the needs and wishes of patients. Many of the standards could form part of Dentistry Action Plans. The themes of access, information, oral health promotion, quality and a modern environment encapsulate key priority areas where services to patients can be improved. The standards also give PCTs a way of reviewing dental services.

4.15 For the local dental profession, the standards represent challenging but achievable outcomes which provide an opportunity for reducing complaints, improving oral health and achieving other benefits such as greater access to occupational health services and greater training opportunities for the dental team. It also puts dentistry clearly on PCT agendas and sets up mechanisms to establish clear channels of communication with the profession locally.

4.16 Patients Forums and PALs will have a practical way of monitoring local dental services by focusing on how the standards are being implemented in terms of access, information, modern premises and quality as well as improvements in oral health. Implementing the standards requires patient involvement and good quality feedback and looking at care provision from the patient’s experience by the use of patient journeys for example. These activities will be new to many parts of dentistry but the implementation of standards provides a
major opportunity to innovate and introduce them with the help of PALs and Patients Forums.

4.17 For all three groups, implementing the standards will mean establishing dialogue, building relationships and working together at a local level. This will empower frontline dental teams, involve patients and help to integrate dentistry into the NHS.

**Scenario D**

<table>
<thead>
<tr>
<th>Improving Children’s Oral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current position</strong></td>
</tr>
<tr>
<td>- Dental care for children is free under the NHS but in some areas access is patchy and may be dependent, in general practice, on parents/carers being private patients</td>
</tr>
<tr>
<td>- The majority of children enjoy good oral health, poor oral health is usually associated with deprivation</td>
</tr>
<tr>
<td>- Children in pain can face difficulties accessing emergency dental services</td>
</tr>
<tr>
<td>- In some non-fluoridated areas of social deprivation, there are very high levels of dental disease in children. These areas also find it very difficult to attract dentists</td>
</tr>
<tr>
<td>- Access to general anaesthesia for young children requiring extractions is increasingly difficult. Specialist care and advice is also not generally available, particularly where travel is difficult</td>
</tr>
<tr>
<td>- Some children do not get into the habit of tooth brushing and do not have access to their own toothbrush or toothpaste</td>
</tr>
<tr>
<td>- Sometimes children’s experience of dental services can be traumatic and lead to phobia in later life.</td>
</tr>
</tbody>
</table>

**After the standards are implemented**

- Children at high risk of dental disease would have access to appropriate prevention and treatment
- Parents/carers will find it easier to locate local NHS dental services
- PCTs will be introducing targeted initiatives to reduce DMF levels which may involve prevention, registration and tooth brushing schemes
- Children and parents/carers who require it will be given more help and encouragement to prevent dental disease
- Dental services for children with special needs will be locally available and easy to access
- There will be comprehensive emergency dental care for children
- Children’s experience of dental services including the communication skills of the dental team, the environment and the care provided, will improve.
Scenario E

**Working Age People**

**Current position**

- Access to NHS dental care can be difficult
- Information on NHS charges is unclear and is not readily available
- Within practices/clinics estimates and itemised receipts are not always provided
- NHS dental charges are complicated
- It can be difficult to obtain emergency treatment
- The availability of certain NHS treatments are not widely understood
- Some dental care settings do not look like the modern NHS and waiting times can be long
- A focus on treatment rather than prevention does not enable patients to take responsibility for their own oral health
- Dental care and treatment can feel rushed and there is not enough time for discussion of options and outcomes
- Communication between patients and the dental team can be difficult
- Having to direct complaints to the practice/clinic can discourage complaints, leading to dissatisfaction and poorer services.

**After implementation of the standards**

- Finding NHS dentistry will be easier and faster with NHS Direct appointment booking
- Patients will have greater understanding of the costs before entering a dental practice
- Patients charges will be simpler and estimates and receipts will be more informative
- There will be more time for discussion and more of a personal touch to NHS dentistry
- Dental teams will communicate better, there will be uniformly high standards of customer service
- NHS care will be provided in a more modern environment by professionals who are less stressed and better trained
- Care will be more focused on prevention and so in the long term there will be less need for treatment
- Emergency care will be easier to access
- There will be fewer barriers to complaints.
Scenario F

Older People
Current position

- There is no comprehensive strategy for NHS oral health services for older people so local services can be patchy
- Access to NHS dental care can be particularly difficult for older people without access to their own transport
- Fear of cost, made worse by lack of information on cost, is a major barrier to older people accessing care
- Lack of availability of NHS dentures and bridges can cause older people a lot of time and expense in finding a dentist willing to provide them
- Although GDS dentists are required to provide domiciliary based care to patients who are housebound, many are not able to fulfil these responsibilities
- Older people in care homes do not receive uniformly high standards of oral health care
- GPs prescribe medicines that can cause very high levels of decay that can be prevented by dental care.

After implementation of the standards

- There will be dentists/Trusts who are under PDS contract to PCTs to provide NHS care to older people on either a surgery or domiciliary basis
- Dental premises will be accessible to older patients with mobility, sensory or other difficulties
- Information, aimed at older people, will be widely available on the cost of care and how to access it
- Where necessary, PCTs will seek to arrange a local specialist service for difficult denture cases
- Where medicines are prescribed by hospitals/GMPs, which have known side effects detrimental to oral health, there will be a joined up approach to providing the patient with appropriate advice and preventive treatment
- Where a dentist is concerned about the safety, health or welfare of an older patient, there will be clear local protocols for action.

Support and Infrastructure

4.18 If all Primary Care Dental Services are linked to NHS net/same IM&T dental strategy then information is transferred as quickly and efficiently as possible. The 500 primary care one stop shops may give us an opportunity to relocate dentistry within our other NHS services and bring dentistry back into the NHS family.
Scenario G

**Integrated care**
The Jackson family’s dental practice is situated in a shopping centre that services their estate. The practice is housed in a ground floor-centre where there is also a GP practice, pharmacist, hairdresser, Citizens Advice Bureau and cafe. The practice is part of a LIFT Scheme and has centrally managed and maintained facilities, the IT system is linked to the local PCT, Acute and Community Trusts as well as the local Social Services Department.

Paula Jackson aged eight had toothache. She was treated, out of hours, through a local NHS Direct operated emergency service who also booked her a subsequent appointment with her practice through a centralised on-line service. The practice were thus aware in advance of Paula’s problem and her dentist was able to provide permanent treatment at her initial appointment through effective use of the practice dental therapist.

**Examples of current good practice**

5.1 The first Focus Award finalists are key contributors to good practice as judged by the following criteria:

- Improving patient experience
- Adopting a team approach
- Information and communication
- High quality environment.

A list of the finalists follows including a summary of the key initiatives they undertook.

**The Melbourne Dental Practice, Derbyshire**
Oral Cancer screening
Nervous patient initiative
Welcome booklets and patient information competitions and exhibitions
Child Care facilities

**68 The Dental Practice, Leeds**
Patient surveys
Anti-smoking advisor
Website/pre-treatment discussion follow up calls
Disabled access/visually impaired

**Strelley Health Centre, Nottingham**
Relaxation techniques
Community workshops
Resource library
Pleasant surroundings
5.2 Personal Dental Service Pilot providing new ways of providing NHS dentistry are having a positive effect on patients.

Staff perceptions which were included in the Annual Report (99/00) of the East London and City Personal Dental Services Skill-Mix Pilot:

“We provide a high level of care for our patients and have forged links with local schools, encouraging children via Open Days to form good dental habits and observe oral hygiene. We have a good relationship with the patients and we are hopefully altering people’s perception of dental care. We consider our practice to be patient-orientated, providing easy access, information and a friendly atmosphere for patients, and we spend more time with our patients, listening to them; it makes them feel important. Integral to this is the high standard of treatment and care, and inclusion of the local ethnic population and their needs.

We provide a feedback form in the surgery, and conducted a phone survey in 1999 with 98% of those surveyed considering care to be good or very good. That we offer our patients a quality service has been confirmed by their comments.”

Funding implications – cost benefit analysis

6.1 Most of the standards have funding implications but many are outweighed by the benefits they would bring i.e.:

Access
6.2 By having support and shared infrastructure locally, sharing receptionists/administrative staff, cost benefits as well as benefits to patients could be considerable. It is important to ensure that funding for dentistry is “ring fenced” for dentistry so that PCTs have the funding to deliver including for the management of existing salaried services.

Information
6.3 Change to the patient charging system would have funding implications. Improved and more widely disseminated information may also impact on patient take-up of services
Quality

6.4 For any new complaints procedure to work there needs to be an availability of independent facilitators who are aware of the nature of dental care and yet able to identify with patient needs and expectations from the service. Resolving complaints requires speed, ownership and sympathy. Primary responsibility lies with the clinical team concerned, however local PAL facilitators and PCTs should share an over-riding concern to resolve issues swiftly, clearly, fully and fairly. Initial investment may result in longer-term savings in time, resource and indemnity related costs.

6.5 For dentists to spend more time with patients changes to the GDS remuneration system would be implicated.

Prevention

6.6 Methods of GDS remuneration must be devised which promote oral health, with maximally effective care and treatment and a minimally interventive approach. Separating oral health improvement from complex interventive treatment requires both educational and remunerative change. Modelling of this scenario is required.

Support and Infrastructure

6.7 The cost to link all Primary Care Dental Services to NHSnet/ICT strategy has a considerable potential for cost efficiency, but is dependant on central capital investment.

Conclusions/Recommendations

7.1 In 1988, a paper by Helen Finch reported (‘Barriers to the Receipt of Dental Care’) that anxiety, and issues around the clarity and levels of charges for dentistry, were the principal concerns of patients, followed in importance by patients' failure to perceive a need to attend, and the attitude and communicative abilities of the dentist. In 2000, in a similar review, Tracy Land noted similar issues to be prevalent, adding that access to care was now a primary concern. Over this 12 year time interval, it may be concluded that whilst the original concerns of the 80s have been largely unaddressed, there has also been a failure to reinforce the confidence of either the public or the dental professions in the availability and standards of NHS dentistry.

7.2 The Dental Strategy of 2000 (‘Modernising Dentistry – Implementing the NHS Plan’) has provided the opportunity to review the recent past and the future of NHS dental services. A new locally responsive and integrated structure to address the needs and expectations of the patient now stands possible. This task group has been charged with defining standards which should be applicable to patients seeking NHS dental care in the 21st century. We recognise, however, that whilst the structure and operation of such a service is not yet fully operational, and the 11,000 primary care dental practices in the UK have at present differing levels of knowledge and expertise, clear standards will give focus and prioritise planning and implementation.

7.3 In considering the themes for this new, integrated and consistent quality service, we have clearly identified those areas in which service standards are necessary. We recognise that these in turn are underpinned by scientific knowledge and the growing evidence basis for ‘best practice’ in dental care.
and treatment. Existing guidance and standards are published by a variety of professional organisations, but their existence and dissemination remains piecemeal throughout the dental professions. These should be made more widely available from a central source.

A summary of known guidelines and standards of professional organisations is published below

<table>
<thead>
<tr>
<th>Submitting body</th>
<th>Title</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Dental Practice Managers’ Association</td>
<td>Code of Practice and Guide to Members</td>
<td>BDPMA April 2001</td>
</tr>
<tr>
<td>British Association of Dental Nurses</td>
<td>Occupational Standards</td>
<td>BADN c/o Healthworks UK</td>
</tr>
<tr>
<td>British Association for the Study of Community Dentistry</td>
<td>Oral Health Promotion Policy</td>
<td>BASCD 1999</td>
</tr>
<tr>
<td>British Association for the Study of Community Dentistry</td>
<td>Public Health Aspects of periodontal disease</td>
<td>BASCD 1994</td>
</tr>
<tr>
<td>British Association for the Study of Community Dentistry</td>
<td>Dental Screening</td>
<td>BASCD 1990</td>
</tr>
<tr>
<td>British Association for the Study of Community Dentistry</td>
<td>Dental Services for Older People</td>
<td>BASCD 1990</td>
</tr>
<tr>
<td>British Association for the Study of Community Dentistry</td>
<td>Frequency of Attendance for Examination</td>
<td>BASCD 1988</td>
</tr>
<tr>
<td>British Association for the Study of Community Dentistry</td>
<td>Home use of Fluorides</td>
<td>BASCD 1988</td>
</tr>
<tr>
<td>British Association for the Study of Community Dentistry</td>
<td>Dental Services for Handicapped Elderly People</td>
<td>BASCD 1986</td>
</tr>
<tr>
<td>Dental Laboratories Association</td>
<td>Dental Appliance Manufacturers’ Audit Scheme (DAMAS)</td>
<td>DLA, issue 4 May 1999</td>
</tr>
<tr>
<td>Faculty of General Dental Practitioners (UK)</td>
<td>Self Assessment Manual and Standards</td>
<td>Dental Advisory Board RCS 1992</td>
</tr>
<tr>
<td>Faculty of General Dental Practitioners (UK)</td>
<td>Selection Criteria in Dental Radiography</td>
<td>FGDP (UK) 1998</td>
</tr>
<tr>
<td>Faculty of General Dental Practitioners (UK)</td>
<td>Adult Antimicrobial</td>
<td>FGDP (UK) 2000</td>
</tr>
<tr>
<td>Faculty of General Dental Practitioners (UK)</td>
<td>Current Guidance in General Dental Practice</td>
<td>FGDP (UK) 1999</td>
</tr>
<tr>
<td>Faculty of General Dental Practitioners (UK)</td>
<td>Prescribing in Primary Dental Care</td>
<td>FGDP (UK) 2001 (in press)</td>
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7.4 We believe that the adoption of these recommendations will lead directly to the setting of local and national standards responsive to the needs and expectations of patients. More significantly, they will concentrate the efforts of the dental professions and the professional and NHS organisational structure towards the delivery of a patient-centred and effective service for the promotion of optimum oral health.
4 Systems of delivery of dental care

The terms of reference for this task group were:

‘to propose a range of models for local delivery of NHS dentistry including possible changes to the remuneration system’.

The Task group’s main conclusions are as follows:

- In order to create a system of NHS dentistry focused upon health outcomes rather than technical volume it is essential that the remuneration system separate income from treatment. No one system of remuneration suits everybody, practices and patients are different and there must be some accommodation for this in any new system. The group advocates that in the next few years, Primary Care Trusts (PCT’s) offer a menu of arrangements to dentists that might involve methods such as sessional payments, capitation, salaries or fee per item or often a combination of these.

- Primary care dentistry as it currently exists (community dental services, personal dental services, and general dental services) needs to be integrated. It is the view of the group that in this way PCTs will find it easier to provide a dental service that is properly responsive to the changing needs and demands of local communities.

- NHS dentistry needs to be fully integrated with the rest of NHS primary care provision. One way to achieve this would be to initiate multi-surgery health centres in some geographical areas from which dental, medical and pharmacy services could be provided for the locality. In order to underpin the integration of dentistry with the rest of the NHS substantial capital investment in IT for dental practices would be required.

Membership of Task Group

Dr Barry Cockcroft (Chairman)
Dr Janet Clarke
Dr Matthew Gill
Dr Judith Husband
Dr Tony Jenner
Dr Andrew Keetley
Dr Alan Ross
Miss Sonia Coxon (Secretariat)
Mr James Murphy (Secretariat)
**Introduction**

1.1 The terms of reference of this Task Group were to propose a range of models for local delivery of NHS dentistry including possible changes to the remuneration system.

1.2 The group met on three occasions to discuss the various systems of delivery of dental care with a particular emphasis on the primary care setting. Scenarios are included which help illustrate the proposed options and possible reactions to them.

**Identifying the Issues**

2.1 Our initial consideration concerned the objectives of change. We began by asking what we wanted change to deliver for key stakeholders.

2.2 For patients

- access to a transparent, clearly sign-posted service where it was obvious what was available and for what cost
- choice within the NHS (choice of treatments and location) as well as the option to choose alternative treatment outside the NHS
- once receiving treatment, patients should be able to expect a ‘quality experience’ and a form of redress if things go wrong.

2.3 For the dental team

- stability of income and fair reimbursement for reasonable work
- the ability to deliver quality care within a fair and transparent system
- fair reward for capital investment in the NHS and less administrative and clinical bureaucracy
- a system within which support for the dental team is generated and encouraged. An important benefit of working within the NHS should be professional support for all members of the dental team as part of the NHS family, including full involvement in the NHS superanuation scheme
- finally, it is important that there should be no losers and that entry to any new system is voluntary for general dental practitioners.

2.4 For Government

- politicians want happy constituents and cost control
- the Government also wants to be seen to respond to the concerns raised by the Health Select Committee
- we felt that it was unclear, at this stage, what methods the Government was prepared to employ and what parameters it would work within in order to achieve its objective.

2.5 For Primary Care Trusts

- the changes should enable PCTs to become much more engaged contractually with all dental care services and particularly those provided by independent contractors
therefore, ‘Options for Change’ must support PCTs by providing models for delivery of these services that can be applied effectively, are locally sensitive and are supported by local dental practitioners.

Proposed Options for Change

Organisation of services

3.1 Integration of primary dental care services – Fundamental to the new system would be the integration of General Dental Services (GDS), Community Dental Services (CDS) and Personal Dental Services (PDS). Hopefully, this would result in a fully integrated system of primary dental care carried out in an environment that encouraged strategic planning between service providers, an effective referral service and an holistic approach to patient care. The integration of the various sections of the service should, ultimately, result in the creation of large multi surgery sites where all primary dental care providers are working side by side. We believe that services managed on a larger scale have increased flexibility, economies of scale and opportunities for patients and those who work within them. There is a need to identify an optimum size for effective service delivery and help services work towards this.

3.2 Development of a seamless interface between primary and secondary care – facilitating a smooth running clearly defined referral process based on agreed clinical protocols. This would assist in reducing current bottlenecks that restrict access. Current limitations of capacity in the HDS are imposing barriers for elective care and it is essential that the dentally-based specialties be considered in all short, medium and long term planning.

The role of PCTs

3.3 Given the publication of ‘Shifting the Balance of Power’ we recognised that the service would be managed at PCT level and thus PCTs would need to develop competencies in this area. It was recognised that the most appropriate way of delivering service development (commissioning) and dental service provision could be through a host PCT which undertook the work on behalf of a number of PCTs. For this to work successfully, a network approach would be necessary and a managed clinical dental network could provide all the advice required by a host PCT in discharging its functions. The network would require appropriate management and clinical leadership from individuals who were selected (not elected) and who should receive appropriate training and remuneration for this work. If PCTs are to manage primary dental care, it is also essential that there is a dental member working in primary care on each Professional Executive Committee.

3.4 We are aware that dentistry has been identified as a specialist area in the National PCT Development Programme and that a Dental PCT Development Group has been established, chaired by the Chief Dental Officer. We believe that the issues we have identified above should form an important part of the working brief for this group.

3.5 Given the apparent lack of specific dental knowledge within PCTs at present, new schemes of delivering primary dental care would need to be developed centrally with possible local variation. Discussions with the profession would be necessary to decide which areas could be developed centrally and which locally, in order to avoid patients experiencing a large degree of variation in
the provision of care across different PCT areas. Strategic Health Authorities would need to performance-manage PCTs against planned outcomes. We suggest that the Health Authority Dental Action Plans are reconstituted into PCT Dental Service Development Plans (DSDP), which should be an intrinsic part of the PCT Health Improvement Plan. Each PCT should be required to have a DSDP even though in some instances service development and provision will be managed through a host PCT.

Dental Health Inequalities

3.6 There are still significant inequalities in dental disease experience and access to primary and secondary care dentistry. Currently the CDS and trust-based PDSs provide dental advice and treatment to many vulnerable people with special needs and those in socially deprived socio-economic groups with no history of regular dental attendance. Currently, patients with special needs are usually treated under CDS or PDS arrangements. It is important that these patients continue to receive access to care under any new Primary Dental Care Service arrangements and thus it would be essential that PCTs include them as part of their overall strategy in their DSDP.

Different systems of remuneration

3.7 New systems of remuneration will be of crucial significance to service providers. Before discussing individual options, we have identified certain factors that would be fundamental to the success of any new system.

- no one system will suit all; therefore a range and probably combinations of options should be available
- initially, continuing in the GDS should remain as one option for existing GDPs and entry into a new system should be on a voluntary basis
- running too many different systems would be both confusing and expensive
- the Government would have to underwrite any new system.

3.8 It was also stressed that private dentistry was essential in order to meet the public’s growing demand for the type of dentistry and service it provides. Private dentistry contributes to patient choice, provides dentists with options and independence and delivers those treatments that the Government does not wish to finance.

3.9 We believe that the following options for changing the system of remuneration should be considered and piloted both individually and in combination, according to local circumstances.

Option A

3.10 We have concluded that the best way to deliver care is to separate dentists’ income from individual treatments delivered and this could best be achieved effectively by paying salaries. Dental services need to be strategically planned around outcomes that meet clinical need rather than measured by technical volume, as at present. Primary dental care could be delivered via a service managed within a clinical dental network, commissioned by the PCT and utilising salaried dentists – paid within a transparent pay scale. Any salaried option would need to include elements related to both expenses and income.
Where a practice owner is providing premises and equipment for use within the NHS within a salaried option he or she would need to be fairly recompensed and due a fair return for the capital invested.

3.11 The CDS and Trust based PDSs are already operating on a salaried basis so this would continue, although other aspects of a new system (for example planning around outcomes and eligible patients paying charges) would also apply.

Option B

3.12 Capitation payments could provide an alternative remuneration system to item of service, without moving to a salaried system. Some private schemes – and at least one PDS pilot – are based on capitation and appear to be working well. If this kind of arrangement were to be implemented, the items that fall outside the capitation system could be negotiated according to need.

3.13 Providers of the service benefit from a more stable, predictable income, can develop a preventative regime and are rewarded for taking a long-term approach to patient care. However, it may be difficult to make capitation work in areas where disease is hard to control and where the population does not have a culture of regular attendance.

3.14 Any shift towards a capitation type scheme would need to be carefully monitored and subsequent changes in treatment patterns analysed.

Option C

3.15 An updated and simplified version of item of service should remain as an option for those who wish to continue working within the present system, since it has proved an effective way of delivering income. The system is widely used around the world and has delivered real health gain for the British public during the first 50 years of the NHS, particularly when the treatment of rampant dental disease (mainly caries) was paramount.

3.16 This method of payment is not well suited to pay dentists for diagnostic or preventive services, which require varying amounts of time for individual patients. Expenses can vary by wide amounts in different parts of the country and there can be an element of unfairness in a national scale of item of service fees. However, some dentists like working in a system that is mainly based on item of service.

3.17 Item of service is likely to form the major part of some dentists' remuneration for the next few years, but could be in a simplified version. In addition to a national fee-scale, there would need to be local incentives.

Further points that apply to each option

3.18 We would like to see PCTs encouraged to invest in NHS dentistry and we have concluded that this would be more likely if they could exercise greater influence in the development and management of the service. Contractual arrangements should be transparent and dependent on factors such as experience and qualifications. Such arrangements might also depend on the area in which dentists work or the types of patients they care for. The PCT could use incentives to address the distribution of workforce issue and encourage dentists to care for members of the population with the greatest
oral health need. The service should be driven by monitoring outcomes with the aim of promoting oral health and reducing inequalities.

3.19 Transition to an eventual salaried service for GDPs could be achieved by way of a system of ‘sessional’ payments (rather like an extension of the current mini PDS schemes) eventually evolving into a salaried service. A system whereby practitioners chose to sell a number of sessions to the NHS (initially on a self-employed basis) would allow services to be developed swiftly in order to address local needs, whilst allowing practitioners to maintain a degree of independence and choice, still retaining the right to mix NHS and private treatment.

3.20 One important factor in a sessional system would be the terms attached to any contract, as we would want to avoid a return to the treadmill of having to see large numbers of patients in a limited time period. We also felt that there would have to be a slow transition to a situation where PCTs owned and managed many of the buildings where dental care was provided. We recognise that the logistics of this transitional phase require development.

3.21 Many GDPs could feel that a move away from item of service would lead to the eventual loss of some elements of independent contractor status. Although we note that independent contractor status had played an important role in the development of the GDS, we believe that the benefits of the totally independent contractor status concept are somewhat overrated, being perceived as advantageous with little evidence to support this contention. Many of the perceived advantages of retaining independent contractor status could still be available under new contractual arrangements, under a sessional payment system of funding for example there would be good arguments to maintain self-employed status.

3.22 A more serious problem for the profession and service development is the detached status of dentistry in the NHS. Even under a salaried system, dentists should ultimately retain the right to carry out some private work. Furthermore, dentists should retain the right to refuse to undertake a particular patient’s care, in circumstances where a personal relationship had broken down and the patient’s needs would be best served by seeing another dentist. During the transition period where sessional payments are used, the practice owner might also, initially, continue to contract with other dentists and PCDs.

Information Technology

3.23 Our options for new systems of delivery for primary care dentistry are dependent on dentistry becoming fully integrated into the NHS Information network. About 70% of dental practices within GDS have PCs. The main problem is that each practice system exists in isolation from the rest of the NHS. In part this isolation has been due to the lack of an Information and Communication Technology (ICT) Policy for dentistry in the UK and in part because dentists are not resourced for systems or for connectivity to NHS Net. Trust based salaried services generally have much less access to PCs, although the move towards PDS has improved this dramatically for those services which have moved into PDS.

3.24 PCTs will be moving towards the development of integrated electronic systems for records and for communication amongst local NHS staff. From April 2002,
they will need to liaise with NHS Direct to manage local access to NHS dentistry, along with out of hours and unscheduled care. It is inconceivable that this can be achieved successfully if dentistry remains in electronic isolation from the rest of the NHS.

### 3.25
The key aim should be to have all dental surgeries computerised and all branches of dentistry electronically linked and using a standardised dental electronic patient record by 2005, which will enable patients to move much more easily within the system.

### 3.26
Recommendations for Information Technology:
- we believe that a major investment linking dentistry electronically to the rest of the NHS is fundamental to the ‘Options for Change’ programme
- central resources for capital investment in ICT technology are urgently required.

**Patient charges**

### 3.27
Patient charges are a driver of health inequalities and this issue needs to be addressed by the Government. Dental disease is related to socio-economic factors and at present, those in greatest need are least likely to access the service and often pay the most for their dental care.

### 3.28
We are aware of socially based insurance schemes in operation in Europe, but have not investigated how individual schemes work. We fear that the introduction of a further party to the funding arrangements may not produce simplification and that it could not be introduced without considerable investment, taking further valuable resources away from service delivery.

### 3.29
It is important to attempt to separate the payment of dentists from the collection of charges. The profession wishes to reduce the bureaucracy of having to collect small amounts of money from patients for items of treatment and would welcome a system that separates fees from charges. Separating patient charges from dentists fees means that PCTs have much more flexibility concerning how to deliver the service, because one is not dependant on the other. The principle of separating charges and fees is generally accepted and already exists within the process of prescription charging. We do favour a system of dental payment cards whereby the patient pre-pays for a certain amount of dental treatment over a set period of time. We believe, however, that both systems warrant further exploration. Changes to the patient charging system should be further investigated.

**Consider outcomes and develop scenarios**

### 4.1
We believe that in the future, all current GDS, PDS and CDS services should be merged into what we would term simply Primary Dental Care Services. Ideally dental care should be provided in a well-equipped, modern surgery, which is easily accessible for all, offering a comfortable environment for patients and staff. It has been recognised that there is a need for dentists to be brought into the NHS family, and that they should play a more integrated role in the provision of NHS care.
4.2 We feel that the best way for this to be achieved would be through the creation of purpose built multi-surgery health centres, from which dental, medical, pharmacy and other community services such as chiropody and physiotherapy could be provided for the locality. Such premises would also provide a suitable base for the provision of emergency out of hours dental services. Wherever possible we should be moving away from isolated practices with a view to having a service built on fewer, larger practices, having better facilities for patients, whilst also providing an appropriate environment for continuing professional development through clinical and management career structures.

4.3 In some localities (particularly rural, more isolated ones) provision of care from large health centres is neither possible nor suitable and we recognise that in these areas single-handed practitioners play an important role and will continue to do so. The primary concern is not one of geographical isolation, but professional isolation and to overcome this these practitioners could be brought into a system of mutual support, with its own strategy negotiated with the PCT and systems of communication.

4.4 In the long term, when the GP and GDP facilities were reviewed it would be hoped that they would merge. It may be that the practitioners who have been professionally isolated up to now, and who possibly have the most to gain, will be the most resistant to joining a network, and thus we must provide an attractive package in terms of education and practical support if any new initiative is to succeed.

4.5 A major advantage afforded by integrated multi-surgery centres would be that the improved facilities could also provide the opportunity to move specialist dental care into a primary care setting, with specialists being able to work on a sessional basis across various centres in the region. This would vastly improve the current referral process, free up hospital resources and provide a more familiar environment in which patients could receive care. Furthermore the greater accessibility of specialist skills would be beneficial for the clinical development of dentists working in the centres, who would be able to learn new skills, which may ultimately reduce the need for some referrals.

4.6 For the profession, the health centres would provide a better working environment and make available a new form of career development, which is currently somewhat lacking in the GDS. We would see dental involvement in the management of service delivery as being the first stage in development of a dental management career structure for dental professionals, with particular emphasis on leadership. A salaried service would remove some of the management burden from those practitioners who wish to concentrate on a clinically orientated career whilst opening up a management career structure for those who wished to pursue it.

4.7 We are not suggesting that in the short term PCTs would have the funding available to embark on the construction of numerous multi surgery health centres and then ‘buy dentists out’ from their existing practices. This would be neither realistic nor an effective use of resources (even if they were available). However, PCTs could begin the process by taking steps to address the problems of isolation, through networking of practices.

4.8 In view of the anticipated relaxation of restriction on Corporate Bodies within dentistry, it is possible to consider another scenario. Some corporate bodies have been primarily interested in private dentistry, and have concentrated...
themselves in areas where this is likely to succeed. The possibility that groups of dentists may cooperate to form new corporate bodies, very different from those in existence at present, offers an opportunity for the NHS. PCTs could tender the dental services to new corporate bodies, which in effect could then become the dental network managers for an area.

Scenario A

Partnership with a PCT in a rural community
Smithside is a PCT situated in a rural corner of England. Most of the dental practices within Smithside’s boundaries are small and run by single-handed practitioners. Many of these practitioners had chosen to opt out of providing NHS care for adults and the PCT is faced with an access problem. In order to tackle this problem the PCT approached a group of dentists and proposed that, if they could maintain their NHS list sizes at a certain agreed level, the PCT would provide the following:

- logistical support; administration of bulk ordering facilities
- free waste collection; a centralised out of ours service involving NHS Direct
- the administration of a system whereby each of the dentists in the group cover for absence from the practice due to sickness, holiday and attendance on continuing professional development courses.

It was recognised by both parties that since integrated IT systems had been installed, the improved communication links and sharing of electronic patient records between practices would help to make this sort of proposal work. Members of the PCT and representatives of the dentists’ group met and agreed to draw up a contract, which would be reviewed annually.

Scenario B

New dentures for Mrs Smith
Mrs Smith is edentulous and has experienced a lot of trouble with her dentures over recent years. She goes to see her dentist in the community health centre, where she also sees her GP and chiropodist. Over the last few years several dentists have made four complete dentures for her, but despite their best efforts, have been unable to provide a comfortable, well fitting denture. The dentist knows that the PCT has an arrangement whereby a specialist in prosthetics attends the health centre for one session each week. He decides to refer Mrs Smith to the specialist and suggests that she makes an appointment to see the specialist, which can be done via the receptionist she saw when she arrived at the practice. By the time Mrs Smith gets to the reception desk the receptionist has received details of the referral request from the surgery and has accessed the electronic diary of the specialist. Meanwhile, the dentist sends Mrs Smith’s referral notes and records on to the specialist.

When Mrs Smith visited the specialist her regular dentist was shown that the problem related to a very mobile upper ridge on her gums and that by changing his impression technique he could have much more success with making dentures for patients like Mrs Smith.
Scenario C

**Dr Jones changes to capitation**
Dr Jones is the only dentist providing NHS treatment in the town in which he works. He has a list size of 2000 registered patients, despite the fact that he has not seen a new patient since 1992. He stills sees patients at 6 monthly intervals and his income is based around 6 monthly checkups.

The PCT approached Dr Jones to see if he was interested in changing his contract to one of capitation, so that he could then accept some new patients. Dr Jones agreed and changed his recall regime to reflect more closely the clinical needs of his patients. He has found that many of his patients do not need to see him every 6 months, but annually instead. Despite the reduced frequency at which he sees the patients his income is maintained, thus freeing up some time to see new patients who have previously had difficulty in accessing NHS care. This means that he has improved access to NHS care in the area and at the same time is now seeing a wider diversity of patients with different treatment needs.

Scenario D

**Inner City problems resolved**
Dr Johnson is a single-handed practitioner working in a particularly deprived inner city area. Her practice is very run down with old equipment, but she is not willing to upgrade anything because she has been burgled four times in the last year. The staff are highly stressed, having to deal with crank calls and a local gang of youths who sometimes appear and cause trouble. It is not unusual to arrive at work to find used syringes on the doorstep, and the staff are apprehensive about walking to the bus stop at night, as one of them was mugged recently on her way home. Dr Johnson has been off sick intermittently for much of the year, due to stress, and is thinking of applying for early retirement on grounds of ill health.

As part of an inner-city development programme, the PCT is building new premises for the local GP and they are planning to incorporate a pharmacy and some other local services. They approach Dr Johnson and ask her if she would be interested in moving her practice to the premises as part of the development. They offer to provide all the equipment for a new surgery and access to a hygienist and dental therapist, provided that she maintains a certain agreed level of NHS commitment.

Dr Johnson makes the move to the new surgery, bringing her patient list with her and is free to sell her old premises. The new premises are less than a mile away and are situated in a modern building with good security, in a bustling, well-lit area and are not far from the shops and a bus stop. The staff are more relaxed as they are confident that they can travel home in safety and are no longer having to deal with incidents of intimidating behaviour. Patients are delighted to be treated in such a modern surgery, and respond well to the improved mood of the staff. Furthermore, attendance improves as the surgery is in a more convenient location. With happier staff and patients, Dr Johnson is also appreciating the benefits of the change and feels more able to get on with the day to day business of dentistry. She has not been off sick since moving to the new premises and decides not to apply for early retirement.
Scenario E

Dentist keeps to the system he knows
Dr Da-Costa owns a five-surgery practice and is quite happy with the GDS system at the present moment, although he concedes that it has many flaws. His practice is computerised and efficiently handles the complications of the fee-scale.

Dr Da-Costa has been watching developments concerning the delivery of primary care dentistry in his area with interest. The PCT has elected a secondary care dentist onto the their local PEC. However, although this dentist is highly qualified he does not have a handle on primary care and does not have much of a grasp on GDS matters. The local PCT have over recent months been encouraging dentists to become more involved in the NHS by committing to providing purely NHS sessions. A new health centre has also been established in the area, which some dentists are considering joining on a salaried basis.

Dr Da-Costa, despite being offered a new deal and premises, decides to remain as he is for the time being – preferring to try and increase the percentage of private work he does. He is unconvinced that his practice will benefit from the new arrangements and decides to see how the land lies in a couple of years, once the results of various pilot schemes are known.

Scenario F

Private dentists fill gaps in emergency services
In an area of predominantly private dentists the HA lacked weekday emergency provision for non-registered adults and children. All remaining NHS practices were no longer taking on new patients. With new money and in conjunction with the LDC a proposal for local practitioners to provide limited cover was designed.

A rota for weekends was proposed, providing Sunday cover for non-registered patients, in conjunction with practices covering their own registered patients. A scheme involving an hourly rate of £130 and limited numbers of patients (a maximum of four per hour) was negotiated locally. The scheme would operate in a way that involved patients contacting NHS Direct, who then directed them to the appropriate practice for that day and time.

When the bidding process for practices had opened the scheme was massively oversubscribed, with great interest from private practices. The scheme successfully fulfilled the HA’s responsibility, patient needs and attracted dentists back to NHS dentistry in a limited way. Practice and individual practitioners were able to mix private and NHS care on a specific time basis, thus providing a pre-set regular income for the dentist.
Scenario G

VDP joins Dental Body Corporate
A vocational dental practitioner was coming to the end of her VT year and deciding on future careers. Due to her having to make extensive student debt repayments, for at least the next five years, she wanted some predictability in her income.

She was aware from her VT year just how dramatically her income could fluctuate in the GDS and this concerned her greatly. Local PDS posts were available, but these offered considerably lower salaries than she could expect to earn in the GDS. Recruitment companies had been in regular contact with her since qualification so she knew her skills were in demand, but no associate positions (even in private practice) offered any form of salary.

A corporate body contacted her with open day details at a flagship store. After discussions with the manager, her mind was made up. An excellent salary, company pension, staff discounts, private health insurance, car, sickness cover and relocation costs if she wanted to move further a field were all on offer. The building was purpose built with computers, intra oral cameras and full clerical and surgical backup.

Her great concern was that all treatment was on a private basis. She had always believed in the NHS, but her personal situation as the main wage earner and the stability this job provided could not be matched in the NHS. She was not hopeful for the future regarding NHS care as she could not see conditions improving at all.

Examples of Good Practice

5.1 There have been and still exist some examples where innovative and imaginative thinking has been applied to try out an alternative way of delivering primary dental care services. Many of these examples were established as PDS pilots and we feel that the change in emphasis of PDS, from innovation to access, was a major lost opportunity.

5.2 We also recognise that such pilots were very dependent on the people involved and local circumstances. We feel that we do not have sufficient information at present to be able to quote verified examples of good practice, as it is too early to provide a robust evaluation of more than the first wave of PDS schemes. In addition, due to the diversity of these schemes, it will be difficult to provide measurable results which can be compared easily.

Funding implications

6.1 An NHS estate exists that has been developed since 1948 and provides NHS treatment, but a large part of it does not belong to the NHS. The cost of addressing this issue is enormous, especially since many of these facilities in all branches of primary dental care have been under-funded. We do, however, believe that quality NHS patient care and the question of the very existence of the service depends on the adequate funding of infrastructure.
6.2 Funding for Managed Dental Networks could present another challenge. However, initially funding for the networks could be provided from the PCTs own general allocation, with the possibility of new funding from national initiatives or other sources such as commercial sponsorship sustaining their development in the future.

6.3 The importance of private funding for NHS initiatives should not be overlooked if we are to work towards a scenario whereby premises providing Primary Dental Care Services, are owned by PCTs. We should, evaluate the possible use of NHS LIFT in developing premises, as a matter of urgency.

Conclusions and recommendations

7.1 Our conclusions were:

● there is an absence of vision and strategic thinking in NHS dentistry. Unless there is fundamental change, the future of NHS primary care dentistry is uncertain

● any new system of service delivery would need to be incentivised (financial and otherwise) and presented effectively to the profession

● redistribution of current resources will not achieve the objectives set out at the beginning of this paper. If sufficient resource is not available for a comprehensive service there will have to be an element of prioritisation.

7.2 Our recommendations were:

● a strategy should be developed for the integration of dentistry within the NHS family

● pilots, covering all aspects of primary dental care should be established as a matter of urgency over diverse geographical areas, with an evaluation system clearly defined from the outset

● these pilots should be designed in such a manner that if shown to be successful upon evaluation, they could be adapted quickly to provide services over a wider area

● each PCT must be signed up to a Dental Service Development Plan into which primary care dental providers and patients have had input

● central investment in infrastructure and an integrated IT system is urgently required

● the direct relationship between dentists’ income and patient charges should be severed and a review of methods of charging patients across primary dental care is required.
The terms of reference for this task group were:

‘to develop proposals for the education, training and development needs of the whole dental team’.

The Task group’s main conclusions are as follows:

● Training should be directed towards the dental team as a whole, and particular efforts should be made to ensure that curricula planning across the dental team recognises the complementary contributions of the different members of the team. The majority of dental treatment is undertaken in primary care so it is important to include this setting within the educational experience of the whole team in order to ensure that priority is given to the development of relevant practical and communication skills.

● With the suggestion to increase the number of specialist dental practitioners in the primary care sector, patients will be able, to access specialist services more readily in their own locality. Such a change in the skill mix in general dental practice would inevitably lead to changes in the undergraduate dental degree programme and would also impact on the training needs of professionals complementary to dentistry.

● Continuing professional development needs a new approach, with a proper appreciation of which skills are most useful to each individual to best meet patient need in the areas where they practice. Clinical Audit could highlight particular areas for development that would be of benefit to patients. In order to ensure that CPD could be readily available, inter-active computer based training should be introduced, subject to the necessary investment.

Membership of Task Group

Professor Anthony Blinkhorn (Chairman)
Professor David Gibbons
Dr Janet Heath
Dr Susie Sanderson
Mrs Sue Skinner
Dr Penny Vasey
Miss Diana Wincott
Mr Derek Busby (Secretariat)
Ms Linda Wallace (Secretariat)
Introduction

1.1 The terms of reference of NHS Dentistry: Options for Change were to develop proposals for modernising NHS dentistry in line with the principles in the NHS Plan and building on progress in delivering the NHS dental pledge. This Task Group was responsible for developing proposals for the education, training and development needs of the whole dental team.

1.2 The context within which this work was done was one in which there is already a considerable amount of change underway. NHS dentistry needs to move forward in line with:

- the NHS Plan, which sets a clear direction for the NHS overall and signals the need to consider shortening undergraduate courses
- Modernising NHS Dentistry, which provides a foundation for the development of NHS dentistry and includes the intention that professionals complementary to dentistry are able to register with the General Dental Council and work in more areas
- A Health Service of all the Talents, which is changing the ways that education and training is funded and supporting the multi-professional agenda, and
- Shifting the Balance of Power, which is establishing a more localised system of health delivery.

1.3 This paper describes areas for change, suggests NHS Dentistry: Options for Change in these areas and then makes recommendations. Throughout the fundamental emphasis of the paper is on whether changes are needed to education, training and development to ensure dental staff are well equipped to deliver patient care. We have also sought to identify ways in which dental staff can be given scope to fully use the skills they have learned and to ways in which education and training can offer prospects for personal development.

1.4 In writing this paper the Task Group was conscious that some of the changes, which might best improve the education process and best enhance patient care could not be delivered immediately. We have sought to identify improvements, which could be made relatively quickly, as well as proposing longer-term aims.

Identifying the Issues

The role and clinical responsibilities of the members of the dental team

2.1 The changes signalled in Modernising NHS Dentistry are now being taken forward and legislation is being amended to allow professionals complementary to dentistry to work in more areas of the NHS. The increased scope for other members’ of the dental team to offer clinical care in the General Dental Services will create opportunities for dentists, as leaders of the team, to concentrate on more complex items of clinical treatment and further develop their role as Team Leader.

The education of the dental team

2.2 The focus for NHS dentistry must be on delivering high quality patient care and on ensuring that trained professionals in the NHS are able to make the
most of the skills they have learned. As indicated in section above, the role of the dentist may change as other members of the dental team are enabled to take on more clinical care. This could be expected to impact upon the content of dentists' training, if other members of the team are increasingly taking on much of the straightforward clinical tasks, then the training of dentists should focus more on complex clinical and preventive items.

**The duration of education and training and how it is provided**

2.3 The length of training for the dental team owes much to history and the gradual increase in training time reflects a desire for training institutions to cover the subject in as much depth as possible and ensure educational quality. The NHS Plan has signalled the need to consider whether medical degrees are the appropriate length. The same consideration should be given to the dental degree programme with particular emphasis on whether it best prepares dentists’ for working in practice and meeting the needs of patients.

2.4 A similar assessment of the training of professionals complementary to dentistry is also required. Currently dentists wanting to run their own NHS practices have to undertake a year’s vocational training after qualifying. Should there be changes to the dental curriculum it would be important to consider whether there should also be changes to the arrangements for vocational training.

**Location in which education and training is undertaken**

2.5 Unlike medicine, the dental team works predominantly in the primary care sector; yet the basic training is centred on secondary and tertiary care. This raises questions about the appropriateness of current training arrangements and their impact on all members of the dental team.

- firstly, whether training for careers in primary care is best served by the basic training being undertaken mainly in secondary and tertiary care
- secondly, whether oral health care professionals are perceived by the managers of Primary Care Trusts as generally not part of the NHS and therefore dental education is not an issue which, in general, PCTs should be greatly interested in.

**The continuing development needs of members of the dental team**

2.6 Continuing professional development now has a much higher profile in dentistry. For dentists, from January 2002, there will be a requirement to undertake a minimum amount of continuing professional development each year and for a specified proportion of this to be verifiable. NHS dentists also have to participate in clinical governance as a term of service requirement.

2.7 As professionals complementary to dentistry take on a greater role it is likely that similar arrangements will develop for them. In terms of the delivery of continuing professional development consideration has to be given as to whether current arrangements can effectively deliver these needs; whether they best suit a team based system; and whether the training of NHS dental professionals is organised to ensure that delivery of patient care is enhanced.
The impact of technology on training

2.8 The increasing emphasis being given to continuing professional development raises important issues of both capacity and funding. At present, most courses are provided by NHS consultants and academics, as well as GDPs. Each of these groups are under considerable time pressures to deliver waiting lists targets; undertake research, and provide treatment to patients. Any future increase in postgraduate courses would impinge on these tasks if course based activity remains the main educational approach. Computer based interactive learning offers a means to increase the scope and range of postgraduate courses for all members of the dental team. It could also play a role in undergraduate teaching and potentially offers scope for links between educational institutions and training centres outside of dental schools.

Development of specialist training

2.9 The dental profession has developed a number of specialist services and appropriately qualified dentists can register with the GDC as specialist practitioners. The ‘specialists’ will offer care within the context of primary care and may well reduce waiting lists for consultations in the secondary care service.

Options for Change

3.1 This section discusses *NHS Dentistry: Options for Change* in each of the areas identified in section 2. The same headings are followed and an attempt will be made to bring the themes together in the Conclusions and Recommendations section of this chapter.

The role and clinical responsibilities of the members of the dental team

3.2 The increase in areas where PCDs work provides an opportunity to develop a Team based approach, which will enable practitioners to make best use of the skills they have learned and ensure that patient care is of an appropriate high standard. Dentists who have been more highly trained could focus on work, which demands higher skill levels rather than undertaking tasks, which other members of the Team are fully capable of doing. Enabling dentists’ to release some areas of work to focus on more challenging and skilled care should enhance the practitioners’ satisfaction with their professional activity.

3.3 Such a change in clinical responsibilities will have to be matched by further training to help the dentists take advantage of these new career opportunities. Having more clearly defined roles would also help to ensure that PCDs are able to fully use their skills and make effective contributions to the work of the Team so as to benefit patient care. To take this forward an expansion of places on PCD training schemes may well be needed to make a reality of the team based approach. However any increase in training should focus on innovative schemes which provide educational opportunities in areas where recruiting PCDs is difficult.

The education of the dental team

3.4 Education should be focused on developing professionals who are best suited to providing appropriate, high quality patient care. The need to ensure that education and training is designed to develop dental professionals who are best suited to working in practice argues for an increased use of primary care outreach schemes throughout training. There also needs to be a proactive view
of the dental curriculum, which ensures that the training of dentists’ is focused on meeting the oral health, needs of the population. Forward planning using national survey data on oral health trends could provide a means to ensure that the skills dentists’ learn (and increasingly other members of the dental team) are appropriate for the patient activity they are likely to be engaged in, as well as ensuring that core skills are learned.

### 3.5

Focusing on the skills needed to deliver effective patient care should apply to all members of the dental team and consideration of their roles would also suggest changes to the training undertaken. Moving to dentists’ undertaking more complex work whilst PCDs were responsible for a range of other activity would require that training be replanned accordingly. Dentists’ would need more time given to training in complex clinical care and there would also be a need to address the issue of specialist training to ensure that appropriate numbers of practitioners are trained. Curriculum planning should be undertaken on a dentistry-wide basis to ensure skills learned by different team members are complementary (Scenario A).

### Scenario A

<table>
<thead>
<tr>
<th>Curriculum planning</th>
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<tbody>
<tr>
<td><strong>Reviewing the dental programme and shifting the focus to skills needed by practitioners</strong></td>
</tr>
<tr>
<td>● Redesign the dental course to concentrate on basic skills</td>
</tr>
<tr>
<td>● Review the curriculum on the basis of oral health trends and skills needed by practitioners</td>
</tr>
<tr>
<td>● Alter basic science component to reflect scientific skills required in clinical practice</td>
</tr>
<tr>
<td>● Link post-qualification specialist training with the BDS programme</td>
</tr>
<tr>
<td>● Use of outreach – gives greater experience of working in a primary care environment</td>
</tr>
<tr>
<td>● Develop a modular programme to allow PCDs to be exempt from some modules should they wish to study dentistry. Give credit to prior learning.</td>
</tr>
</tbody>
</table>

**Achieving these goals would require management of a number of issues**

| ● Concentrating on core skills for dentists would only be possible if there were more opportunities for specialist training once qualified |
| ● Perceived downgrading of the BDS degree if there is an overt shift to training for actual practice |
| ● Potential difficulty of funding and recruiting a sufficient number of suitable training practices would mean that changes could not be made immediately |
| ● Greater emphasis needed in post qualification education and training. |
3.6 To support the Team based approach there would also need to be greater emphasis given in training Team leaders in management, leadership, facilitation and staff development to ensure that both staff and patients benefited from this new way of working. The change in role of the dentist will require a different approach to candidate selection, as leadership and communication skills will be so important. The use of psychometric tests should be considered (Scenario B).

Scenario B

Training team leaders
The role of the dentist
- Less emphasis on routine care
- Utilise specialist skills
- More time for difficult cases
- Improved quality of advanced care
- Greater job satisfaction.

Achieving these goals would require management of a number of issues
- Currently too few PCDs, so need for planned development
- Higher training in the dental specialties compromised by a lack of training opportunities
- Specialist training is not funded
- Confusion between specialist and consultant training
- More emphasis in the curriculum on communication and leadership skills.

The duration of education and how training is undertaken and how it is provided
3.7 Currently the undergraduate course is of five years duration. The key elements of the curriculum are presented in the General Dental Council’s guidelines, ‘The First Five Years’. Dental Schools are inspected on a regular basis by appointed representatives of the GDC to ensure that the curriculum is being delivered in an appropriate manner. In addition, dental schools are included in the Quality Assurance Agency process common to all universities. Therefore, dental schools undergo a double inspection system.

3.8 Changing the focus of dental training to be more orientated to developing the skills needed in practice could also support consideration to be given to whether the length of the programme is appropriate, which is an issue that The NHS Plan has highlighted. A considerable part of the dental degree covers basic science and there is doubt within parts of the profession as to the value of all of this for the dentist in practice. A course that concentrated more on practical skills which would provide dentists with the skills needed in practice
could well be shorter than the present five years. However a dentist should be able to understand and interpret published papers as well as having training in behavioural sciences and psychology. These topics are an important part of a scientific education.

3.9 Options might include, reducing the part of the dental programme spent in a dental school with more time being allotted to more practically orientated activity after a base had been established in the early part of the programme – possibly three years in dental school followed by two years in practice and hospital based training.

3.10 Equally PCDs training should focus on the skills required to work effectively in the dental team to deliver appropriate, high quality patient care (Scenario C).

Scenario C

**Hygienist and Therapist training**

**Shortening the time frame**

- Concentrate on core skills
- Joint therapist/hygienist training in 2 years
- Shorter programme will help to release greater numbers
- Aim for flexibility and allow for part-time training.

**Achieving these goals would require management of a number of issues**

- Need to ensure that clinical quality is maintained
- Intensive programme
- Need for well structured management
- Pilot scheme to assess whether distant learning a possibility.

3.11 Another way forward might be the development of a more modular approach to training in dentistry. This could contribute to the building of a team ethos and to ensuring opportunities for progression were open and thus making the concept of the ‘skills ladder’ meaningful within dentistry. This is important to *A Health Service of All the Talents* as it provides opportunities for talented people to progress and to be given credit for earlier education; particularly for PCDs to gain credits for their qualifications. The modular approach could also be effective as it recognises that the majority of the clinical part of dental undergraduate programmes is skills based (Scenario D) and accepts the principle of accredited prior learning.

**Location in which education and training is undertaken**

3.12 Many of the patients presenting for care at dental hospitals/schools are referrals from primary care dentists for secondary care and are not necessarily appropriate for undergraduate education. Some schools have overcome this problem by moving student teaching to the primary care sector either in the Community Dental Services or in novel PDS schemes.
3.13 Primary care patients are treated in a convenient local setting and over time it should be possible to reduce staff and equipment costs within the dental schools. This hub and spoke arrangement fits in well with the development of PCTs and can also give undergraduates greater experience of serving a specific community. Any expansion of ‘outreach’ teaching will need a robust infrastructure and assessment processes, as well as training courses for the ‘outreach’ trainers.

3.14 In addition to providing a more appropriate casemix for students the use of ‘outreach approved training practices’ would provide scope for them to acquire key skills in dealing with patients and working with team colleagues. Increasing the use of outreach teaching may also provide much of the clinical and managerial experience that is currently acquired by dentists during their vocational training year.

3.15 Developments in the curriculum, which emphasised increased use of outreach, would require a review of vocational training to ensure that it continued to provide educational benefits. Experience of actual practice may also be helpful in providing people with the chance early in their training to judge whether they are suited for dentistry; at present some individuals only discover that practice life is not for them several years after qualification.

3.16 The development of outreach training in primary care could also contribute to strengthening the place of dentistry in the NHS. More PCTs would be able to see that dental education is something with which they should engage, whereas now it would appear that only those areas where a dental school is located have any clear view on this (Scenario D). The development of teaching Primary Care Trusts will enhance the importance of teaching dental students. However capital funds are required to develop multi-surgery health centres and the teaching costs may be somewhat increased as outreach is based on small group teaching.

Scenario D

**Modular Training**

- Facilitates flexible access to dentistry and helps PCDs move up the skills ladder
- Supports use of outreach training practices to deliver appropriate training for practitioners.

**Achieving these goals would require management of a number of issues**

- Difficult to develop modules which would be appropriate across the profession given differing skill levels required
- Potentially compromises emphasis on education being evidence based which is likely to require a more directed approach.
The continuing development needs of members of the dental team

3.17 Whilst continuing professional development is a responsibility for the profession, and has been placed upon practitioners’ by the General Dental Council, public funds do support provision of courses. At present the emphasis is on participation in continuing professional development and the cultivation of the culture of lifelong learning and the CPD undertaken is self-directed by practitioners within the range of courses provided.

3.18 The Department of Health could reasonably expect, in respect of publicly funded CPD activity, that the training provided should enhance the provision of quality clinical care to patients. Therefore the needs of patients rather than demand from dentists’ should be the determining factor in programming courses. Structured programmes on the basis of identified priorities for NHS dentistry could effectively deliver improvements in quality and ensure that publicly funded continuing professional development met the needs of dental professionals in their NHS practice activities.

3.19 Local plans should encompass the whole of the dental team and training programmes should be targeted at the skills needed to meet oral health needs and provide specific training where appropriate so that duplication is avoided. Wherever appropriate, training should be on a whole team basis (Scenario E), including dental practice managers and receptionists.

Scenario E

Continuing Professional Development
For the dental team this means

- Structured development for practitioners to ensure improvements in patient care
- Opportunities for practitioners to enhance career satisfaction
- Contributing to professionals moving up the “skills ladder” and taking on new roles to develop their careers
- Joint training for all the dental team to encourage ‘real’ team work.

Achieving these goals would require management of a number of issues

- Building local competence to develop managed development programmes
- Resource requirement building as the strategy developed
- Funds required for PCDs.

3.20 There could also be scope for planned development of additional skills to enable practitioners to take forward their career aspirations by developing in specific directions i.e. there could be support for training plans which might allow practitioners in one of the PCDs to move to qualify in another area of dentistry, including becoming a dentist should they so wish.
The impact of technology on training

3.21 As indicated above, there is growing pressure on capacity to deliver continuing professional development to dentists and, in future, this can be expected to extend to the whole dental team as their role increases. Interactive learning systems provide a means to deliver the increased amounts of education needed which it is unlikely will be possible by other means. Section 3.4 discussed the development of more structured continuing professional development to ensure that public funds delivered activity which led to improvements in GDS dentistry. Interactive learning should be part of this planned training and could provide a way to deliver large amounts of training in future with tutors supporting more specialised activity.

3.22 The difficulties of capacity could be solved, in part, by linking with the new NHS University, which will be developing modules in many areas of clinical practice, management, communication and general key skills. There could be an excellent opportunity to pilot further training programmes for the dental team based on this new technology, including teledentistry (Scenario F). In addition the training of PCDs at sites distant from a Dental Hospital could also be considered.

Scenario F

An example of e-based education

Cross infection control updates for the dental team
- e-Based interactive programme aimed at all members of the dental team
- Enable general dental practices to compare their cross infection control procedures with the ideal
- Non-practice based education.

Achieving these goals would require management of a number of issues
- Availability of IT in practices
- Access to NHSnet
- Funds required for NHS University to develop teaching modules.

3.23 Over time, links between educational institutions and local training centres might also provide scope for more firmly based primary care led education; this could help with the integration of dentistry within the NHS as more PCTs see activity in their areas rather than just those which happen to house a dental school.

Development of specialist training

3.24 The specialist practitioner has an important role to play in the provision of dental care in the primary care sector. Currently the training is too similar to that for consultants and a radical review is required. There should be a greater role for specialist practitioners to offer training together with bursaries to offset the loss of income training entails (Scenario G). However, the excellent quality control systems developed by the Colleges should not be overlooked and
a partnership of training organisations should be considered as a way of increasing training courses.

Scenario G

**Specialist Training**

**Aims for Specialist Training**

- *Expand the number of specialist training places*

- *MFDS not necessarily a requirement to enter training, but further discussion required*

- *Exit exam supervised by Royal Colleges under the GDC accord to ensure quality*

- *Specialist practitioners to undertake part of training*

- *Use e-based programmes for knowledge component*

- *NHS University has a role to play.*

**Achieving these goals would require**

- *A radical review of higher training in dentistry*

- *Finance would be required to support training.*

**Conclusion – Recommendations**

4.1 This paper has discussed a range of options, some of which would take some time to implement. Changes are already underway in relation to NHS education and training arrangements; and dentistry needs to be fully part of these. In making recommendations we thought it was important to highlight the fact that some matters could be progressed more quickly than others and that real improvements could be made without all issues progressing at the same time. The recommendations that follow seek to propose ways that education, training and development for the dental team can be improved to help the quality of patient care, and enhance job satisfaction.

4.2 Changes that could be implemented within the next 3 years

- pilot novel ways of training hygienists and therapists at sites distant to Dental Hospitals, in order to increase numbers in the workforce

- pilot training programmes for clinical dental technicians

- ensure the whole dental team, where appropriate, receive continuing education together

- review the training of dental specialists with a view to delivering greater numbers to work in the primary care sector

- increase the proportion of training for dental undergraduates, therapists, hygienists and dental nurses in primary care outreach schemes
● develop continuing education for the dental team utilising interactive e-learning and teledentistry, in collaboration with the NHS University

● dental technology must be given more publicity and commercial laboratories should develop an educational policy to promote training

● structured CPD to deliver educational and clinical priorities

● link clinical audit outputs with local CPD plans

● more flexible selection processes and consideration of use of psychometric tests when recruiting dental undergraduates and Professionals Complementary to Dentistry.

4.3 Changes that would require a longer period of time

● changing the dental undergraduate programme to a modular pattern will require considerable work and consultation

● altering the focus of the dental undergraduate programme by reducing some clinical components and increasing other types of clinical experience will need a working party to assess the impact of such changes

● if clinical outreach teaching forms a greater part of the undergraduate programme, there should be a review of vocational training as presently organised to consider whether outreach training provides the skills currently learnt during the vocational training year

● the development of a two year primary degree in health care sciences would give Universities the opportunity to develop:
  – One year training for hygienists and therapists for a Diploma
  – Three year clinical training for dentists to gain a Masters Degree

● investigate whether new types of professionals complementary to dentistry are required to meet the needs of patients.
Annex A
Terms of reference

1 In line with the principles in the NHS Plan and building on progress in delivering the NHS Dental Pledge, to develop proposals for modernising NHS dentistry. In particular:

- to propose achievable standards for NHS dentistry to meet the needs and wishes of patients
- to propose a range of models for local delivery of NHS dentistry including possible changes to the remuneration system
- to develop proposals for the education, training and development needs of the whole dental team to deliver the above.

2 The work will take account of:

- the views and wishes of patients and the dental team
- the preparatory work by the Dentistry Modernisation Steering Group
- the evidence base for clinical dentistry
- existing and likely future financial resources
- the likely future workforce building on the work of the parallel Dental Workforce Review.

3 The Review will report to Ministers by Spring 2002.
## Annex B
### Membership of working group

*Members were invited as individuals by the Chief Dental Officer*

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
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<td>Dame Margaret Seward (Chairman)</td>
<td>Chief Dental Officer DH</td>
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<td>PCT Chair</td>
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<td>Dr Chris Audrey</td>
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Mr James Murphy  
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Miss Penny Stayte  
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Annex C

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