citizens advice bureau

CAB evidence briefing March 2007

Gaps to fill

CAB evidence on the first year of the NHS dentistry reforms

Summary

Fundamental changes to the delivery of NHS dentistry were introduced in April 2006, aimed at addressing the significant problems which patients have faced over the last 15 years in finding an NHS dentist. Primary Care Trusts (PCTs) in England and Local Health Boards (LHBs) in Wales now have a statutory duty to provide dental services to meet 'all reasonable requirements', and have been given ring-fenced budgets to help them deliver this.

National statistics for the first six months indicate that the reforms have been effective in halting the decline in NHS dentistry. However there is little evidence of any real growth in dental services. Thousands of patients are still unable to get on a dentist's list for routine NHS treatment and access to dentistry is still a postcode lottery. Others face lengthy waiting lists or long and expensive journeys. Patients on low incomes living in rural areas and reliant on public transport are particularly disadvantaged, and patient choice is often non-existent. People are also unclear about the best way to find out about those services which do exist.

One reason for this slow progress is that in 2006/07 the budgets allocated to PCTs/LHBs to implement the reforms were based on the historic spend in their areas. So, where dentistry provision was already under pressure PCT's/LHBs did not receive any additional funding to help them address the shortfall. Therefore PCTs/LHBs' ability to meet their new statutory responsibilities was put at risk.

This report makes recommendations on what more needs to be done to ensure NHS dentistry delivers a genuinely patient-focused service – an objective clearly reflected in the Department of Health's key Public Service Agreement target to improve the patient experience. **In particular, we argue that additional funding must be targeted at areas where gaps in service are worst to ensure that patients have equal and reasonable access to NHS dentistry, regardless of where they live.**

Inside

Key points

- There is still much to be done before all PCTs/LHBs meet their statutory duties to meet 'all reasonable requirements' for NHS dentistry. As one PCT commented to a would-be patient: "having an NHS dentist should be viewed as an aspiration rather than a reality".
- Department of Health statistics indicate that the reforms have not so far increased overall access to dentistry – 56 per cent of the population in England received NHS treatment in the 24 month period prior to September 2006, the same percentage as in the 24 month period to March 2006.
- Thousands of patients remain unable to access NHS dentistry for routine care. Often the only 'choice' is between private treatment, even when this is clearly unaffordable, or going without.
- The postcode lottery is illustrated by an analysis of the NHS Direct website carried out in November 2006. The website showed that in almost a quarter of PCTs 40 per cent of dentists were accepting new charge-paying adults. However, in another quarter of PCTs, none of the dentists were accepting this patient group.
- Some PCTs are seeking to manage demand by setting up waiting lists, but these are often not well publicised and so may underestimate the scale of the problem. Yet PCTs are using the size of their waiting lists as a measure of unmet demand.
- Many patients are unable to manage or afford the lengthy journeys often needed to reach the nearest NHS dentist. Patients on low incomes living in rural areas and reliant on public transport are particularly disadvantaged.
- To meet reasonable requirements, access to NHS dentistry must be available at the local level, as there is no help through the benefits system with travel costs to a dentist.

Introduction

The last decade has seen major reforms across the NHS. The objectives of the reforms, which have been accompanied by significant increases in funding, have included designing services around the needs of patients rather than providers, delivering patient choice, cutting waiting times and moving away from a sickness service towards one where preventative care is given a central role.

Nowhere has the need for such reforms been more clearly demonstrated than in relation to NHS dentistry. Since the early 90's it has become increasingly apparent that the shape of NHS dentistry services has been driven by the choices of practitioners rather than patients, that patient choice has been replaced by a struggle to find any service at all, and that routine preventative care has been abandoned in favour of the need to concentrate scarce resources on emergency treatment and pain relief.

The cost of this failure has been borne by patients themselves who have either been forced to pay for private treatment at significantly greater cost or, for those on low incomes, go without until acute pain qualifies them for emergency services. The hunt for that elusive NHS dentist has led many to their local Citizens Advice Bureau (CAB). Bureaux repeatedly report the anger, frustration and sense of betrayal which clients experience at being excluded from NHS dentistry.

Given the extent of the problem, measures to tackle it have been a long time coming. In 1999 the Prime Minister announced that within two years anyone would be able to see an NHS dentist just by contacting NHS Direct. In fact it took another seven years to finally put in place much needed reforms intended to address the problem. Even then, as this report demonstrates, much remains to be done before NHS dentistry delivers for patients the bold objectives which the Government has set for the wider NHS reform programme.

Background

The root of the problem of access to NHS dentistry dates back 17 years to the 1990 reforms which introduced changes to the way dentists were remunerated, linking this to numbers of patients registered. Dentists then registered far more patients than had been anticipated, resulting in NHS dentistry costs exceeding forecasts and dentists exceeding the recommended pay levels. The Government responded by cutting fees in 1992, which had an immediate and significant effect on dentists' remuneration.

The long term consequences are still felt today. Dentists responded by scaling back their NHS work and expanding private treatment, particularly in more affluent areas where market conditions were more favourable. The effect of this was dramatic, with five years of year on year underspend on NHS dentistry between 1993 and 1998 totalling some £330 million. Adult patient registrations fell from 23 million in 1994 to 17 million in 2003/04 in England, most of which was between 1994 and 1998.[1] In Wales patient registrations fell steadily from 54 per cent of the population in 1997 to 47.7 per cent in 2006.[2]

The impact on patients has been profound. No longer could people choose between several local dentists on the assumption that virtually every practice would offer NHS dentistry. Instead, many patients already registered were suddenly told that their dentist would no longer be providing NHS treatment, and anyone moving to a new area or seeking NHS treatment for the first time was likely to find lists closed. Bureaux regularly reported that for many people, the only 'choice' available was between going private or going without.

Between 1990 and 2004, NHS spending on General Dental Services increased by only 9 per cent per capita, compared with a 75 per cent increase in overall NHS spending. Since then the situation has improved, with gross investment increasing by about a third, much of it targeted where access was poorest, and the equivalent of 1000 additional whole time dentists were recruited by October 2005. However the fundamental problem was always the nature of the relationship between dentists and the NHS, which in effect meant that the dental profession were in a position to determine where and to what extent NHS dentistry would be delivered.

2006 reforms

This issue was finally addressed in the Health and Social Care Act 2003 which introduced what Ministers have described as the largest reforms to NHS dentistry since its inception.[3] Citizens Advice has very much welcomed these reforms which, for the first time, give every Primary Care Trust (PCT) in England and Local Health Board (LHB) in Wales, a duty to 'to the extent that it considers it necessary to meet all reasonable requirements, exercise its powers so as to provide primary dental services within its area, or secure their provision within its area'.[4]

Given the urgency of the problem from the patient's perspective, implementation of these reforms was a long time coming. The start date of April 2005 was first put back to October 2005 and then postponed again as protracted negotiations continued between the Department of Health and the dental profession.

The reforms finally came into effect on 1 April 2006. Under the reforms, patients pay one of three standard patient charges as set out in Table 1.

1 National Audit Office, Reforming NHS dentistry: ensuring effective management of risks, November 2004
2 Hansard, Welsh Assembly WA, 22 Feb 2007
3 Department of Health press notice, 30 March 2006, New era begins for NHS dentistry
4 Health and Social Care Act, 2003, s 170

Table 1: Bands and charges (2006/07 rates)			
	Treatment includes	**England**	**Wales**
Band 1	Examinations, x-rays, scale and polish	£15.50	£12
Band 2	Treatment covered by Band 1, plus additional treatment such as fillings, root canal treatment or extractions	£42.40	£39
Band 3	All Band 1 and 2 treatment, plus more complex procedures such as crowns, dentures and bridges	£189	£177

Dentists are contracted to deliver an agreed number of Units of Dental Activity (UDAs) over the year. The value of these UDAs relates to the three patient charge Bands, so a Band 1 course of treatment generates one UDA, a Band 2 treatment three UDAs and a Band 3 treatment 12 UDAs.

In order to deliver this new duty budgets, ring-fenced for three years, have been devolved to every PCT/LHB. This has meant that where a dentist decided to reduce their NHS work, the PCT/LHB has been able to act strategically to reinvest the funds in areas where the need is greatest. As a result, the first year of the reforms have seen many new practices opening across the country. The extent of the local press coverage given to these events demonstrates just how much these new services are valued by the local community. A further indication of progress is that the Department of Health have told Citizens Advice that they have seen a 65 per cent reduction in the level of correspondence on access to NHS dentistry problems between July and December 2006.

However the size of the 2006/07 budgets allocated to PCTs/LHBs was linked to the historic spend in their area, rather than taking into account the existing postcode lottery in access to dentistry across the country (although the Welsh Assembly Government did target 10 per cent of the additional 2006/07 funding on those LHBs with greatest access difficulties). It was therefore always questionable how PCTs/ LHBs in areas with historically poor access would be able to fulfil their new duties to meet 'all reasonable requirements' for access to NHS dentistry without additional pump priming resources. Yet ironically it was precisely to address the problems of poor access that the reforms were introduced in the first place and it was in these areas that patient expectations of the reforms were likely to be greatest.

Early statistics released from the Department of Health relating to England only, indicate that the more modest aim of the April 2006 reforms to stem the flow away from NHS dentistry has been achieved. Following some early 'churn' where dentists delivering some 4 per cent of NHS services did not sign the new contract, PCTs have been able to recommission those services so that in the two years ending September 2006, around 28.1 million patients in England – 56 per cent of the population – were able to access NHS dentistry, the same percentage as in the two years prior to March 2006.[5] However there is no evidence of any noticeable progress towards meeting the needs of the two million people in England which the Department of Health has estimated would like to access NHS dentistry but are unable to do so.[6] (There has

5 NHS dental statistics for England, Quarter 2, September 2006, The Information Centre
6 Hansard, House of Lords, 27 April 2006, col 44 .

been no comparative estimate published for Wales.)

Moreover, the situation has not been uniform across the country: in the two Strategic Health Authorities with the lowest percentage of patients treated (South East Coast and South Central) the percentage actually fell between these two periods. This is further evidence that the reforms are not yet sufficiently targeted on areas in greatest need.

The picture in Wales is broadly similar, with 55 per cent of the population having received treatment in the two years ending September 2006. This figure varies significantly at LHB level – from over 70 per cent in Swansea to just 30 per cent in Pembrokeshire. Overall there was a 1 per cent drop in the number of patients treated as compared with March 2006, suggesting again that at best the reforms are delivering 'steady state'.[7]

The CAB network, with over 3,000 local outlets across England and Wales including over 1,000 in healthcare settings, is well placed to identify any *problems* which patients experience with the dentistry reforms. Between April and September 2006 Citizens Advice Bureaux dealt with around 3,500 enquiries relating to NHS dentistry, of which 35 per cent related to access problems.

This report is based on the reports and local surveys which bureaux submitted as a result of these enquiries, along with the results of an on-line survey on problems with access to dentistry which Citizens Advice included on its public information website (www.adviceguide.org.uk) between May and October 2006, to which 4,705 people responded. In addition, information was sought from PCTs where access problems are worst, in order to assess their capacity to deliver on their new duties, and an analysis was undertaken of the access information published on the NHS Direct website.

The report is structured around the main issues for patients arising out of the implementation of the reforms. These are:

- the adequacy of information about what is available
- the adequacy of NHS dentistry provision at the local level
- what patients do when they fail to find an NHS dentist and
- how PCTs/LHBs are assessing unmet demand and monitoring dentists' compliance with the new contract.

On the basis of this evidence, the report makes recommendations for what more needs to be done to build on existing progress and to ensure that NHS dentistry delivers a genuinely patient-focused service which achieves the Government's wider ambitions for NHS reform.

Looking for an NHS dentist – information gaps

A brief study of the dental pages of the NHS Direct website for England demonstrates the postcode lottery which exists for NHS dentistry. Set up in order to help people find a local NHS dentist, the website lists for every PCT details of dentists contracted to provide NHS services. For each one, the colours red and green are used to indicate whether those dentists are currently taking on new patients.

In November 2006, Citizens Advice analysed the website for all 152 PCTs to compare levels of access to NHS dentistry across the country for charge-paying adults. (We were unable to do a comparable analysis for Wales because the NHS Direct website is structured differently there.)

This patient group was selected as being the category for which access was poorest. We accept that the website may not provide the full picture, as in some hard pressed areas the

7 NHS dental statistics, Wales July-September 2006, issued by Statistical Directorate, National Assembly for Wales, November 2006.

situation changes from day to day, and in others the information is simply incorrect. However this is the most publicly accessible way of assessing access to dentistry and indeed is the approach which the Department of Health recommends patients use.

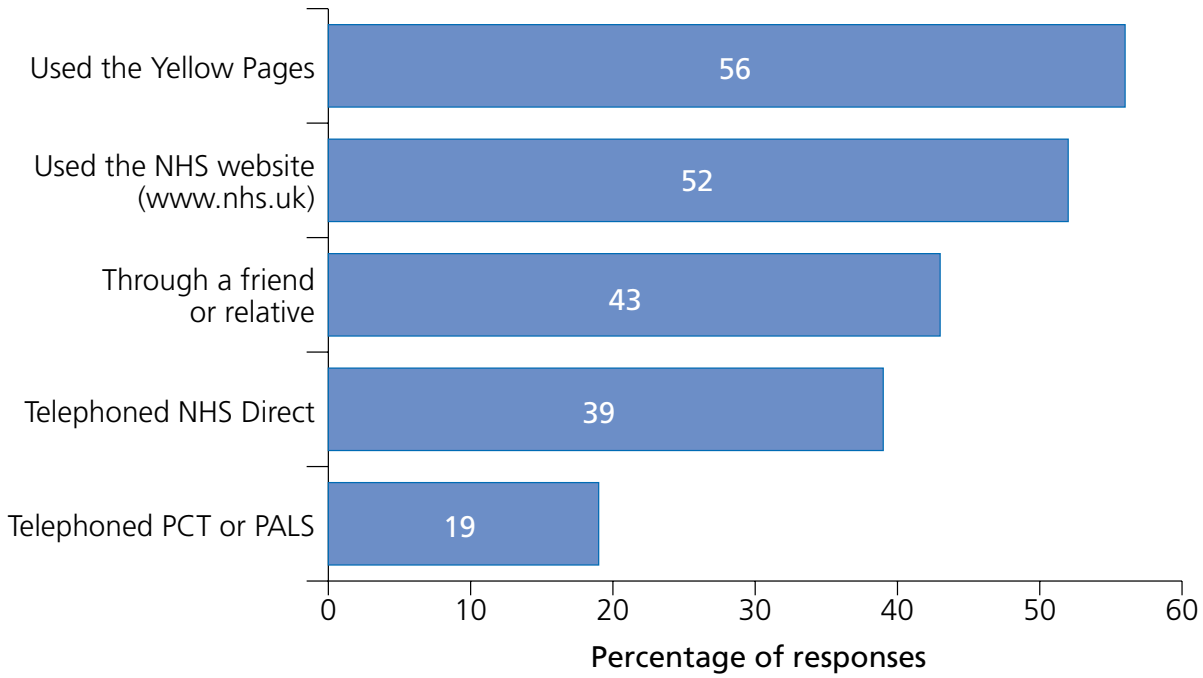
Our analysis revealed huge differences between PCTs (see Appendix). In 22 per cent of PCTs at least four in ten contracted dentists were accepting new adult charge-paying patients. However the website showed that in 26 per cent of PCTs there were *no* dentists currently accepting this group of patient. This raises the question as to whether these PCTs were in fact meeting their new statutory duty to provide reasonable access to NHS dentistry. As one survey respondent in West Yorkshire commented:

> "When I complained to my local trust they told me that having an NHS dentist should be viewed as an aspiration rather than a reality."

Particularly in these areas of poor access, having an effective searching strategy is key. In the past, many people would have relied on recommendations from friends or relatives, or used the telephone directory on the assumption that most dentists would provide NHS treatment. But in many areas this is no longer likely to be effective. The Department of Health recommends that people searching for an NHS dentist should either contact their PCT or use NHS Direct, either by phone or by using the website. However these are relatively new search strategies, and the CAB on-line survey of people who had had problems finding a dentist suggests they are not yet well used: as Table 2 shows, only 19 per cent had contacted their PCT or their Patient Advice and Liaison Service (PALS). Moreover, even amongst these self evidently 'internet friendly' respondents, only 52 per cent had used the NHS Direct website.

The most frequent response (56 per cent) was using the Yellow Pages phone book, a method unlikely to be successful, and nearly half were

Table 2: How did you go about trying to find an NHS dentist?



(Based on 3,763 responses. Percentages do not add up to 100% as respondents were able to select more than one option.)

continuing to rely on friends and relatives. This suggests that much more must be done to promote the role of PCTs and NHS Direct in finding a dentist.

But this is not the full story. In the areas with greatest access problems the NHS Direct website is often of least use and can even be misleading. We contacted the 40 PCTs which our analysis of the website had suggested had no access for new charge paying adults. We found that in some areas, if patients got as far as using the dental enquiry line, it was possible to be matched up to a dentist as vacancies became available. Other PCTs were operating a central waiting list. In other words a locally managed system was replacing the national 'self service' approach for which the NHS Direct website was designed. As one PCT explained:

> "I would like to point out that our website doesn't indicate that any dentist is taking on new patients because we operate a central waiting list system that tries to ensure fair and equitable access to routine NHS dental care."

Operating a waiting list clearly has the potential to be a fairer system, and one which also avoids the negative publicity which has been associated with reports of people queuing round the block when a new NHS dentist opens in a local town. However it does not support policy objectives to promote patient choice.

Creating and managing a waiting list also raises a new set of challenges for PCTs. In particular, it is crucial that the waiting list itself is well promoted so that everyone, especially those in 'hard to reach' groups, knows of its existence and how to join.

> One CAB in the West Midlands reported a client who had been without a dentist for five years. During that period he had had one check up at the Dental Access Centre. However despite this contact, he was unaware of the fact that the PCT was holding a central waiting list.

> A CAB in Hampshire helped a traveller in pain to access emergency dental treatment. In the process they also tried to help him register on the waiting list. However he could not complete the process because he did not have a telephone which was a condition required for registering on the list.

The experience of the following young man also demonstrates the confusion which can result when patients are not aware of the local access route:

> A CAB in Cheshire reported a young man in part time work, who had 'fallen off' his dentist's list because he had not attended for over a year. He rang the practice because he was suffering acute toothache but was informed that they no longer saw ex-patients, even in an emergency. Another dentist refused to see him on the NHS but offered private treatment at £75 for a half hour appointment, which the client declined. After making numerous calls to other dentists, the client eventually rang the PCT, which resulted in an appointment being made for the following day. To his surprise he was treated on the NHS by the dentist who the previous day would only see him privately.

Where local waiting lists are in operation, the NHS Direct website is not helpful. Although it includes details of PCT helplines for people having difficulties in finding a dentist, there is no information provided as to whether or not a waiting list is in operation and if so how to join it. In practice, the route onto the waiting list is usually via the PCT helpline, but that crucial piece of information is not given, and many website users, confronted with a screen of dentists with closed lists, will simply assume that there is no local access and will not use the helpline.

Other promotion strategies are essential to reach people not using NHS Direct. Responses from the PCTs we contacted in areas of poor access who were operating waiting lists, revealed that some were taking a more pro-active approach than others. Strategies ranged from a one-off advertisement in the local press, to the production and distribution of posters to local GPs, pharmacies, libraries and bureaux. Only one of the 40 PCTs had done a mass mailing to households telling them how to access local NHS dental services.

Managing waiting lists also requires systems to keep patients informed of their progress and estimate their likely waits. Several survey respondents commented that they were on a waiting list but had no idea how long they might have to wait. As one CAB in Dorset commented regarding a pensioner whose dentures needed attention:

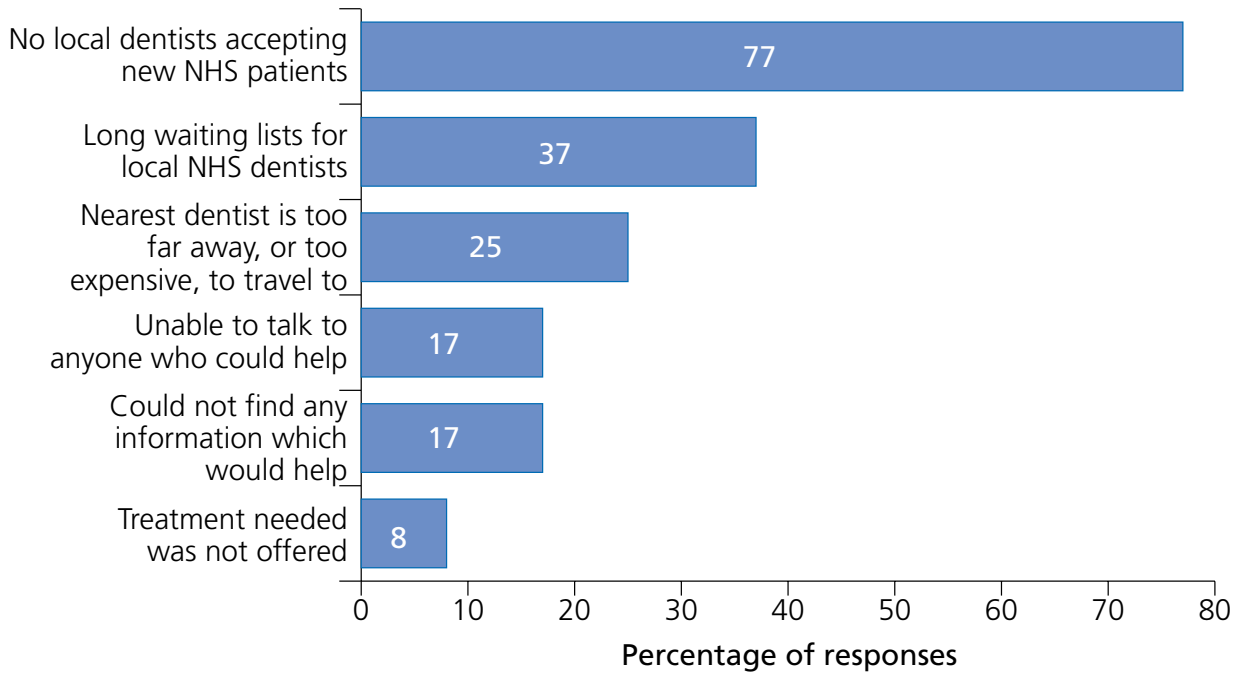
> "Our local PCT has made assurances through the local press that they are working on the problem and that they have created a waiting list so that as soon as places become available they will contact clients. But this does not seem to work in practice…our client's problem was not an emergency but she certainly wanted to know a timescale in which she could expect to be sorted out."

Other respondents commented on the difficulty in getting through on the telephone or finding anyone able to provide up to date information on likely waits.

Failing to find an NHS dentist

The CAB online survey respondents were asked why they had been unable to find an NHS dentist. Table 3 outlines their replies.

Table 3: Why couldn't you find a suitable NHS dentist?



(Based on 3189 responses. Percentages do not add up to 100% as respondents were able to select more than one option)

A local service?

It is clear from this Table that the most significant problem is the lack of a local service in many parts of England and Wales. When asked why they could not find a suitable dentist, over three quarters of respondents cited "there are no local dentists accepting new NHS patients". In addition, a quarter of respondents said that the nearest NHS dentist was too far away or too expensive to travel to.

This is by no means exclusively a problem facing people living in rural areas. However in England the number of dentists per thousand of the population is lower in rural than in urban areas: 4.5 dentists per 10,000 of the population compared to 5.4 per 10,000[8], and a 2004 survey of rural services in Wales showed that only 16 per cent of communities had access to a dentist.[9] In 2006, the Commission for Rural Communities produced for the first time a Rural Services Standard (RSS) for England. This "calls for local standards of service and for these to cover the quality of services as well as access for rural people".[10] It does not however contain any specific standards for accessing local NHS dentistry. Similarly the Welsh Assembly Government is currently working towards a practical benchmark for a rural services standard but it is unclear whether NHS dentistry will be included.

Comments from the survey respondents reveal the distances that some people are travelling:

> "Travelled to old dentist 70 miles away (ie where they used to live)."
> (survey respondent, East Riding of Yorkshire)

> "Went to an NHS dentist in Birmingham 50 miles away."
> (survey respondent, Gloucestershire)

Even those willing to travel that extra distance may still not be able to find an NHS dentist. One respondent from Lancashire commented that dentists were not accepting patients from outside areas. Another respondent from Devon stated,

> "Some dentists over 40 miles away would not take me on because I did not live locally even though they were accepting NHS patients."

Access to a car is a major factor in enabling people to choose more distant locations.

> "I have to travel an hour by car to get [to the dentist]. Without a car I wouldn't have a hope in hell of seeing a dentist."
> (survey respondent, Hampshire)

Yet car availability is strongly related to income, with those in the lowest income groups having the least access. In 2005, 53 per cent of households in the lowest income quintile had no car compared with 10 per cent in the highest income quintile.[11] For those who do not have access to a car, the difficulty of finding an NHS dentist is compounded by the problem of finding one they can access by suitable public transport.

> For one survey respondent in Cheshire, the nearest dentist was just 14 miles away. A car journey would take about 25 minutes but the journey by public transport would take far longer. There were no rail services and only a few bus services each day. One option involved leaving at 7.40 am and another involved three changes and took four hours including a wait of an hour.

> A CAB in Nottinghamshire reported a woman who needed to see a dentist when she lost a filling. NHS Direct had suggested a dentist in Mansfield, involving two bus journeys taking two hours in total. Buses ran infrequently so

8 Hansard, HoC, col 2286W, 13 September 2006.
9 Wales Rural Observatory (2004). Based on Town and Community Councils in rural areas
10 Fifth annual monitoring report on the Rural Services Standard, Commission for Rural Communities, December 2006
11 National travel survey, 2005. Department for Transport

the client would have had to wait some time before coming back. The train would have taken over an hour and involved a change as well as walks of about 30 minutes at each end.

Often the consequences of making such lengthy journeys are disproportionate; bureaux reported clients having to take a whole day off work, or removing their children from school for all or part of the day:

A CAB in South Wales saw a mother on a low income who had three children. She was unable to find a dentist near to where she lived and had to travel 13 miles each way. In the previous month the client had had to travel to three separate appointments, a total of 78 miles. She had also missed two appointments for her youngest child because she didn't have a car and would have missed picking up her other two children from school. Her child lost a tooth as a result.

The same bureau saw another woman with three young children, who was dependant on benefits. She had to travel 24 miles to reach the nearest dentist. She did not have a child minder so each time one child needed to visit the dentist, she had to take all of them, and because she did not drive she had to take public transport and pay fares for all the family. She had to travel twice in one month because she did not have appointments on the same day.

"I live in Wadebridge. The nearest (NHS) dentists are Camelford or Truro, both of which are too far away to reach, involving a whole day away and taking my six-year-old daughter out of school for the whole day just to get her to a dentist."
(survey respondent, Cornwall)

For others, public transport may be unsuitable because they have health or mobility problems or have small children.

"My son is 11 months and has seven teeth. I have been advised to take him to a dentist, and I still cannot find one close to us as I can only use public transport and with a buggy I can't get very far."
(survey respondent, Greater Manchester)

A CAB in Suffolk reported a client with mental health problems including severe anxiety. Her total income was £62.45 per week. The nearest dentist accepting charge exempt NHS patients was nearly 20 miles away and there was only limited public transport. The trains only ran every two hours, took 40 minutes, cost £5-£6.00 and included a change. The bus journey would have also included a change and took 40 minutes each way, costing about the same as the train. A local volunteer car organisation quoted a £25 return fare for the journey. The client was very worried about going all that way and was not happy to travel by herself. The adviser stated that client would find it very difficult to get to the dentist, both emotionally and financially.

Public transport can be very expensive, even for short journeys. For many clients on a low income this may prove prohibitive. A CAB adviser in Lancashire stated that as the majority of their clients were on a low income, they would probably choose to go without treatment.

"I am a mother of three on income support, we were very happy with our dentist but then with the new NHS changes the practice became private, so we had to find a dentist that was NHS to still get free treatment. The nearest one we could find was in the next town and

the last time we went it cost me £18 in bus fares! That was just another slap in the face for the 'poor'."
(survey respondent, Kent)

A Surrey CAB saw a client who could not find a dentist for herself or her children. There were no dentists within six and a half miles. The bus cost £5.70 for herself and £3.70 for each of her children, and took over 45 minutes each way. The train cost £5.00 for herself and £3.10 for each of her children and they would then need to take a further bus to reach the dentist.

There is currently no specific help available with the costs of travel to a dentist. The means-tested hospital travel costs scheme (HTCS) does not include help with travel to primary care services such as dentists, presumably on the assumption that people will not need to make lengthy journeys to reach these services because they are available in the local community. Regrettably though, as this report has shown, this is not the case for NHS dentistry. In 2005, Citizens Advice wrote to the Health Minister Rosie Winterton to suggest that, at least as a temporary measure, the HTCS should be extended to cover journeys to dentists. Her response was that "Any monies spent on such schemes…would reduce funds available locally to expand the service in the way that is needed. Our plans to significantly increase the number of dentists available… will reduce the need for excessive travel in a sustainable and long term-way."

We strongly agree with the sentiment behind this response – it is very clear from CAB evidence that what people want is a *local* service so that the cost and inconvenience of lengthy journeys is avoided. However it is equally clear that, two years on, despite the Government achieving its aim to recruit 1000 extra dentists in 2005, this objective has not yet been met. There therefore remains a strong case for some help with travel costs to access dentistry, at least on a temporary basis, to ensure that people on low incomes are not disadvantaged.

It is also vital that PCTs/LHBs consider travel issues when deciding where to locate new services, but some bureaux have reported that transport factors often do not appear to rank highly in PCT/LHB priorities.

For some people in rural areas, the choice of either a tortuous and costly journey by public transport, or expensive private treatment is, in reality, no choice at all. To meet reasonable requirements, access to dentistry must be available at the local level.

"There was no dentist closer than a 50 minute car/train ride. I now have to pay £80 for [a private] check-up and hygienist every 6 months. I only earn an average wage and this is a huge cost."
(survey respondent, Hampshire)

An elderly widowed client visited a CAB in Hampshire because her dentures needed attention but her dentist, who did not sign the new NHS contract, would only treat her privately. He had quoted £500 for the work. Her only income was a state retirement pension and pension credit. The nearest dentist was 11 miles away. The client did not have a car, and the journey by public transport was particularly difficult.

Waiting lists

Thirty seven per cent of survey respondents referred to long waiting lists for access to a local dentist. As outlined above, PCTs have increasingly been setting up waiting lists in an attempt to manage the mismatch between demand and supply. It is however ironic that this is taking place at a time when in other parts of the NHS there are clear targets to cut waiting times – to 48 hours for access to a GP and 18 weeks from GP referral to hospital treatment.

Replies from PCTs with central waiting lists showed that patients on lists could expect to wait anywhere between three months and two years before being allocated to a dentist. Even then, some patients could face further waits before getting an appointment. Similar waits were reported at the level of individual surgeries in areas where there was no central waiting list:

> A CAB in Hampshire reported a single woman who was pregnant and in receipt of income support. She could not find an NHS dentist and was faced with having to pay an unaffordable sum of £1,420 for private treatment. The bureau contacted a local NHS dentist who said they had a six month waiting list of 500 patients. The bureau resorted to contacting a charity for help with the costs of private treatment.

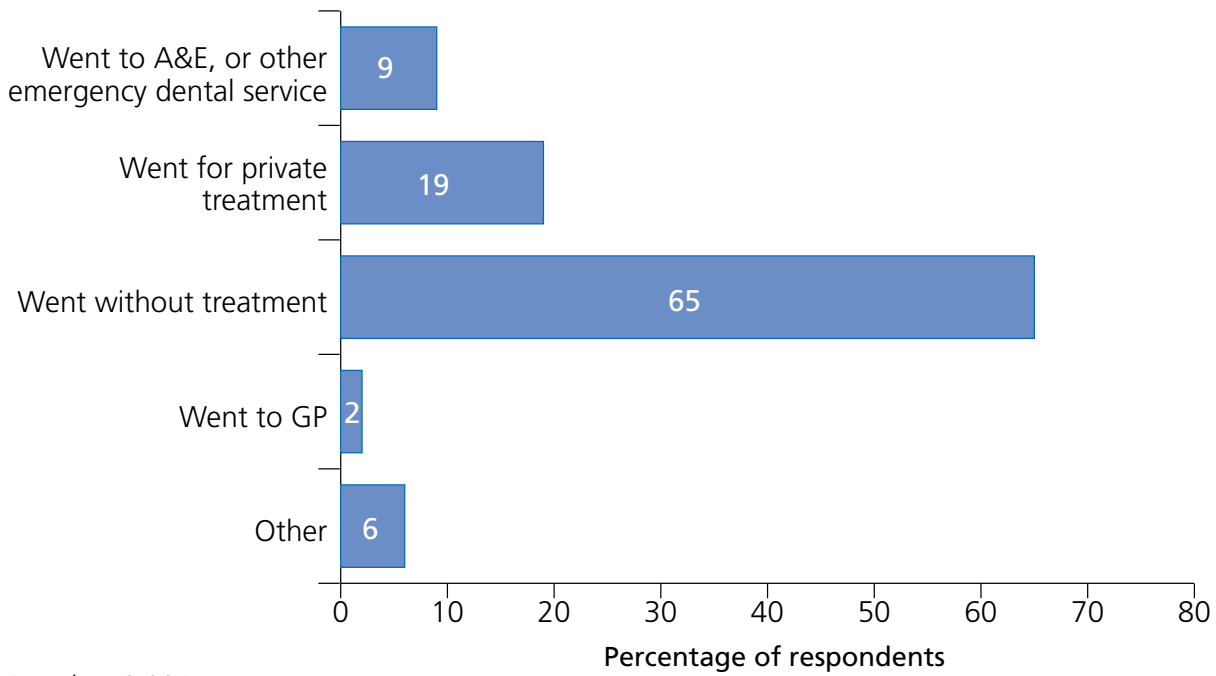
Consequences for patients

Survey respondents who were unable to find a suitable dentist were asked what they did as a result. Table 4 outlines their replies.

Emergency treatment

Emergency dental services are generally available, for example through Dental Access Centres, even in areas where access to routine treatment is poor. Nine per cent of survey respondents unable to find a dentist for routine treatment ended up using A&E or other emergency dental services when a crisis arose. However the scope of this help is often restricted. Patients may find that their problem does not meet the locally applied definition of an emergency, even though they are in pain. They may have to wait until their problem is acute before they can be seen – precisely the opposite to the preventative approach to healthcare which the Government is keen to foster. In addition, the treatment provided

Table 4: What did you do as a result?



Based on 3,094 responses

may not deal with the underlying problem. Where there is easy access to routine follow up treatment this would not be a problem, but where emergency treatment is all that is available, it is far from satisfactory.

> A CAB in Lancashire reported a client who had been suffering from toothache for two months. She had been repeatedly contacting NHS Direct who were unable to help her find a local dentist or refer her to emergency treatment as her pain did not count as an emergency.
>
> A CAB in Devon reported a client who had a front tooth knocked out. The emergency dental hospital cleaned it up but he faced a long wait for NHS treatment for a replacement tooth. Unemployed and job hunting, he was finding it embarrassing going for job interviews with a missing front tooth.
>
> The same CAB reported another client with severe toothache. He attended the emergency service which provided temporary treatment, however his underlying problems remained and he was unable to eat properly.

In some cases patients have felt forced into private treatment as a consequence, even when this was unaffordable.

> A CAB in Gloucestershire reported a client with long term sickness problems who was treated for an abscess caused by ill-fitting dentures as an emergency at the Dental Access Centre. She needed replacement dentures to prevent the problem recurring but these could not be provided as it did not count as emergency treatment. When her doctor told her she should get her dentures replaced she borrowed money from her family to meet the cost of private treatment.
>
> "In July my partner's toothache was so bad he called NHS Direct, only to be told that because his jaw was not swollen enough to restrict his speech, they couldn't offer emergency treatment… (Later) it got to the point where he was taking time off university so we phoned NHS Direct again. This time he got an emergency appointment but the dentist just gave him antibiotics and told him to find an NHS dentist. The pain in his teeth was so incredible that he has gone to a private dentist…The total cost of the treatment will be £831 for which we have just taken out a loan that we cannot afford."
> (survey respondent, West Yorkshire)

Going private

Many patients have felt forced to accept private treatment even when this is not what they wanted or indeed could afford. This was the case for 18 per cent of survey respondents. Many bureaux have reported similar cases.

> A CAB in Wales reported a client in her 80s and on a limited income who had had dentures for 35 years and needed replacements. As she was unable to find an NHS dentist she sought private treatment. She was very distressed that the bill came to £642.
>
> A CAB in Hampshire reported a client whose only income was his state pension, who had received private treatment at a cost of £397 after five attempts to find an NHS dentist. He faced financial and personal stress as a result and wanted to know if he could be reimbursed.
>
> Bishops Waltham CAB asked people visiting the bureau to complete a questionnaire on the issue after the bureau had failed to convince the PCT of the need for more dental provision in the

Meon Valley area. Of the 230 people who responded, 32 per cent had a NHS dentist, 58 per cent had a private dentist and the rest had no regular dentist. Only 10 per cent of those with a private dentist said this was their preferred option. Eighty seven per cent of all the respondents said that they would choose to move to a local NHS dental practice if one opened in their area. Interestingly, the survey also showed that on average, NHS patients were travelling twice as far as private patients to reach their dentist.

Often people have reluctantly agreed to go private when their dentist decided to withdraw from NHS work. In these circumstances there is no requirement for the local PCT/LHB to provide patients with information and support in finding an alternative NHS dentist. As a result, the fear of being left without any dentist can make patients an easy target. Yet often the regular payments required are not affordable and create a serious strain on limited budgets.

A CAB in Devon reported a client on income support who suffers from multiple sclerosis. She was unable to find a local NHS dentist and therefore used a private practice as she has difficulty travelling far. However she fell behind with her payment for treatment, and is now faced with a county court claim for £428 plus costs.

A CAB in Northumberland reported a client in her 70s in receipt of means tested benefits who signed up for Denplan with her local dentist because she was afraid that otherwise she would be unable to get treatment when needed. She pays £10.50 per month which covers two check ups a year; however she will have to pay extra if she needs other treatment – e.g. £40 for a filling. She is constantly worried about making ends meet, cannot afford holidays and has to be careful buying food.

A CAB in Cheshire reported a client in his 90s who was told that he could only continue to see his dentist on a private basis if he paid a minimum of £132 per year. He could not find an alternative NHS dentist in the area.

Going without

As a result of their failure to find a suitable NHS dentist, by far the most common outcome, reported by 64 per cent of survey respondents, was that they simply went without regular check ups or treatment. Many were angry and bitter at being let down by the system, and for others the knock on effects were significant.

"I am currently on maternity leave and should be in receipt of free dental treatment…However this is a complete waste of time as no NHS dentist will take me on. In addition to this, like too many unfortunate people to mention, I am unable to pay for private treatment…Finally as a result of this I was forced to give up breast feeding my baby due to having to constantly fill myself with strong pain killers to rid myself of the agonising pain. This in itself has been extremely annoying and upsetting. At the end of the day my child has also had to suffer."
(survey respondent, Lancashire)

A CAB in Buckinghamshire reported a woman who had had surgery for cancer and was due to start chemotherapy. However she was told she must have some dental work done first. She and her husband are struggling on a low income with a mortgage and with outgoings exceeding their income. She was unable to find an NHS dentist and could not afford private fees.

Clearly from the patients' perspective there remains much to be done before the goal of reasonable access is achieved across England and Wales.

The role of PCTs/LHBs – commissioning and compliance

For PCTs/LHBs, implementing the NHS dentistry reforms from April 2006 has presented a significant challenge. Firstly, in England the timing was hardly auspicious as many were facing the upheaval of reconfiguration only six months later, as the 303 PCTs were reduced to 152. Inevitably this will have meant changes in staff and structures, created budget uncertainties and made the development of long term strategies more difficult. The reforms to patient charges created further uncertainties as budgets have had to be set on assumptions about the relative proportion of charge paying and exempt patients treated under the new contracts.

In addition, PCTs/ LHBs in areas of poor access were faced with the duty to provide reasonable access to NHS dentistry from April 2006 with a budget based on their historic spend.

Within this context PCTs/ LHBs have had to take on the commissioning of general dental services as well as responsibility for monitoring dentists' compliance with the new contract. The latter includes a number of changes aimed at ensuring a more patient centred approach to delivery.

Commissioning

A number of bureaux have contacted their local PCTs/LHBs to find out what plans are being made to address access issues, and to feed in their local evidence of the problem. In addition as outlined above, Citizens Advice sent out a brief questionnaire to 40 of the PCTs which appeared from the NHS Direct England website to have poorest access (defined as no access for new charge paying adult patients). The questionnaire asked how unmet demand was being measured, what plans there were to meet this demand, and what help was currently available to people seeking NHS dentistry. Thirty nine PCTs responded, and from their responses it was clear that many PCTs have used the opportunity created by the withdrawal of some dentists from the NHS, to reallocate resources to areas of greatest need.

There was little evidence however that the net result had been a significant increase in overall access to NHS dentistry. Indeed several PCTs appeared to be interpreting their responsibilities simply in terms of recommissioning the provision lost from dentists who declined to accept the new contract, and spending their allocated, ring fenced budget, rather than in developing broader strategies to meet their new statutory duty to provide reasonable access. Thus one PCT replied that it had some 30,000 patients on its waiting list to whom it did not expect to allocate dentists before the end of 2007. It also commented that whilst it was aware it was "an area of high need," it currently had no specific plans for further expansion. Another replied to a question asking how it was meeting its statutory responsibility by commenting simply that the recommissioning "action that the PCT has taken will ensure that the ring-fenced dental allocation is fully spent on providing an equitable access for local residents". Only two of the PCTs we contacted in areas of poor access clearly indicated that they had spent any funds on top of their ring-fenced budget in order to improve access.

This is perhaps not surprising given the financial pressures and competing demands under which PCTs are operating. **However it does strongly suggest that without additional ring fenced funds directed specifically at those areas with poorest access, the potential of the NHS dentistry reforms to resolve access problems will**

not be achieved. It is also important to ensure that PCTs facing budget deficits do not raid their ring- fenced dentistry budgets to resolve wider financial problems.

Another cause for concern is that many of the PCTs we contacted in the poor access areas appeared to be relying heavily on calls to their helplines or PALS, and/or the numbers of people on their waiting lists, in order to assess unmet demand. Yet our survey shows that only 19 per cent of respondents, all of whom had had difficulty in finding a dentist, had actually contacted their PCT or PALS, which is usually the route onto any waiting list. If patients looking for a dentist do not know about these sources of help and therefore do not use them, then this data inevitably underestimates the scale of unmet demand. We believe this goes a long way to explain why, in some areas, there appears to be a sharp contrast between the view of the PCT and the evidence from patients as to whether it is indeed meeting 'all reasonable requirements' for NHS dentistry, as the legislation demands. A better estimate of demand is probably the Healthcare Commission's most recent survey of patients in primary care which found that 69 per cent of those not registered with an NHS dentist said they would like to be (up from 67 per cent in their 2004 survey.)[12]

Only one of the 39 PCTs in poor access areas which responded to our questionnaire, mentioned that they were considering undertaking a local patient survey in order to more accurately assess local demand for NHS dentistry, although several were undertaking oral health needs assessments. Additionally very few appeared to be consulting with local patient bodies such as Patient and Public Involvement Forums or local authority overview and scrutiny committees, or indeed with local advice agencies such as bureaux, in order to fully assess unmet demand.

Compliance

As commissioning bodies, it is also PCTs'/LHBs' responsibility to ensure that dentists comply with their contract in delivering their services. The new contract includes a number of provisions intended to address some long standing concerns and ensure that NHS dentistry delivers a more patient-centred service.

For example before 2006, a common source of complaint was that patients were given private treatment when they thought they were being treated under the NHS. The fact that dentists are able to provide a mix of NHS and private care in the same course of treatment means that such confusion is always a possibility unless very clear procedures are in place. Under the 2006 reforms, the patient charging system has been dramatically simplified, so that patients now pay one of three standard charges for a course of treatment. In addition, dentists are required under their contract to display in the waiting area a poster detailing these three charge bands. Several bureaux have however reported instances where this poster was not displayed. In some cases patients were unable to successfully challenge incorrect charging as a result:

> A CAB in Sussex reported the case of a client in his 70s who came to the bureau because he thought he had been overcharged. However when he had queried it with the receptionist, he had simply been told that that was what he had to pay. He had had a check up and a small filling which then caused him problems. The dentist said he could have a crown which would be at least £200 or have the tooth out. He chose the latter which he assumed would cost £42.40, but ended up paying £42.40 twice, plus £15 for an x-ray.

12 Healthcare Commission, State of Healthcare 2006

A CAB in the West Midlands reported a client who had to have extensive treatment including five extractions plus dentures, x-rays and fillings. The total cost was agreed at £189 and the client started on some of the treatment. He has now been to see another of the dentists in the same practice who says he wants another £189 to cap some of the damaged teeth and to complete the dentures.

A CAB in Merseyside reported an unemployed client on income support who had to have emergency treatment. She paid £65 for the treatment but was told that it was done under the NHS and that she could claim the money back by picking up a form from the Jobcentre. When she tried to do this she was told that this was not the case.

Another key change is that dentists are no longer allowed to set conditions for accepting patients – for example they should not refuse to accept patients with poor oral health or make the acceptance of a child as a patient conditional on the parent registering for private treatment. These practices are inconsistent with the fundamental principles of the NHS. Again there is evidence that not all dentists are complying with this condition as the following examples demonstrate.

"I am extremely upset that when my dentist wrote to me in March advising that he was 'going private', the letter stated that unless we paid the Denplan fee of £20 per month for me and my husband, the practice would not treat my young sons aged three and four. Because we are on a tight budget we are too poor to afford £20 per month."
(survey respondent, West Sussex)

"Was told (they) would only accept my daughter as an NHS patient if I went as a private patient. As I am registered disabled and on full benefits I cannot afford this."
(survey respondent, Leicestershire)

"My dentist will give my son a free check up if I make a private appointment so I feel I have no option…"
(survey respondent, Merseyside)

"I went to an NHS dentist and paid for a check up and she said you have so much work to do we will not do it on the NHS…"
(survey respondent, Surrey)

"There is one remaining NHS dentist locally but you must first have any treatment done privately with them and be 'stable' before you can become an NHS patient"
(survey respondent, London)

A CAB in Oxfordshire reported a client who has had long term mental health problems which have resulted in years of neglect of her teeth. Her health is now improving and she has made efforts to overcome her self neglect. She approached two NHS dentists for treatment but both refused to accept her because of the amount of work required. She therefore took out a loan for private treatment which she is now facing difficulty in repaying.

Other conditions such as the requirement to deliver all treatment necessary to secure and maintain oral health were always part of the NHS contract, although were not always delivered in practice. Again there is evidence that these conditions are still not always being met under the new contract.

A CAB in Lincolnshire reported a client in his 70s and in receipt of pension credit who had all his teeth removed by his dentist under the NHS. However the dentist has now informed him that they will not provide him with dentures on the NHS. He is left unable to eat properly and as he is on a low income he is not in a position to pay for private treatment.

A CAB in Warwickshire reported a client whose 55 year old daughter is disabled with hemiplegia and epilepsy. She fell and broke two front teeth. Her dentist was unable to save the teeth and prescribed a fixed bridge because a removable denture is a choking hazard for an epileptic. However he did not give her the choice of having the work done under the NHS, at no cost, but instead did the work privately, charging £2,400.

A CAB in Essex reported a client who needed an essential crown. The dentist refused to do this work under the NHS at a patient charge of £189, and insisted on doing the work privately at twice the cost.

Another CAB in Essex reported a client who was incorrectly told that root canal treatment was not available on the NHS and that the work could only be done privately.

It is not easy for patients to check whether what they are told by their dentist is correct, or indeed to know how to challenge such practices when they do occur. As long as access problems continue, patients are in a vulnerable position. Few will want to risk taking up the issue with the practice itself, for fear of jeopardising the dentist/ patient relationship or even being removed from the list altogether.

A CAB in Surrey reported a client who made a complaint about her experience of poor treatment from her dentist. The dentist then told her she was not wanted as a patient. She is currently in pain but has been unable to find an alternative NHS dentist.

The NHS Direct website does provide some information about patients' rights with regard to NHS dental treatment but there is a need for this information to be available in other forms. PCTs/LHBs also need to develop their public profile by making patients more aware of their monitoring role and encouraging feedback both positive and negative, to help develop a more patient centred monitoring process.

With regard to the formal complaints process, the CAB service has long argued that PCTs should have more direct involvement. Many patients are reluctant to make a complaint to their primary care provider and would prefer to deal with an independent third party such as the PCT. Channelling all primary care complaints via the PCT would also create a better evidence base for the PCT to monitor patient satisfaction with services commissioned.

Conclusions and recommendations

Citizens Advice has welcomed the April 2006 dentistry reforms which we believe provide a good foundation on which to rebuild the service as PCTs/LHBs are now able to invest resources more strategically. However, this report has demonstrated that in some areas there is still much to be done before PCTs/LHBs are fulfilling their statutory duty to meet all reasonable requirements for NHS dentistry. It is clear from Government statistics that, whilst the reforms have been effective in arresting the decline in access, there has been no significant growth in NHS dentistry since April 2006. The evidence set out in this report indicates that as a result, access to dentistry remains a postcode lottery. In many areas patients face unacceptably long waiting lists and/or long and expensive journeys to reach a dentist. Patients on low incomes and living in rural areas are therefore particularly disadvantaged. Too often patient choice is non existent and many people have felt forced to use private dentistry as a result, even when they are struggling on low incomes.

This situation is not surprising since, whilst the reforms brought in new contracts and new duties, they were not accompanied by additional funding to enable PCTs/LHBs to fulfil these duties to ensure reasonable access. Moreover in England no allowance was made for the fact that PCTs were starting from very different levels of provision: in some areas access for new patients was not a significant problem, whilst in others it was virtually non-existent.

Levels of funding

We therefore recommend that the Government takes the opportunity presented by the Comprehensive Spending Review to address this problem. It should end the postcode lottery by targeting additional ring-fenced resources at those PCTs with historically poor access to NHS dentistry, and making similar funds available for targeting LHBs in Wales. The reforms have had time to bed down and can now provide a stable base for growing NHS dental services and ending the postcode lottery on access to this much-needed NHS service. Although there has been some discontent among dentists about aspects of the new contract, none of the PCTs we identified as having poor access told us they had any problem in finding dentists ready to take on additional Units of Dental Activity (UDAs). Several did however comment that the main obstacle to expanding provision was financial. Further evidence of this has been recent reports of dentists running out of UDAs before the year end, and PCTs being unable to provide them with additional resources to bridge the gap.

We also recommend that in these areas of poor access, PCTs/LHBs should set local access targets as recommended by the Commission for Rural Communities' Rural Services Standard. No decision should be made to end the ring-fencing of the dentistry budget until these access targets have been met in all PCTs/LHBs. The responses we received from PCTs in areas of poor access indicated that plans were largely being drawn up in terms of their allocated budgets rather than on comprehensive assessments of local demand. PCTs/LHBs are currently facing significant financial pressure and if the ring fencing were ended before access problems had been resolved, there is a real danger that investment in dentistry would lose out through competition with other demands, especially where cuts in services are needed to balance budgets.

In these areas, PCTs/LHBs should consult with local stakeholders including patient representatives to set local access targets, which must reflect that there is no help with travel costs to a dentist available through the benefits system. An inclusive service must therefore ensure that no one is denied access to an NHS dentist by the difficulty or cost of travel.

We also recommend that the Hospital Travel Costs Scheme should be extended to include help with travel costs to NHS dentistry appointments until a sustainable local service is available for all patients. Without this change, patients on low incomes will continue to be disproportionately disadvantaged in accessing what provision is available.

Assessing demand

This report has indicated a number of areas where the work of PCTs/LHBs needs to be expanded in order to properly underpin their new duties to meet all reasonable requirements.

Firstly, it is essential that PCTs/LHBs develop more inclusive strategies for monitoring unmet demand. The numbers of people on waiting lists will not fully reflect demand if many people are unaware of their existence. **We recommend that PCTs/LHBs are required to undertake full assessments of local demand by employing a range of strategies including asking specific questions on access to dentistry in patient surveys.**

Raising the PCT/LHB profile

More broadly there is a need to promote the patient-facing role of the PCT/LHB in relation to dentistry. Many patients will not have had direct interaction with their PCT/LHB and, in England, particularly since reconfiguration, there may be no PCT presence in the local community. The National Audit Office has raised similar concerns in its recent report and has recommended that PCTs should demonstrate how they have built patients' views into the design and delivery of services.[13] **We therefore recommend that PCTs/LHBs work with local Patient and Public Involvement Forums, as well as local advice agencies such as Citizens Advice Bureaux, to encourage patient feedback on dentistry issues and publicise the role of the PCT/LHB in helping people find a dentist, in assessing and meeting unmet demand, and in monitoring dentists' compliance with contracts.**

Improving information provision

It is also clear that many patients are not well informed about the best way to find a dentist under the new arrangements. In particular, where PCTs/LHBs are operating waiting lists, more needs to be done to advertise this route. **We therefore recommend that the Department of Health and Welsh Assembly Government draw up, in consultation with patient organisations, guidance to PCTs/LHBs on best practice in publicising how people can join waiting lists.**

We also recommend that the Department of Health should amend the standard text on the PCT dental pages of the NHS website to make it clear that where the website information shows limited access, the PCT may be holding a waiting list, and that patients wishing to join the waiting list should contact the helpline number provided.

There is also a need to provide a more joined up service for patients without a dentist who are left with ongoing needs after receiving emergency treatment, and for patients who lose access because their dentist ceases NHS work. **Where patients are left with underlying problems following emergency treatment, we recommend that PCTs/LHBs should ensure patients are given appropriate information and advice on finding an NHS dentist for routine treatment and if necessary given priority on any waiting list that may be in operation.**

Where a contracted dentist ceases to provide NHS treatment, it is essential that a patient is fully informed about options to continue receiving NHS treatment**. We therefore**

13 Improving quality and safety – progress in implementing clinical governance in primary care: lessons for the new Primary Care Trusts, National Audit Office, January 2007

recommend that, where this happens, the PCT/LHB should have in place arrangements to contact all patients on the dentist's list to provide advice and information including any options for transferring to an alternative NHS provider.

Complaints

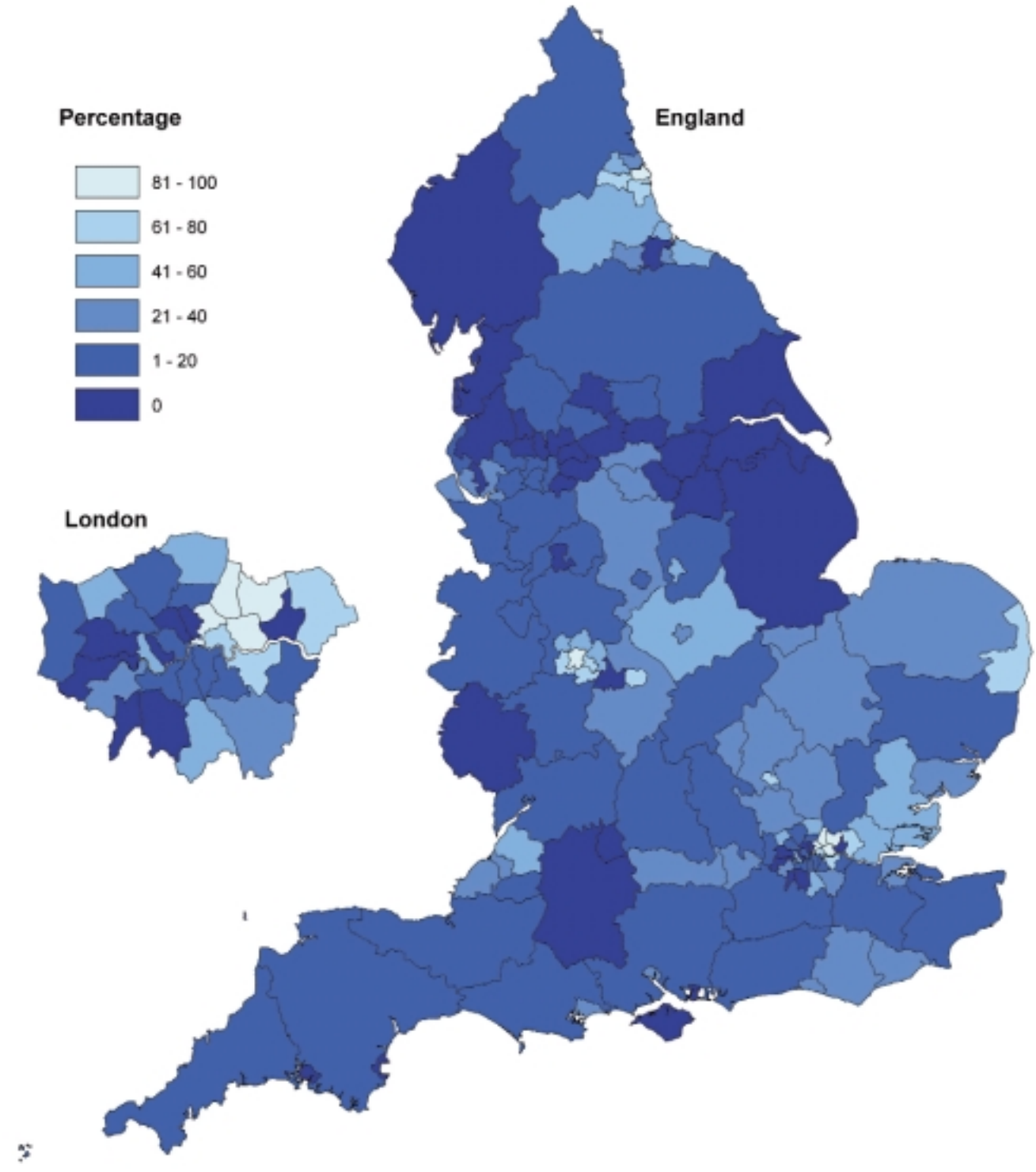
We also reiterate the recommendation we made in our 2005 report on health complaints[14], that, as recommended by the Health Service Ombudsman in 2005[15], patients in England should have the option to lodge complaints about primary care providers, such as dentists, directly with their PCT. This option, which already exists in Wales, would help overcome patients' reluctance to make a complaint about their local health practitioner, for fear this will have an impact on their ongoing care. It would also help PCTs with their monitoring role by increasing their sources of information.

Monitoring the PCT/LHB role

Finally, we recommend that Strategic Health Authorities, the Healthcare Commission, the Healthcare Inspectorate Wales, and the Welsh Assembly Government all include within their monitoring procedures measures to assess the extent to which PCTs/LHBs are fulfilling their duties to provide dental services to meet all reasonable requirements. We believe that the recommendations in this report are some of the indicators which should be used to measure this.

14 The pain of complaining, Citizens Advice, 2005
15 Making things better? Health Service Ombudsman, 2005 (HC413)

Appendix – Percentage of NHS dentists accepting charge paying adults by PCT (source – www.nhs.uk November 2006)



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