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Statement to the Wellbeing Policy Development & Scrutiny Panel of B&NES Re. Dental Access (Item 11 on Agenda) via the Public Speaking Scheme

PCT responses are in bold.
ADP responses are in italics and bold.

I began looking into NHS dentistry in B&NES in November 2010 after receiving two episodes of extremely poor treatment from ADP Oldfield Pk which required remedial work at the Riverside Centre. When I mentioned to the Riverside I was going to complain about ADP's treatment they told me to make sure that I did because they were fed up of having to complete unfinished work or rectifying failed treatments provided by ADP Oldfield Park.

1. ***Mr H-B's original complaint was thoroughly investigated by ADP and responses sent to Mr H-B from the clinician and the practice. Practice procedures have been reviewed, and updated where relevant, following the investigation of the issues raised in the complaint.***

   Riverside raised verbal concerns about some local high street (GDS) dentists when the PCT met with the previous clinical lead. JG advised them of the process of raising concerns via the lead commissioner of this service which is NHS Bristol. The PCT attends quarterly meetings with the other commissioners of this service and no complaints were raised either at this meeting or with the PCT direct.

I began asking the PCT how they monitored practices in B&NES to be told they monitor dentists using three criteria; Access -patients seen in the last 24 months; Quality-using criteria such as patients re-attending within 3 or 9 months, complaints, DRS reports and thirdly Activity. Activity though was only measured using the cumulative total of UDAs delivered, there was no analysis of treatments ie. identifying the provision of particular types of treatment and their number.

2. The PCT carries out a risk assessment of all dental practices in B&NES each year and then chooses certain practices to concentrate on. The PCT looks at location – so all geographies are covered, BSA exception reports, activity levels and whether the practice is meeting their contractual activity levels, the size of the contract, a clinical advisor looks at low % of band 3 treatments and very low band 2 to ensure that practices are providing the full range of treatments on the NHS, and whether the PCT has received any PALS enquiries. In February 2012 this resulted in the PCT (PCT lead commissioner and local clinical advisor who is a B&NES dentist) meeting with 13 practices across B&NES. In addition the PCT decontamination lead asked all NHS dental practices in B&NES to complete a self assessment. On the basis of their return a further risk assessment was carried out and practices of concern received a visit from the decontamination lead.

3. The practice visit included looking at their vital signs report for last year (2010/11) and year to date this year(2011/12). The PCT also discussed the End of year (2010/11) statement with each practice that includes the clinical dataset. The PCT also discussed any PALS issues notified to the PCT and any complaints that the practice had received from patients in the previous year. As a result of this visit the PCT drew up an action plan which all the practices signed up to achieving. This process was reported to the PCT PEC and Board within the integrated performance report.

4. The risk assessment process was carried out because the PCT was unable to visit all dental practices due to capacity issues. This was logged formally on the PCT risk register.

As you all know the new dental contracts act as a disincentive to dentists to undertake the more complicated work, such as root canals, because they are paid a fixed rate which takes little account of how complicated the treatment is in terms of the labour or material costs. This is why it is essential that the PCT and the new CCGs monitor the type and quantity of treatments to ensure that dentists don't 'cherry pick' or 'game' the system. The PCT has not been doing this.

5. As stated above the PCT does monitor the type of treatment provided such as root canals. It will not be the role of CCG to commission dental services in the future as this will be part of the National Commissioning Board's responsibility.

I asked the PCT through an FOI request to provide me with a copy of the most recent Dental Reference Officer's inspection report for ADP Oldfield Park which was undertaken in June 2010 to be told, on 22 Feb 2011, that they had not received the report. I also asked the PCT whether they monitored treatments by type and number to be told and I quote;

" Some PCTs may monitor this level of detail with their practices but we do not in B&NES."

6. Please see above. The PCT at this time did not routinely check every dental practice clinical dataset but used the risk assessment process described above.

After some basic checking by phoning the Dental Services Division the PCT then agreed that in fact they would have received the Dental Reference Officer's report online from the Dental Services Division two or three days after the Dental Reference Officer's visit but the report had not been studied because Val Janson and one other had visited the practice in person and found no issues of concern.

7. The DRO has stopped visiting dental practices in England as part of this work is carried out by CQC now. Normally the PCT receives the DRO reports from colleagues in NHS Bristol PCT who lead on commissioning dental services across old Avon. But there was long term sickness and maternity leave in this team so in this instance the PCT did not receive the report in a timely way. Normally when the PCT had received the DRO report the PCT sent a request 6 months later to ask the practice if they had carried out the actions as agreed by the DRO. This did not happen in this instance. As a result of a higher than average number of PALS/complaints received at the PCT the clinical governance lead clinician and the quality lead manager attended a contract meeting to discuss complaints and general quality management systems and processes with ADP. They also visited the practice in February 2011 to discuss a particular

complaint and at that time received assurance from the ADP Clinical Director that clinical competency and clinical record keeping were assessed on a regular basis and it was felt that the practice could improve its complaints record management and implement a more effective system for learning from complaints. On the basis of the issues discussed and the actions agreed the PCT was satisfied that progress would be made.

Furthermore the PCT then denied they received the General Clinical Data Set from the Dental Services Division, either the quarterly 'vital signs' reports or the annual reports for every NHS dentist in B&NES. The criteria the PCT said they DID use to monitorAs an attachment to this document I have included the General Clinical Data Set for ADP Oldfield Park for 2010/11 with causes for concern regarding activity highlighted
access, activity and quality can only be found in this data! What were they trying to hide? Was it the complete lack of monitoring taking place and/or trying to obscure what the data would show?

8. The PCT was not trying to hide any information. The PCT does not receive these reports direct but can download them from a website. At the time of Mr HB request there was no-one in the PCT who could access this website. (As a key member of staff had just left). As stated previously stated the PCT does review these reports as part of the risk assessment process.

I have submitted to Lauren Rushen the full General Clinical Data sets for each NHS practice in B&NES for 2009/10 and 2010/11 and the Dental Contract Management Handbook 2010 which gives advice on how to interpret this data. It gives guidelines for figures that should raise concerns. I believe the PCT was unaware of this document or didn't use it if they were. This document also gives specific guidelines in chapter 9 regarding "Questions for the Overview and Scrutiny Committee."

For example-
"Does the PCT protect patients by ensuring the quality of dental services?"
"Does the PCT have audited processes for monitoring efficiency and effectiveness of dental contracts?"

9. The PCT is aware of the Dental Contract Handbook 2010 which gives very helpful advice for dental commissioning. This was reviewed to form the basis of the risk assessment process.

Also, the report used by this committee for today's meeting, "Developments in NHS Dentistry" Section 7 page 4 states that PCTs have a responsibility to improve oral health through prevention as well as by access to treatment. One of the treatments it lists is the application of fluoride varnishes to children at high risk of dental decay. The figure for this treatment for Oldfield Pk for 2010/11 is zero per 100 FP17s; fissure sealants is zero per 100 FP17s; scale and polish is 5.6 per 100 FP17s Band 1 when the national average is 39.5 per 100 FP17s. They treated a total of 13,518 patients and specifically 3,032 under 18's during this period. Prevention, what prevention?

10. ***In the contract year 2011-2012 the percentage of child course of treatment receiving Fluoride treatment was 9.25%. The current computer systems use the pre-2006 fee scale in order to record what treatment is performed and unless a dentist assiduously uses these codes it is not possible to accurately measure activity. It has historically been common to simply write a note indicating that these areas have been covered. The use of metrics has increased as the 2006 contract has progressed but the interpretation of this kind of data can be unreliable. ADP can now produce clinical datasets at practitioner level and is now able to discuss the importance of correct recording of this information. The Pilots for the new dental contract are specifically trialling methods to assess the effectiveness of preventative measures by looking at treatment outcomes.***

The PCT has noted that rate of fissure sealants and fluoride varnishes were low for this practice according to the dataset. The clinical director of IDH who now own this practice agreed to look into this further at a future contract review meeting with the PCT. This may be a data recording issue.

This is a practice that has an unending, permanent contract, awarded without competitive tendering to provide just under 60,000 UDAs which was increased from 39,000 UDAs 18 months/two years ago. This is more than double the next largest provider in B&NES.

11. When the PCT inherited commissioning dental services from the DH in 2006 all dentists providing General Dental Services (GDS) were given permanent contracts. This was a DH decision to stabilise dental services. 18 months/two years ago in order to improve access to dental services the PCT procured £1.4M worth of services from 11 practices in B&NES. There were two other practices awarded a similar level of increase in this process. The process used by the PCT included a review of quality standards and health promotion.

The damning report from the CQC into Oldfield Park , published two days ago, raises major concerns regarding patient safety with regard to infection control, Legionella risk and fire risk. The issues raised by the CQC highlight factors that were in place at the time of the previous inspections by the PCT and DRO. For example no sink for staff to wash their hands in the equipment decontamination room with staff stating that “we just didn't wash our hands.”

12. ***The practice has produced an action plan to addresses any areas of concern following the CQC inspection. Progress to implement this action plan is under review by both the Practice and the Company and all areas of concern flagged by the CQC have already been addressed. A new decontamination room has been created in the practice and is fully HTM01-05 compliant. A legionella test was completed in March 2011 but the evidence for this was not available for inspection at the time of the CQC inspection. PAT testing is arranged for the end of July 2012.***

CQC have only recently instigated a review of dental services. Prior to this starting in the B&NES area CQC contacted the PCT to discuss areas of concern. The PCT advised CQC of the information that has been reviewed as part of the risk assessment process and the decontamination self assessment. The quality manager advised CQC that the PCT has had cause to carry out a quality visit to ADP Bath as a result of complaints/PALS enquiries. CQC alerts the PCT when the reports are in the public

domain. We know that after a CQC visit the practice has 14 days to respond to the report. Dentists with agreement by the Avon LDC will send the PCT a copy of their report for information. The PCT will then follow up on any issues of concern.

ADP Oldfield Park's reputation precedes it. If I speak to people about it very rarely does anyone have anything good to say about it. If the PCT was unaware of this it is because it is was not asking the right questions. The CQC report, I believe, shows that the practice was not being monitored sufficiently. ADP's business model is profits first with patients coming a poor second. The decision to give so many UDAs to ADP Oldfield Pk was simply about getting a provider operating in B&NES that would always take on NHS patients, this was at the expense of quality. The PCT, due to the historic problem in Bath of limited NHS dental capacity, has concentrated on access at the expense of what happens when a patient is through the door. Access, access, access seems to have been the mantra for the provision of NHS dentistry in B&NES. As an attachment to this document I have included the General Clinical Data Set for ADP Oldfield Park for 2010/11 with causes for concern regarding activity highlighted

13. See previous comments. The PCT is being performance managed by the Strategic Health Authority on Access to NHS Dental Services as this was a priority in the NHS Commissioning Framework in 2011/12.

The current vital signs data (March 2012) indicates that 87.8% of patients were happy with the dentistry they have received. This is more than amplified by the recent Patient Satisfaction Survey (PSS). This clearly shows that the large majority (90% +) of patients are happy with the service provided. The only PSS question scoring in the blue is the 3.4% who had to wait more than 15 minutes. These results are being considered by the practice and an action plan is produced as a result.

The General Clinical Data sets for dentists in B&NES highlight areas as causes for concern if the Dental Contract Management Handbook 2010 is used as a guide. The levels of scale & polish across B&NES are low compared to national averages. In two cases they are far too high, again a cause for concern. I have been asked to pay for a hygienist at ADP Oldfield Park when the treatment was deemed clinically necessary. I have had clients at the Citizens Advice Bureau who have said the same.

14. The levels of scale and polish are low across B&NES because a number of practices in B&NES only see children. Children should not need scale and polish. Scale and polish should not be needed for patients who have good oral hygiene. NHS hygiene services are made available to patients but only for those patients that clinically require treatment to maintain their oral health.

ADP is currently undertaking a review of the provision of hygienist services to ensure that clear information is available to patients around the provision of NHS periodontal treatment. This will ensure that patients understand the clinical need for periodontal treatment, what treatments are available to patients under the NHS and any private options.

The CQC report, page 12, talks about fees and states that,

" If an individual requests a scale & polish for cosmetic reasons, it was the practice's custom to refer the patient to the dental hygienist. This was then charged for privately."
The scale & polish figures are very low so it may be that dentists are not routinely offering this treatment when clinically necessary on the NHS which is why patients are having to ask for this treatment. The report states that the PCT has now raised concerns with the provider and I would ask the Committee to follow this up and check the specific data for 2011/12 and 2012/13 to make sure the figures for scale and polish have risen and that the PCT or CCG is regularly using the General Clinical Data Set to monitor on a continuous basis.

15. The clinical dataset is produced quarterly and a summary of the whole year on an annual basis. We are waiting for 2011/12 outturn data. The PCT meets with 4 dentists across B&NES on a quarterly basis for to discuss issues with commissioning dental services from a clinical perspective. We have agreed as part of this years work programme that the dentists will go through all the clinical datasets for 2010/11 and 2011/12 to see if they can see any areas of concern whether this is data quality issues or an unusual clinical practice. The PCT will then write to dental practices asking them for feedback.

I then moved practice to 1a Queen Sq, twice I was told I needed to see the hygienist and would have to pay £35. I pointed out twice that I was an NHS patient. No offer of treatment on the NHS was forthcoming. I complained to be told that the dentist concerned had offered me both options. This was a total untruth. The General Dental council states that dentists must put their patients ahead of any personal or business interest. Why is it that two completely different dental models; one a national company and one a family run partnership, felt confident enough to breach the General Dental Services contract by asking me to pay privately for mandatory preventative treatments that should be available on the NHS?

16. ***A Basic Periodontal Examination (BPE) is the accepted screening tool used to assess the presence of periodontal disease. A BPE of 3 or higher suggests that a diagnosis of periodontal disease should be considered, a lower score does not diagnose periodontal disease and therefore, on the NHS, scaling is not appropriate.***

The reason, I believe, is because the PCT has given a green light to dentists and through their lack of effective monitoring they've said "Don't worry become an NHS provider so that we can improve access and once the patient is through the door we wont bother you!"

17. see previous comments outlining that the PCT does monitor quality.

I had a meeting with the practice manager at 1a Queen Square to raise my concerns. She was very honest. She stated that she thought their figures for scale and polish would be low because many of their NHS patients paid privately for the hygienist. She had never seen the General Clinical Data Set figures for any of the practice's dentists. Finally she told me she had had no contact with the PCT for several years. There is no guidance being given to NHS providers in B&NES. Does the PCT have any knowledge of what's happening at the NHS/private interface?

18. The practices in B&NES received the general clinical dataset figures directly from the BSA in June 11 as shown by the report that Mr HB sent you. The PCT can assure the committee that the PCT has been in regular contact with Queen Square. The dentists in this practice have separate contracts with the PCT and they correspond

directly with the PCT on a regular basis. This practice manager has contacted the PCT on a number of occasions.

I have spoken to Karen Taylor of the CQC who stated that there is an issue with regard to the accuracy of the data because there is a lack of uniformity on recording protocol. But the Dental Services Division does have explicit instructions on it's website on how to record data using the FP17s and dentists do after all get paid from this data so it's inaccuracy cannot be significant. If the PCT believes the data to be less than accurate then it should ensure reporting is consistent via oversight.

19. The PCT piloted the use of clinical datasets with dentists as part of the practice visit process. See previous comment about work programme this year for the 4 B&NES dentists.

Has any dentist in B&NES in the last three years had a remedial or breach notice issued against it? What are the bench mark figures the PCT uses when action will be instigated? NHS dentistry in the UK is in state of flux. Dentists find it hard to provide all the treatments available on the NHS and make a living because of their contracts. So the patient pays the price through a blurring of the NHS/private relationship.

20. Some dentists in B&NES have been issued with remedial notices that relate to not achieving activity targets. But these issues have been resolved as part of the year end reconciliation process. There are no outstanding remedial notices.

The difference in quality between NHS and private treatment is significant. This disparity is not something we would put up with from our local GP and yet we have to accept a two tier health service when it comes to oral health.

21. The PCT does not have access to the quality of private dental treatment so is not able to comment.

This point onwards the report is making recommendations to the Wellbeing PDS

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I don't expect the Committee to make recommendations based solely on what I have said today and I would be happy to be proved wrong. But I would ask that you recommend an investigation into the NHS/private relationship in B&NES and set up a system to monitor the type and number of treatments using the General Clinical Data Set.

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This could be investigated by:

1. Sending a letter reminding dentists of their statutory duties to provide mandatory services under the General Dental Services contract and not to direct patients to private care where that treatment is clinically necessary.

2. Compel dentists to place the document “Guide to NHS Dental Services in England”, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097431 (see pages 11 & 13) which is about NHS dental rights, in their waiting rooms with signs informing patients they should read it.

3. Lastly 6 months after that has been done undertake a patient questionnaire survey listing the treatments available on the NHS and ask the basic question “Have you ever been asked to go private for any of these treatments available on the NHS or told that the treatment would be better if done privately?”

4. Monitor the number and types of treatment being offered so that the PCT/CCG knows that ‘gaming’ or 'cherry picking' is not occurring.

At the present time if you need root canal work that’s moderately complicated on the NHS you loose your tooth because it's not economically viable for a dentist to spend two hours treating a patient. Look at the General clinical data set and see how low the figures are for this treatment. Why not do what Wiltshire have done and provide a dentist with an endodontic specialism one afternoon per week?

One of this Committee's remits is reducing health inequalities. In B&NES if you can afford private treatment you save your tooth, if you are an NHS patient you lose it. To me that is a glaring example of a health inequality.

I would also recommend watching Channel 4's Dispatches programme ‘The Truth About Your Dentist’ broadcast on the 18 May 2011 and still available on Channel 4 OD.

Finally, I would agree with today’s proposition that access has improved, but now let’s also concentrate on what happens when a patient gets through the door.

NB. As a separate attachment to this document I have included the General Clinical Data Sets for 2010/11 for B&NES. Please look at the first two practices on the list (page 5 of both) which are ADP Oldfield Park and ADP Walwyn Close, Twerton for 2010/11. In particular see 'scale & polish' and 'fluoride varnish'. Remember the PCT only monitors 'activity' by the cumulative total for UDAs not the breakdown of that activity ie. the number of 'scale & polishes' or the number of 'fluoride varnishes'. This is what needs to be monitored.

Below is the criteria the PCT will state they use to monitor for 'quality', 'access' and 'activity'. Ask the PCT to provide evidence of this monitoring not just a list of what it states it uses!

Access
Patients seen in 24 months
Activity
Cumulative percentage of contracted UDA delivered

Quality
% of FP17s for the same patient ID Re-attending within 3 months
% of FP17s for the same patient ID Re-attending between 3 and 9 months

% of FP17s for Band 1 Urgent Courses
% of FP17s Relating to Free Repair or Replacements
% of FP17s Relating to Continuations
% of Patients satisfied with the dentistry they have received
% of Patients satisfied with the time they had to wait for an appointment

PALS and complaints & DRS reports