HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 7th January, 2011

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 7th January, 2011, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone: **01622 694486**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (10):	Mr B R Cope (Vice-Chairman, in the Chair), Mr A D Crowther, Mr G Cooke, Mr K A Ferrin, MBE, Mrs J A Rook, Mr C P Smith, Mr R Tolputt, Mrs J Whittle and Mr A T Willicombe
Labour (1):	Mrs E Green
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor J Cunningham, Councillor C Kirby, Councillor M Lyons and Councillor Mrs M Peters
LINk Representatives (2)	Mr M J Fittock and Mr R Kendall

Webcasting Notice

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item		Timings
1.	Introduction/Webcasting	
2.	Substitutes	
3.	Declarations of Interests by Members in items on the Agenda for this meeting.	

4.	Minutes (Pages 1 - 8)	
5.	Dentistry (Pages 9 - 60)	10:00 – 11:45
6.	Draft Forward Work Programme (Pages 61 - 62)	11:45 – 11:55
7.	Update on Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust (Pages 63 - 68)	11:55 – 12:05
8.	Committee Topic Discussion (Pages 69 - 70)	12:05 – 12:20
9.	Date of next programmed meeting – Friday 4 February 2011 @ 10:00 am.	

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

29 December 2010

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 26 November 2010.

PRESENT: Mr B R Cope (Vice-Chairman, in the Chair), Mr A D Crowther, Mr G Cooke, Mr D S Daley, Mr K A Ferrin, MBE, Mrs E Green, Mr C P Smith, Mrs J Whittle, Mr A T Willicombe, Cllr M Lyons, Mr M J Fittock, Mr R Kendall, Cllr Ms A Blackmore (Substitute for Cllr Mrs M Peters), Cllr R Davison (Substitute for Cllr J Cunningham) and Mr M J Northey (Substitute for Mrs J A Rook)

ALSO PRESENT: Paul Absolon, Cllr John Avey, Ms C Boland, Su Brown, Gordon Court, Ms L Denoris, Ms T Gailey, Cllr P Gulvin, Mr R Kenworthy and David O'Brien

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Mr P D Wickenden (Overview, Scrutiny and Localism Manager)

UNRESTRICTED ITEMS

1. Introduction/Webcasting
(Item 1)

Godfrey Horne MBE, In Memoriam.

Members, officers and guests stood in silence as a mark of respect for Godfrey Horne MBE, the late Chairman of the Health Overview and Scrutiny Committee, who had passed away suddenly on 13 November 2011.

2. Minutes
(Item 4)

RESOLVED that the Minutes of the Meeting held on 8 October 2010 are recorded and that they be signed by the Chairman.

3. Primary Angioplasty - Update.
(Item 5)

Corrine Stewart (Senior Service Improvement Project Manager, Kent Cardiovascular Network) and Clare Boggia (Cardiology Matron, East Kent Hospitals University NHS Foundation Trust) were present for this item.

(1) The Kent Cardiovascular Network led on the work to establish a coordinated pathway of care around a 24/7 emergency primary angioplasty service being established for Kent and Medway at William Harvey Hospital, Ashford. Corrine Stewart and Clare Boggia were able to provide an overview of the first six months of the system in operation. A formal 6-month review was being undertaken, and this would be shared with the Committee once it had been completed.

(2) Ambulances attending cases of suspected heart attacks were able to carry out electrocardiograms (ECGs) and transmit the results to William Harvey Hospital, where nurses were able to interpret the results to decide whether primary angioplasty was appropriate. Of 2255 ECGs transmitted, 476 patients were taken by ambulance direct to William Harvey Hospital, which equates to around 15 each week. Around 75% of those admitted received primary angioplasty. Some received thrombolysis for clinical reasons or because of patient choice. 5% are transferred to London for "cabbage" (coronary artery bypass graft surgery, or CABG). William Harvey Hospital works on an 8 am to 6 pm day and 60% of patients are admitted during these hours. The length of stay has been reduced to an average of 3.79 days, and the target is 3.5 days. Some patients are repatriated to hospitals closer to home where possible. In terms of geographical spread, 44% patients were from the NHS Eastern and Coastal Kent area, 34% from NHS West Kent and 22% from NHS Medway.

(3) It was stressed that the primary angioplasty service at William Harvey was an emergency service only. The service was only appropriate for patients suffering from a type of heart attack called ST-elevated myocardial infarction (STEMI). This means that not every patient experiencing a heart attack would be sent to William Harvey or receives angioplasty.

(4) The target is for 75% of patients to experience a call-to-balloon time of 150 minutes and this means the time from when medical help was called for to the time the angioplasty balloon is first inflated. Performance has been improving against this target since the service began and is now achieving the 75% target. The service was designed around a maximum travelling time of 75 minutes, but in practice the maximum time was 60 minutes from the furthest points in Kent. In response to a specific question from a Member, the time from Edenbridge was given as 50 minutes. As services in neighbouring areas like Surrey achieve the required standard, it may be that in the future the best option for patients in some areas of Kent would be to go to a different centre outside the county.

(5) In terms of local factors which may affect travelling time, such as Operation Stack, it was explained that there was a memorandum of understanding with the police which would mean there was a police escort available for ambulances in these circumstances.

(6) Members accepted that high levels of patient satisfaction were reported, but some expressed concerns about the existence of only one centre and the problems this could cause for patients and their families. The attendees were able to refer to clinical evidence that demonstrated centralisation in the case of this service did deliver better outcomes. A practical demonstration of this was that there were 12 cardiac specialists in the county able to perform the procedures, and to deliver a 24/7 service, this meant the consultants only had to work an out of hours shift 1 night out of every 10 and this delivered better quality of care. The relevant national mortality figures were 5.2%, whereas for the county the figure was 3.7% for the first six months. It was explained that the review currently underway should help answer a Member's question as to whether the benefit of the service was felt equally across the county.

(7) Both the hospitals at Medway and Tunbridge Wells were able to carry out angioplasty, and the service's contingency plan was for patients to be diverted to

Medway. This arrangement held for when contingencies were planned for, such as equipment maintenance, but also the occasional time when there was an unplanned contingency such as equipment failure. To reduce the number of times when the service was disrupted for these unplanned reasons, a business case for a second resilience laboratory was currently being finalised. If approved by the Board of East Kent Hospitals University Foundation Trust, it would require 40 weeks to be built.

(8) There was positive discussion around the role that public education could play in improving the service, through first-aid training in schools and businesses and through educating the public that if they were showing the symptoms of a heart attack calling an ambulance was more appropriate than presenting themselves at their local Accident and Emergency Department.

(9) One challenging area was extending the service to prisoners. The numbers were few, but formed a disproportionately high number of the access problems faced by South East Coast Ambulance Service. This was due to accessing high security prison grounds. The Network was working with the Sheppey Prison Cluster and was looking at the feasibility of putting telemetry equipment in the prisons to speed up the process.

4. Community Mental Health Services.
(Item 6)

Lauretta Kavanagh (Director of Commissioning for Mental Health and Substance Misuse, Kent and Medway PCTs), Paul Absolon (Social Care Commissioner for Mental Health, Kent County Council), Erville Millar (Chief Executive, Kent and Medway NHS and Social Care Partnership Trust), Marie Dodd (Executive Director of Operations, Kent and Medway NHS and Social Care Partnership Trust), John Hughes (Director Community Recovery Services, Kent and Medway NHS and Social Care Partnership Trust), Mark Fittock (LINk Governor), Cate Boland (LINk Development Worker), Di Tyas (Deputy Clerk, Local Medical Committee), and Dr James Kelly (Local Medical Committee) were present for this item.

(1) This section of the meeting built on the meeting in June (Minute 3, 11 June 2010) when hospital based mental health services were considered. As then, Lauretta Kavanagh, as lead commissioner for mental health for Kent and Medway Primary Care Trusts, provided an introductory overview. She indicated the summaries of the *Live it Well* mental health and wellbeing strategy which had been provided for Members at the start of the meeting in addition to the information contained within their Agenda. This strategy had the support of the three PCTs in Kent and Medway along with Medway Council and Kent County Council.

(2) She explained that the strategy took a twin-track approach, that of promoting mental health and improving access and outcomes. There were three areas where large scale transformation was envisaged. The first was to increase the confidence and ability of primary care professionals in dealing with mental health. The second was to redesign community services so there was less reliance on hospital based services; the vital role played secondary care was acknowledged, but this redesign was aimed at enabling secondary settings to deal with the more severe cases more effectively. Thirdly there was a need to develop currencies and tariffs in mental health to shift from the current block contract to payment by results.

(3) As Chief Executive of Kent and Medway NHS and Social Care Partnership Trust (KMPT), the largest provider of mental health services in the county, Erville Millar provided an overview of the range of community health services available. He explained that increasingly self-referral to services will be seen as important as GP referrals. The Increasing Access to Psychological Therapies programme (IAPT) was increasingly important. Among the other services available, there was also the Early Intervention in Psychosis Service that was aimed at the 14-35 age group, the First Response Intervention Service (FRIS) as the first line of assessment and the 24/7 crisis services which looked to prevent admission to accident and emergency departments wherever possible.

(4) Mark Fittock, a LINK Governor, introduced a draft version of a LINk report into mental health services and which Members had before them. Mental health problems affected 1 in 4 of the population and LINks had difficulty getting to grips with the subject and the service available. He explained that LINks felt that although KMPT had there own user group, there needed to be better public/service user engagement with KMPT. Overall, the findings of the LINk report were reflected by the recent Care Quality Commission (CQC) survey of people who use community mental health services.

(5) On the subject of user involvement, Paul Absolon from Kent County Council explained that there was heavy investment in user forums and there was a high level of input into the *Live it Well* strategy. More users could be involved if there better tie up with KMPT, he suggested.

(6) There was a lot of discussion surrounding the CQC service users report. KMPT expressed respect for the report and it is used as a guide to focus improvements but indicated that the results were based on less than 1% of the patients seen by the Trust. Some Members expressed the view that a stronger response to the survey would have been welcomed and one Member indicated that Kent County Council was often judged on the basis of smaller survey samples. KMPT indicated that their own local surveys provided better results. From the perspective of the commissioners, Lauretta Kavanagh explained that a number of successes had been achieved by the Trust and there was work ongoing on an action plan to improve. There was also a move towards systems that would capture patient data in real time. By way of context, James Sinclair from KMPT explained there was a need for more local initiatives in order to involve service users and improve, but that the Trust delivered services from 117 sites and this made getting consistent quite a complex process.

(7) From the perspective of General Practice, Dr James Kelly from the Local Medical Committee explained that he shared the concerns expressed by Members around capacity in the future when GPs will be expected to handle local commissioning as well as continue to see and treat patients. However, GPs were closest to patients and their needs and currently 90% of mental health treatment activity was carried out in primary care, but only 20% of the funding for mental health went to this sector. However, this also meant that GPs gave a high priority to mental health and were in a good position to act as effective gatekeepers to services. One challenge he saw was in the need to move away from the current block contract system, which made services difficult to decommission, and enable a range of providers to enter the market.

(8) Responding to a question on the adequacy of inpatient mental health services, the perspective of the commissioners was that there were enough beds to meet the need and that work was going on with the Trust and GPs in East Kent to approve a business case to reduce the number of acute beds by 20 by 2012. A number of conditions had been set the Trust to ensure adequate community provision was available before this could happen. Erville Millar explained that within KMPT bed occupancy was around 93-97% capacity and so there were times when there were pressures. In order to reach the goal of reducing the number of beds by 20, work was being done to reduce length of stay from the current 23-25 days.

(9) Connected with the issue of acute mental health services, Lauretta Kavanagh explained that there was 'section 136' suites adjacent to acute mental health wards where there was liaison with the police and there was currently an education programme underway to raise awareness within the police of the range of options regarding the best way to handle a member of the public with mental health care needs with whom the police would come in contact.

(10) In response to a particular point around Mother and Infant Mental Health Services, the service was commissioned from KMPT and Erville Millar explained that the service had been commended by the recent Ofsted report and CQC and that the Member was quite right in indicating that the importance of identifying physical phenomena which may be contributing to mental health phenomena was crucial not just to this service but right across all mental health services.

(11) Regarding mental health services for members of the armed forces, it was explained that the same services were available and better access guidance was followed. Information on the mental health service needs of servicemen was just beginning to be collected.

(12) The issue of Child and Adolescent Mental Health Services (CAMHS) was raised by a number of Members as a topic that needed to be looked at urgently, in particularly those services for 17 year olds where there was a transition from CAMHS to adult mental health services.

(13) There was also a discussion on forensic mental health services. Representatives from KMPT explained that secure services involved a heavy investment in monetary terms, and as a proportion of the mental health spend. It was explained that the average length of stay in a medium secure setting was 2 years and for a high secure setting, 7 years. For low secure settings in Kent, the average was 21 days. In these latter settings it was explained that there was balance to be struck and often the challenge was to prevent people entering, rather than preventing people leaving. In response to a specific question about one site, Erville Millar explained that Hucking Hill House was no longer used for rehabilitation for forensic services.

(14) As a final point, Lauretta Kavanagh explained that 3 public awareness campaigns around mental health were planned.

5. The Future of Community Service Providers - Written Update.
(Item 7)

Di Tyas (Deputy Clerk, Local Medical Committee), and Dr James Kelly (Local Medical Committee) were present for this item.

Members had before them written information providing an update on the subject of the future of NHS community service providers following on from the meeting of 3 September when this topic was last considered and prior to the meeting of 4 February 2011 when this topic will be revisited.

There was a broader discussion of the context within which these changes were taking place, in particular the move to GP commissioning and the possible distraction from service delivery it would involve. Members felt there was a lot of confusion around key areas such as the transfer of estates and the cost of the changes.

Dr Kelly conceded there were risks in the move to GP commissioning and mentioned the 'clean slate' campaign of the British Medical Association. Community services were given as one of the biggest frustrations felt by GPs and that GPs felt that under the current system is was often the most vulnerable, such as children, the elderly, and those with mental health needs, who suffered most.

6. Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update.
(Item 8)

(1) Members expressed regret that the response of the Strategic Health Authority did not result in the Committee receiving a copy of the report submitted to the Secretary of State for Health. Members then discussed a range of possible follow up actions.

(2) Mr. Cooke moved, Mr. Ferrin seconded, that a Freedom of Information Act request be made to the Secretary of State to ask him to release to the Committee a copy of the report he had commissioned to be prepared by the South East Coast Strategic Health Authority on the reconfiguration of Women's and Children's Services within the Maidstone and Tunbridge Wells NHS Trust.

Carried by 9 votes to 1.

(3) RESOLVED that a Freedom of Information Act request be made to the Secretary of State to ask him to release to the Committee a copy of the report he had commissioned to be prepared by the South East Coast Strategic Health Authority on the reconfiguration of Women's and Children's Services within the Maidstone and Tunbridge Wells NHS Trust.

7. Committee Topic Discussion.
(Item 9)

(1) Members discussed the item on primary angioplasty and felt that the concerns raised during the discussion had been dealt with in a most satisfactory manner.

(2) On returning to the request that the Committee consider CAMHS as a matter of urgency, a range of views were expressed including whether the topic could best be approached by breaking it apart into different aspects and whether it would be more useful to wait six months given the recent publication of the Ofsted report into

safeguarding children. Due to its cross-cutting nature, Paul Wickenden, the Overview Scrutiny and Localism Manager, undertook to bring the matter to the attention of the Scrutiny Board to discuss what would be the most appropriate forum for the subject.

8. Date of next programmed meeting – Friday 7 January 2011 @ 10:00am
(Item 10)

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 7 January 2011.

Subject: Dentistry.

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1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve. Another has been the need to make the work of the Committee more accessible to members of the public.

(2) This paper is intended to be a way to progress towards achieving these twin aims. Two sets of questions are set out below, both of which the meeting will look to having answered by the end of the meeting: the strategic, overarching questions, and the more detailed questions. All were sent to the relevant attendees in advance.

2. Strategic Questions

(1). Overarching Questions

a) What are the main challenges in the way of delivering first class community health services for the people of Kent?

b) How can the Health Overview and Scrutiny Committee help to achieve this goal?

3. Detailed Questions

(1). Questions submitted to NHS Eastern and Coastal Kent and NHS West Kent.

1. Please provide some key facts about the levels and types of dentistry activity in your PCT area, including:
    a. Numbers of dentists providing NHS dental treatment, and the percentages working under the different types of contract;
    b. Numbers of dentists providing NHS dental services to children but not adults;
    c. Information on the levels of dental activity (Units of Dental Activity) and Courses of Treatment, broken down into patient type (i.e. adults and children); and
    d. Total number of patients seen by an NHS dentist, and what this is as a proportion of the resident population.
    e. For a-d above, how have these numbers changed over the last three years?

2. How much is spent on commissioning dental services and how do dentists receive remuneration for providing services?
3. Can you please provide comparative data showing where your PCT resides in the national and regional table for dental funding? How is this allocation determined?
4. How are dentists remunerated for carrying out preventive work?
5. Is any dental provision commissioned from community service providers?
6. What information can be provided on the state of children's oral health in your PCT, and how this has changed over time?
7. What plans are there to develop children's dental health and dental health services?
8. Regarding orthodontic services:
    a. How many orthodontic courses of treatment are provided on the NHS to residents of your PCT area?
    b. How are orthodontic services accessed by patients?
    c. How are providers of NHS orthodontic services remunerated and what decisions are being made around commissioning orthodontic services after 31 March 2011?
9. Who provides out of hours dental services and how do patients access these?
10. What is the patient pathway for those with advanced oral health needs (such as cancer, and/or courses of treatment involving referral to a consultant)?
11. Are there any particular geographical areas where there are issues around commissioning adequate dental provision?
12. Are there any particular times of year where there are issues around commissioning adequate dental provision?
13. What are the challenges faced by PCTs in commissioning adequate dental provision, what plans does the PCT have to develop dental services in the future and what will be the impact of the NHS White Paper proposals?
14. What actions are you taking to ensure dental care is provided to groups with a traditionally low take up?
15. Is there any mobile dentistry provision within your PCT area, and is this something you have considered?
16. What powers of prescription do dentists have and how much prescribing is carried out by them?
17. Please provide the following information relating to customer services (including information from PALs):
    a. How many enquiries are received each quarter relating to dental services and what trends can be identified regarding the nature of these enquiries?
    b. How many complaints/compliments/comments have been received about accessing dental services?
    c. How many complaints/compliments/comments have been received about the quality or cost of dental services?
    d. How has information from customer services about dentistry informed service development?

18. What part is your organisation playing in the development of a new dental contract following the Steele Review?

(2) Questions submitted to the Kent LINk.

1. From the information received by LINk, have any trends emerged about the problems faced by people in Kent in accessing dental services, and any specific areas of the county where issues exist?
2. From the information received by LINk, have any trends emerged about the problems faced by people in Kent in the quality of the dental services provided?
3. Is the LINk involved in, or planning to get involved in, any work relating to dentistry in Kent?

(3) In addition, the Kent Local Dental Committee was asked for any information they wished to provide on this topic.

4. Recommendations

(a) The Committee is asked to assess whether the outcomes in section 2 above have been achieved or if further information on this topic is required by the Committee.

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By: Tristan Godfrey, Research Officer to the Health Overview and Scrutiny Committee

To: Health Overview and Scrutiny Committee – 7 January 2011

Subject: Dentistry – Background Note.

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1. Introduction

(a) On 8 December 2010, the Adult Dental Health Survey for 2009 was published. This was the fifth in a series which has been carried out every ten years since 1968. The key facts identified in this survey are as follows:

- "Over the last 30 years the proportion of adults in England who had no natural teeth ("edentate") has fallen by 22 percentage points, from 28 per cent in 1978 to 6 per cent in 2009.
- Eighty-six per cent of dentate adults had 21 or more natural teeth.
- The average number of teeth among all dentate adults was 25.6.
- Over three-fifths (61 per cent) of dentate adults said they attended the dentist for regular check-ups;
- Twelve per cent of all adults (who had ever been to the dentist) were classified as having extreme dental anxiety. "[1]

2. The Dentistry System

(a) In 2006, a new system of dentistry was introduced. There were three main components:

- Three payment bands were brought in to replace a system of around 400 possible charges.
- Responsibility for commissioning services was devolved to local Primary Care Trusts (PCTs).

(b) The charges for the different bands of treatment from 1 April 2009 are:

- Band 1. £16.50. "This covers an examination, diagnosis (e.g. X-rays), advice on how to prevent future problems, a scale and polish if needed and application of fluoride varnish or fissure sealants. If you require urgent care, even if your urgent treatment needs more than one appointment to complete, you will only need to pay one Band 1 charge."
- Band 2. £45.60. "This covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or if your dentist needs to take out one or more of your teeth."

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[1] The Information Centre for Health and Social Care, *Adult Dental Health Survey 2009,* *http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/adult-dental-health-survey--2009-first-release*

- Band 3. £198.00. "This covers everything listed in Bands 1 and 2 above, plus crowns, dentures or bridges."[2]

(c) There are various groups that are exempted from dental charges (including those under 18), or who receive help with costs.[3]

(d) Charges offset 29% of the cost of NHS dentistry[4].

3. Dental Commissioning

(a) Primary Care Trusts commission most dental services through either a GDS (General Dental Service) or PDS (Personal Dental Service) contract.

(b) PCTs can also commission services of a more specialist nature through the DwSIs (Dentist with Special interest scheme) – the scheme was launched with four initial key competencies, Orthodontics, Minor Oral Surgery, Endodontics, and Periodontics.

(c) Alongside the independent contractors there are a number of dentists who work as salaried dental primary care dentists. They often provide generalist and specialist dental care for vulnerable groups and are involved in public health work.[5]

(d) Under the new GDS contract that was introduced in 2006, a provider is contracted to undertake a specified number of Units of Dental Activity (UDAs). There is no specified number of patients who must receive treatment. This number can sometimes be provided before the end of the contract period. If a provider has not undertaken all the UDAs by the end of the contract period, money can be 'clawed back' by the PCTs.

(e) A dentist is awarded 1, 3, or 12 UDAs for each course of treatment, depending on its complexity:

- Band 1 treatment = 1 UDA
- Band 2 treatment = 3 UDAs
- Band 3 treatment = 12 UDAs

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[2] All quotations in the section taken from Department of Health leaflet, "NHS dental services in England", http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096611.pdf

[3] Ibid, this leaflet contains details of exemptions.

[4] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Department of Health, June 2009, p.25, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

[5] Salaried Primary Dental Care Services (SPDCS) were formally known as Community Dental Services.

- Urgent treatment = 1.2 UDAs[6]

(f) As a result of the way the transition from the old to the new contracts was regulated, there is no set value for 1 UDA. In other words, different dentists receive differing amounts of money for delivering a course of treatment. The average is £25, with a range of between £17 and £40.[7]

(g) Dentists are allowed to provide both NHS and private dental services (for different patients and for the same patient).

(h) While there has never been a requirement for a patient to 'register' with an NHS dentist, between 1990 and 2006, a portion of a dentists' remuneration was linked to the number of patients registered. "Since 2006, this feature of the remuneration system has no longer applied, but this does not prevent patients from receiving continuity of care."[8]

(i) There are also a range of specialised dental services provided in hospitals such as oral surgery, specialist orthodontics and more complicated root canal and bridge work.

4. The Steele Review and Development of a New Contract

(a) In December 2008, The Secretary of State for Health (then Alan Johnson MP), asked Professor Jimmy Steele to undertake an independent Review of NHS Dental Services in England. This was published in June 2009[9].

(b) "The Review made 38 recommendations. These recommendations were based on a need for:

- Clear care pathways for patients, incorporating oral health maintenance and management of health risks as well as emergency and complex treatments.
- Clearer information for the public on how to access NHS dentistry, and their entitlements, including a right to register with a dentist for continuing care.
- Clear national guidelines for dentists on care pathways, quality and on what the NHS offers

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[6] NHS Dental Services in England, An Independent Review led by Professor Jimmy Steele, Department of Health, June 2009, p.68, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

[7] Ibid, p.28.

[8] Government Response to the Health Select Committee Report on Dental Services, October 2008, p.18, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_088997.pdf

[9] The full version of the report and associated material can be accessed here: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101137

- Greater responsibility for all parties involved in NHS dental services, including dentists and commissioners."[10]

(c) The NHS White Paper, *Equity and Excellence: Liberating the NHS*, stated:

"Following consultation and piloting, we will introduce a new dentistry contract, with a focus on improving quality, achieving good dental health and increasing access to NHS dentistry, and an additional focus on the oral health of schoolchildren."[11]

(d) On 16 December 2010, the Department of Health published proposals for carrying out 50 to 60 pilots across the country from April 2011 to test three different contract models and inform the development of a new contract.[12]

(e) The three elements of the new contractual system being developed are:

1. Registration – A right of registration with a dental practice is to be restored.
2. Capitation – The proposal is to pay dentists according to how many patients they provide care for, not how many courses of treatment they provide.
3. Quality – A system of monitoring and paying dentists for the quality of care they provide will be introduced.[13]

(f) The NHS White Paper also stated that in the future the commissioning of dental services would be the responsibility of the NHS Commissioning Board, rather than GP Consortia.[14] The public health White Paper, *Healthy Lives, Healthy People*, said that GP Consortia will be encouraged to work with professionals, including dentists, "to improve the health of the local population as a whole."[15]

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[10] Steele Implementation Programme: Briefing Pack, p.3, Department of Health, February 2010, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112591.pdf

[11] *Equity and Excellence: Liberating the NHS*, p.26, July 2010, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

[12] Department of Health, NHS dental contract: proposal for pilots December 2010, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122660

[13] Department of Health, *NHS Dental Contract: Proposal For Pilots*, December 2010, pp.9-10, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122789.pdf

[14] *Equity and Excellence: Liberating the NHS*, p.28 July 2010, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

[15] *Health Lives, Healthy People*, Department of Health, November 2010, p.62, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122347.pdf

5. Care Quality Commission Registration

(a) The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. It also protects the interests of people detained under the Mental Health Act.

(b) The Health and Social Care Act 2008 set out that from April 2010 all health and adult social care providers of one or more regulated activities would need to be registered with the CQC. To register, providers need to show compliance with 'essential standards of quality and safety'[16]. Following registration, compliance is monitored and the CQC has a range of enforcement powers. Providers only need to apply for registration once.

(c) All NHS Trusts, including community service arms of PCTs, were registered from April 2010. Adult social care and independent healthcare providers were registered from October 2010.

(d) From 1 April 2011, primary dental care providers will need to be registered. Registration began in November 2010.

(e) The full list of currently regulated activities is set out below. Not all of these activities will be provided by dental service providers. The ones in bold are "Those activities most likely to apply to dentists."[17]

- **treatment of disease, disorder or injury**
- **surgical procedures**
- **diagnostic and screening procedures**
- personal care
- accommodation with nursing or personal care
- accommodation for persons who require treatment for substance misuse
- accommodation and nursing or personal care in the further education sector
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- management of supply of blood and blood-derived products
- transport services, triage and medical advice provided remotely
- maternity and midwifery services
- termination of pregnancies
- services in slimming clinics
- nursing care

[16] *Essential standards of quality and safety,* Care Quality Commission, March 2010, http://www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_March_2010_FINAL.pdf

[17] *A new system of registration. Guide for providers of primary dental care services,* Care Quality Commission, August 2010, p.8, http://www.cqc.org.uk/_db/_documents/8788-CQC-Dentists-Revised_FINAL-300101.pdf

- family planning services

6. Some Key Organisations

(a) *Local Dental Committees* – Established in 1948, LDCs became statutory bodies in 1977. "Primary care trusts/health boards consult with LDCs on matters of local dental interest and, following the NHS reforms in 2006, local commissioning and developments in the provision of NHS dental services."[18]

(b) *British Dental Association* – Founded in 1880, the BDA is the professional association and trade union for dentists in the United Kingdom. It has a voluntary membership of around 23,000[19].

(c) *General Dental Council* – "Anybody who wants to work in the UK as a dentist, dental nurse, dental technician, dental hygienist, dental therapist, clinical dental technician or orthodontic therapist must be registered"[20] with the GDC.

(d) *Care Quality Commission* – From April 2010, all NHS Trusts must be registered with the CQC. "From April 2011, primary care services that directly provide dentistry (NHS and private) must be registered."[21]

[18] British Dental Association, Local Dental Committees, http://www.bda.org/dentists/representation/gdps/ldcs/index.aspx
[19] For further information, see http://www.bda.org/.
[20] General Dental Council, Who we regulate, http://www.gdc-uk.org/About+us/Who+we+regulate/
[21] Care Quality Commission, Who needs to register?, http://www.cqc.org.uk/guidanceforprofessionals/registration/newregistrationsystem/whoneedstoregister.cfm

NHS
Eastern and Coastal Kent

Briefing Paper for HOSC on 7th January 2011

Dental Services

1. Introduction

This paper provides a summary of dental services in NHS Eastern and Coastal Kent.

2. Context

In April 2006 the Department of Health introduced changes to the provision of dental services. The objective of these reforms were to:

- make NHS dentistry more attractive to dentists,
- promote a more preventive approach to dental care,
- facilitate steady improvements in local access to NHS dentistry.

The PCTs Dental Commissioning Plan outlines how oral health services are being delivered most effectively for the population of NHS Eastern and Coastal Kent in order to:

- best meet local oral health needs,
- address national guidance where this is not already being achieved.

3. What is being commissioned?

The PCT commissions dental services from dental practices either under a General Dental Services contract (GDS) or as part of Personal Dental Services contract (PDS).

The GDS contract is between the PCT and each individual practitioner. The individual practitioners may then join together to form a partnership or group practice.

PDS contracts are for the provision of "specialist" high street services such as practices limited to orthodontics, and those providing other services on referral which the PCT may want to commission.

A summary of contract information is shown on table 1 below:

Table 1

	2007/8	**2008/9**	**2009/10**	**2010/11**
Contracts	98	98	105	100
GDS contracts	82%	88%	91%	92%
PDS contracts	18%	12%	9%	8%
Children only contracts	7	7	7	7
Unit Dental Activity (UDA) – Child	43.9%	40.6%	35.4%	20.8%
UDA's – Adults	29.3%	26.9%	23%	31.3%(exempt adults)
% of population seen	301,002 (41%)	345,047; 47%	349,071; 47% of population (September 2009)	368,764; 51% of population (as at October 2010)

Note: -children only contracts are historical pre 2006.
-Information on patients seen is based upon the previous 24 months

In December 2008 the PCT approved an investment of £728,000 to increase access to dental services in Ashford, Sittingbourne and Canterbury. All three new surgeries are now operational.
In addition to this a further investment of £4.5m was made following a needs assessment that has seen new surgeries operational in all of the following localities by early 2010;

Deal, Dover, Chestfield, Whitstable, Faversham, Broadstairs, Cliftonville, Isle of Sheppey and Hawkinge

All of these new contracts provide extended opening hours and provide support with oral health promotion.

In procuring new contracts the PCT has not experienced any difficulties in attracting existing or new providers to any of the geographical areas of the PCT.

The waiting times for Orthodontic treatment have been reduced to less than 3 months following increased investment during 2008.

Orthodontics is available via referral from a patient's dentist, there is an agreed referral process that spans Kent as a whole and dentists are kept up to date regarding Orthodontic Specialists access times.

As part of the GDP and PDS contract, providers are expected to carry out preventative work on examinations and hygiene visits.

Locally within the PCT agreed pathways are in place for advanced oral health needs (such as cancer, and/or courses of treatment involving referral to a consultant). General Dentist can refer to the hospital consultants directly who will triage the patients based on evidence from the referral letter.

In addition to the GDS and PDS contracts NHS Eastern and Coastal Kent also commission the following services in primary care;

3.1 Out of Hours

DentaLine is the PCTs NHS's emergency dental service. DentaLine can treat patients who:

- Are bleeding heavily (haemorrhaging) from the mouth
- have an injury to their teeth or mouth
- have severe facial swelling
- are in pain that started suddenly and cannot be eased by pain killers

Normal opening hours: 7pm-10.30pm every day plus weekends and bank holiday mornings 9.30am to 11am.

Patients should telephone the DentaLine before attending and will be assessed during their call to determine how urgently treatment is needed.

For emergency advice or help in finding a local service residents of East Kent can call DentaLine service on 01634 890300.

3.2 Community Dental Services

Eastern and Coastal Kent Community Health NHS Trust provide Community Dental Service. The service provides a range of functions; they include specialist dentistry to patients who are unable to access mainstream dentistry because of a physical, mental or social disability. In addition to specialist care in periodontology, geriodontology, domiciliary care, bariatric dental care, general anaesthetics, epidemiology and dental health education.

3.3 Mobile Dentists

The use of mobile dental units has been explored recently, and discussed at length within the PCT, with a view to use for hard to reach communities, however, there have been many issues over their use and their cost effectiveness.
However, it was decided that the funding required to operate this service would be better utilised by investing in high street dental services.
Other than being very expensive to equip and operate, the mobiles would be difficult to comply with DDA and infection control guidance, there would be no waiting area for patients prior to appointments, the mobile would need to parked in an area of easy access with parking available, there is a high risk of vandalism and breakdown which would require continual remedial funding.

3.4 Gypsy and Travelling Community

Patients do not need to register with a dentist and are able to visit any NHS dentist that has availability, alternatively they are able to use a Dental Access Centre where services are provided by Community Dental Team. DAC's are located all around the East Kent area and are accessed either by calling the helpdesk or by presenting to the centre where an appointment will be allocated.
Dentists will accept all referrals or "phone and go" patients regardless of a fixed address. The FP17 form that is completed at the time of treatment does need an address but this could be a caravan park or hostel address. The dentist would have no system to confirm addresses.
Several years ago the Community Dental Service ran a specific service for travellers using a mobile to go to Romany sites. It was open access and the problem was cultural understanding. Turning up in a mobile on a site and expecting people to access a public service just didn't work and with so few numbers accessing care the service was too expensive and was stopped.

3.5 Orthodontic Services

The PCT contracts with 8 specialist orthodontic practices who provide 3800 new courses of orthodontic treatment every year. The referral pathway was redesigned in 2009/10 and this was effectively implemented across the whole of Kent and Medway. Patients are referred by their GDP to a specialist orthodontist of their choice in primary care, or to secondary care services dependant on the patient's IOTN score, which are strict guidelines indicating the level of treatment required.
The Orthodontic Specialists in primary care are contracted and paid on Units of Orthodontic Activity (UOA). A course of treatment is usually 21 UOA's and the contractor claims these against agreed contracted activity on an annual basis. Secondary care orthodontic treatment is included within the contract with acute providers and is on a cost per case basis (ie, first and follow up appointment costs).
Following active requests from the primary care contractors in 2009, the PCT investigated and agreed through appropriate governance channels to extend the PDS contracts for a further 5 years to 2016.

4. What is spent on primary care dental services?

All providers of NHS dental services receive one twelfth of the value of the contract each month. A breakdown of spend is shown on table 2 below:

Table 2

	2007/8	**2008/9**	**2009/10 (actual)**	**2010/11 (forecast)**
	£'000	£'000	£'000	£'000
Gross Spend	30,169	29,732	29,522	36,283
Patient Charge Revenue	(6,425)	(7,338)	(7,472)	(8,511)
Net Spend	23,744	22,394	22,080	27,772

4.1 SHA Financial Allocations

Table 3 details PCT dental allocations from their SHA. The population numbers in the detail are from the National Statistics data for population sizes by PCT area for the mid-year 2008. The data has been sorted by "£ per head of population" to demonstrate a comparison of the funding received by NHS Eastern and Coastal Kent and the other PCT's in the country. Highlighted in yellow are the other PCT's within the South East Coast SHA. Of the 8 PCT's in SEC SHA, NHS Eastern and Coastal Kent are 6th in the level of funding per head of population.

The Dental Allocation for the SHA is based upon the PCT's share of the nationally available dentistry resources for 2004-5 and 2005-6. There was an exercise whereby new contracts were awarded based upon the volume and type of NHS dentistry work undertaken by each practice within a defined reference period. The allocations have been uplifted for growth each year and in 09/10 there was an additional uplift so that PCTs could improve access in order to meet demand (in the case of Eastern and Coastal Kent this was an additional £1.35m).

2010/2011 Allocations

SHA code	PCT code	PCT	Net Allocation £000s	Population '000's	£ per population
Q37	5L3	Medway PCT	13,442	254	53.03
Q37	5LQ	Brighton and Hove City PCT	12,392	254	48.83
Q37	5P6	West Sussex PCT	32,717	789	41.49
Q37	5P7	East Sussex Downs and Weald PCT	12,766	333	38.35
Q37	5P8	Hastings and Rother PCT	6,768	178	37.98
Q37	**5QA**	**Eastern and Coastal Kent PCT**	**25,944**	**728**	**35.64**
Q37	5P9	West Kent PCT	23,112	674	34.31
Q37	5P5	Surrey PCT	37,102	1,089	34.08
		South East Coast Region	**164,243**	**4,297**	**38.22**
		England Total	**2,192,000**	**51,465**	**42.59**

5. Children's Oral Health

NHS Eastern and Coastal Kent participates in the national dental epidemiology programme which is sponsored by the Department of health and the British Association for the study of Community Dentistry (BASCD). BASCD studies have been undertaken for many years recording annually the decayed missing and filled (DMF) data of five year old, eight year old and twelve year old children on rotation. The DMF has decreased over the last 15 years but with some children experiencing high levels of decay. Caution should be given in interpreting data from year to year as the organisational boundaries have changed to which the data relates. Access to national and local results are available on the BASCD website.

In Eastern and Coastal Kent 73.2% of children are caries (decay) free compared with the England average of 69%. The average number of decayed missing and filled teeth (DMFT score) is 0.86 against and England average of 1.1.

ECK Community Dental team actively engage with schools around the region where dental oral health has been identified as a risk and provide support and education resource to assist the teaching staff with oral health promotion within theses schools.

The new contracts awarded in 2009 include quality indicators. One of these is to engage with local children focused communities (schools, brownies, scouts, mother toddler groups, playschools etc) to actively promote oral health and ensure there is a wide understanding in both parents and children regarding best practices for maintaining dentition.

6. Challenges

Ultimately funding will be a constraint on the levels of new services that can be commissioned and new measures are being put in place to ensure value for money from existing contracts. Contract monitoring of existing services will give increased efficiency and productivity therefore increasing capacity to treat more patients.

NHS Eastern and Coastal Kent is committed to achieving its national target to provide access to NHS dental services to 57% (420,000 people) of the population of East Kent in the next 5 years, currently the PCT is achieving 51% (368,000 people) so there are plans to improve access and meet the target. The national average is 54%.

Emergency/OOH services are currently under review with the aim improve access and the patient experience.

Specialist services historically provided predominantly by secondary care trusts are being reviewed to determine to what level these types of treatment can be carried out in primary care and therefore improve patient experience and bring services closer to people's home.

NHS Eastern and Coastal Kent will complete a procurement process in January 2011 that will ensure the provision from February 2011 of a Minor Oral Surgery service delivered in primary care by dentists with special interests, which will provide patients with a wider choice of provider and avoid hospital visits for intermediate tooth extractions that require expertise beyond that required by the GDS contract.

An oral health promotion campaign is already undertaken by Eastern and Coastal Kent Community Health NHS Trust and delivers the oral health message to as many people, especially children, as possible. Schools have sessions on oral hygiene and brushing techniques, care homes are visited where possible to help raise awareness of good oral hygiene later in life.

7. Dental Prescribing

There is a national dental practitioners' formulary which provides guidance on what NHS dentists can prescribe. These relate mainly to the management of dental and oral conditions and include analgesics, drugs to treat or prevent infection, anaesthetics and drugs to sedate as well as specific preparations for oral conditions.

There is no way of ascertaining how much prescribing is carried out by dentists. Dental prescriptions, after dispensing in a community pharmacy, are sent to the Prescription Pricing Division (PPD) in Newcastle where they are priced and the community pharmacy remunerated. The DH has not commissioned the PPD to collect any data on dental prescribing so it is impossible to know how much has been prescribed. There are two main areas where this could potentially pose a problem for the PCT:

- Hypnotic prescribing – we know that temazepam and diazepam have a street value to addicts and we routinely monitor GP prescribing in this area. Because we have no access to data on dental prescribing, we are not able to see if a dentist might be under pressure to prescribe these drugs inappropriately.

- Antibiotics – because of the national high priority of tackling Healthcare Acquired Infections, the PCT regularly monitors GP prescribing of antibiotics which contributes to the build up of

resistant strains of micro-organisms. There is no way of knowing the level of dental prescribing in this area or the antibiotic chosen.

8. Customer Services

A dedicated dental freephone helpdesk (0808 238 9797) and texting service (07943 091 958) was launched on 9 November 2009. This helpdesk provides non clinical advice that includes:

- Helping patients, who currently don't have a dentist, access emergency dental treatment.
- Provide information on where patients can receive NHS treatment
- Explain the NHS charges and the treatment included in each price band
- Provide information on specialist dental services such as orthodontics.

Since its launch and upto October 2010, the helpdesk has dealt with:

- 19,612 calls were taken from patients, 11,255 wishing to access an emergency appointment.
- 7,475 callers have been given details of practices with capacity to treat patients
- 813 callers have made general enquiries that include for example dental treatment costs
- 595 text messages have been received requesting details of where their nearest NHS dentist is located.

A promotional campaign has raised awareness of the new dental helpline and raised the public's awareness that it is now much easier to get an NHS dentist than in the past.

Since April 2009 the PCT received ten complaints relating to access and eight complaint letters relating to concerns about the quality of the service they have received. Feedback from the public about the helpdesk has been very positive.

Prior to the opening of the helpdesk the PCTs PALS service was the point of contact for the public although no detailed recording was kept of general dental enquiries. It was however recognised by the PALs service that the volume of calls they received was consistent with the calls now recorded by the helpdesk. This earlier information from PALs helped support the plans to invest additional resources in dental care.

In future the PCT will be better placed from more detailed information from the new helpdesk to enable a more targeted approach to future investment and performance management of existing contractors.

9. Steele review update

The PCT had expressed an interest to be part of the second wave of pilots that was originally planned by the Department of Health as part of the Steele Reviews.
The Department has subsequently changed the format of the pilots and will be announcing a programme for trialling a new dental contract from April 2011.
This will be aimed at individual contractors who will be able to apply in January 2011 to be a pilot practice. The PCT will continue to support those practices who are selected to be part of the pilots.

10. Conclusion

In summary, huge progress has been made this year to improving NHS dentistry and NHS Eastern and Coastal Kent will continue to ensure dental care is a priority to enable more of our population to easily access NHS dental care and treatment.

NHS Eastern and Coastal Kent will endeavour to allocate the lower than national average funding it receives, where it will be best utilised, giving the greatest benefit in the most efficient way, whilst also ensuring value for money.
Continual review of demand data collected by our Dental Helpdesk is assisting with this process and informing commissioning decisions that will best serve our population now and for the future.

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NHS
West Kent

Wharf House
Medway Wharf Road
Tonbridge
Kent
TN9 1RE

Telephone: 01732 375200
Fax: 01732 362525
Freephone Number: 0800-0-850-850

PRIVATE & CONFIDENTIAL
Mr Paul Wickenden
Overview, Scrutiny & Localism Manager
Democratic Services,
Kent County Council,
Legal and Democratic Services,
Sessions House, County Hall,
Maidstone,
Kent, ME14 1XQ

Our Ref HOSC/7.1.11

6th December 2010

Dear Mr. Wickenden,

HOSC Meeting, Friday 7th January 2011 10.00 a.m.

Thank you for your letter of the 9th November 2010 addressed to Marion Dinwoodie our Chief Executive.

In preparation for your HOSC meeting in January 2011, please find enclosed a detailed response to all the queries listed in the Appendix attached to your letter. The overall strategic questions outlined in your covering letter are answered in the enclosed response, but I have provided a summary overview below which I hope is helpful.

1. **The key challenges in ensuring there is sufficient dental provision to meet the needs of the people in Kent**

   The most fundamental challenge facing NHS West Kent in commissioning primary care dentistry is the size of its financial allocation that it receives from the Department of Health. NHS West Kent would like to draw the HOSC's attention to the fact that the PCT receives the 12th lowest level of funding of the 152 PCTs in England (please see Appendix A which is attached as part of overall submission to your questions). NHS West Kent receives an allocation that equates to £34 per resident in comparison with a national average of £43.

   This is highly significant because it means that NHS West Kent receives considerably less in its financial allocation than most PCTs. If NHS West Kent were to receive funding in line with the national average then this would mean the PCT would have approximately £5 million more to spend on primary care dental services than is currently the case.

2. The measures which can be taken to improve dental service provision in Kent.

There are four key areas where further improvements could be made. These are:

(i) Raising public and patient awareness

The key issues here are:

1. To promote the importance of good oral health.
2. To promote the message that seeing a dentist regularly (at least once every two years in accordance with the NICE guideline) is essential in order to maintain health teeth and gums.
3. To address the myth of 'registration' that surrounds NHS dentistry by making the West Kent audience aware of how to access an NHS dentist and to promote the PCT's Customer Services Helpline to facilitate this.
4. To signpost people to where there are available services which have capacity to treat them.
5. To promote the public awareness of their rights as patients including information about treatment and costs.

(ii) Increasing available capacity

Access to dental services could be improved with additional investment. The PCT will review it's current investment in dental services through its Strategic Commissioning Plan. The PCT will consider plans to further improve general access to primary care dentistry as well as to domiciliary services. However these plans will need to be considered against other priorities and pressures.

(iii) Improving delivery

Further improvements in delivery can be found from the money the PCT already spends on securing dental services. In this respect there are a number of dental practices that are underperforming on their contracts. Furthermore, there remains a level of variation in practice between our providers. We have plans in place to address both these areas in order to improve productivity and the consistency of delivery.

In aggregate terms, our dental providers are delivering approximately 97% of their contracted activity volumes. Over the last 2 years this has improved from an aggregate position of 91%. However the current position of 97% aggregate delivery means there is approximately £600K per year of contract value that is not being used to treat patients (this amount would enable 5,000 more people to regularly receive NHS dental care). Dentists are required to repay this underspend to the PCT but our preference would be for dental practices to use the money we are paying them to treat more patients.

There are a number of areas around productivity but one example concerns the rate and frequency with which patients are recalled for check-ups. This is an important area because if all our practices consistently followed NICE guidelines then it would enable a larger number of patients to be seen and managed as NHS patients. Patients that are orally fit do not need to be seen for a check-up every three or six months. If orally-fit patients were seen for check-ups once every 12 months then this would create more capacity for dentists to see and treat other patients.

(iv) Addressing inequalities

We will also be aiming to reduce any potential inequalities which may exist, and in this respect will target specific areas such as:

1. Specific geographical areas and communities where access to NHS dentistry is more difficult.
2. Those communities where there are high numbers of people considered to have poorer oral health.
3. Increasing and improving domiciliary care services which would benefit those that are less mobile including the frail elderly.

I look forward to seeing you on the 7th January. I hope to be accompanied by my colleagues, Allan Pau, Specialist Registrar in Public Dental Health and Maureen Hall, Dental Contract Manager.

If you have any queries in the meantime, please do let me know.

Kind regards
Yours sincerely,

Stephen Ingram

Stephen Ingram
Director of Primary Care

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NHS West Kent

1. Please provide some key facts about the levels and types of dentistry activity in your PCT area, including:

a. Numbers of dentists providing NHS dental treatment, and the percentages working under the different types of contract;

Table 1: Number of dental performers working under different types of contract

	2007/08		2008/09		2009/10	
	Number	**%**	**Number**	**%**	**Number**	**%**
Providing performer	90	32.80%	82	26.70%	81	25.71%
Performer only	208	69.80%	225	73.30%	234	74.29%
Total	**298**	**100%**	**307**	**100%**	**315**	**100.00%**
General Dental Services (GDS)	260	87.20%	300	97.70%	299	94.92%
Personal Dental Services (PDS)	29	9.70%	7	2.30%	9	2.86%
Mixed	9	3.00%	0	0	7	2.22%
Total	**298**	**100%**	**307**	**100%**	**315**	**100.00%**

Table 1 shows West Kent dental provider information. The source of this data is the Information Centre website.

Currently within West Kent there are:

- 110 separate contracts for primary dental services
- 11 practices that hold contracts for the provision of orthodontics only under PDS
- 3 practices that hold contracts for the provision of both primary dental and orthodontic services under GDS
- 27 practices that hold contracts for the provision of domiciliary services and primary dental services under GDS

b. Numbers of dentists providing NHS dental services to children but not adults;

NHS West Kent currently holds ten child only dental contracts. In years 08/09 and 09/10 the PCT held twelve child only contracts; two have been re-negotiated to also include adult patients. The PCT will not be awarding any further child only contracts

and whenever the opportunity arises, will renegotiate contracts to make them non-age specific.

c. Information on the levels of dental activity (Units of Dental Activity) and Courses of Treatment, broken down into patient type (i.e.: adults and children);

Table 2: Data on Courses of Treatment and UDAs by Patient Type.

	2007/08		2008/09		2009/10	
	CoT	UDAs	CoT	UDAs	CoT	UDAs
Band 1	**194,441**	**194,441**	**200,097**	**200,097**	**208,138**	**208,138**
Children	86,360	86,360	87,907	87,907	89,907	30,984
Adult	108,081	108,081	112,190	112,190	118,231	74,411
Band 2	**104,491**	**313,473**	**106,078**	**318,234**	**105,395**	**316,185**
Children	33,371	100,113	33,255	99,765	30,984	92,952
Adult	71,120	213,360	72,823	218,469	74,411	223,233
Band 3	**13,970**	**167,640**	**14,915**	**178,980**	**17,037**	**204,444**
Children	464	5,568	477	5724	632	7,584
Adult	13,506	162,072	14,438	173,256	16,405	196,860
Urgent	**24,677**	**29,612**	**25,986**	**31,183**	**27,241**	**32,689**
Children	3,485	4182	4,045	4,854	4,239	5,087
Adult	21,192	25,430	21,941	26,329	23,002	27,602
Other COT*	**7843**	**6301**	**7865**	**6280**	**7,220**	**5,787**
Children	not collected	not collected	968	728	836	628
Adult	not collected	not collected	6897	5552	6,384	5,159
Arrest of bleeding	16	19	12	14	13	16
Bridge repairs	120	144	96	115	90	108
Denture repair	1,335	1,335	1,260	1,260	1,245	1,245
Removal of sutures	97	97	71	71	58	58
Issue of prescription	6,275	4,706	6,426	4,820	5,814	4,361
PCT Commissioned Activity		**781548**		**768768**		**794102**
GDP Activity Completed		**711,467**		**734,774**		**767,243**
%		**91%**		**95.6%**		**96.6%**

For this current year ending 31st March 2011, 836,167 UDAs have been commissioned. The projected outturn at year end is 812,252 which equates to

97.1%. This demonstrates a continual improvement by year as can be seen from the above table, bottom row.

d/e Total number of patients seen by an NHS dentist, and what this is as a proportion of the resident population (for comparison purposes, could the above information be provided for 2007/8 and 2008/9 along with the most current information you have).

Table 3: Number of Unique Patients Seen over previous 24-month period. Information collected from www.ic.nhs.uk figures are produced quarterly.

Patients	Sept 07	Sept 08	Sept 09	Sept 10
Adults	184,317	170,649	177,153	190,187
% of population	36.1%	33.1%	34%	36.5%
Children	99,150	94,538	94,720	96,374
% of population	65.1%	62.0%	61.70%	62.8%
Total	**283,467***	**265,187***	**271,873***	**286,561***
% of population	**42.8%**	**39.7%**	**40.3%**	**42.5%**

* These figures relate to the total number of individual patients receiving NHS treatment under a dentist in West Kent during the proceeding 24-month period. This is a key performance indicator (a 'Tier 2 Vital Sign' target) for PCTs, underpinned by a NICE guideline which recommends for patients to attend a dentist at least once every two-year's in order to maintain healthy teeth and gums.

2. How much is spent on commissioning dental services and how do dentists receive remuneration for providing services

In 2009/10 NHS West Kent spent £24.67M gross on commissioning primary dental services. This amount does not however net off Patient Charge Revenue which totalled £5.46M. The PCT's net spend was therefore £19.2M.

Dental contractors get paid a monthly sum in line with their contract values. The PCT then performance manages the provider with regard to the value of activity delivered against their contract plan. The dental providers, as independent contractors, determine how much they, and the staff they employ, receive in terms of salaries, taking into account the expenses incurred in running their business.

3. Can you please provide comparative data showing where your PCT resides in the national and regional tables for dental funding? How is this allocation determined?

In so far as the 2010/11 financial allocation is concerned, NHS West Kent has the 12th lowest financial allocation per patient out of 152 PCT's in England. This is illustrated in the Primary Dental Services Indicative 2010-2011 Non-Recurrent Allocations Table (Appendix A). This table shows the range of dental allocations on both a resident population and registered population basis across England and the significant variation in allocation between PCTs. The average allocation per resident for England is £43. In comparison, the allocation for NHS West Kent is £34. This

means that NHS West Kent receives 21% less funding than the average for England. If NHS West Kent were to receive an equivalent average amount of funding then this would equate to approximately an additional £5million with which to commission additional services.

Dental budget allocations were based on historical spend on NHS Dentistry by PCTs. The rationale for this approach was that the historic use of services could be used as a proxy for understanding and meeting need for the future and to maintain historical patterns of provision.

At a regional level, NHS West Kent PCT also has a disproportionately low level of funding across NHS South East Coast (Strategic Health Authority), having the lowest level of funding per resident population, along with Surrey PCT. The SHA range being £34 to £53 per head. See Table 4 below.

Table 4: Primary Dental Services
Indicative 2010-2011 non recurrent allocations

PCT	Net Allocation £000s	£000s	Resident population (000s) - ONS mid 2008	Registered population (000s) - attribution data set Mar 09	Allocation per patient (resident)	Allocation per patient (registered)
Surrey PCT	37,102	37,102	1,089	1,155	£34	£32
West Kent PCT	**23,112**	**23,112**	**674**	**699**	**£34**	**£33**
Eastern and Coastal Kent PCT	25,944	25,944	728	762	£36	£34
Hastings and Rother PCT	6,768	6,768	178	182	£38	£37
East Sussex Downs and Weald PCT	12,766	12,766	333	346	£38	£37
West Sussex PCT	32,717	32,717	789	816	£41	£40
Brighton and Hove City PCT	12,392	12,392	254	299	£49	£41
Medway PCT	13,442	13,442	254	279	£53	£48

4. How are dentists remunerated for preventative work?

Preventive care and treatment is part of the mandatory services that all dental contractors must perform as part of their primary dental service contract. Therefore dentists do not receive specific, separate remuneration for preventive work because this element of the care pathway is included within the price of the activity they are contracted to perform.

5. Is any dental provision commissioned from community service providers?

There are two services provided by community dental providers. These are:

- **West Kent Primary Care Dental Service,** formerly known as the Community Dental Service, provides dental care to patients with physical, mental, social or dental special needs. This service is hosted by NHS Medway Community Healthcare and also provides additional services such as school screenings, residential home screenings, oral health promotion, orthodontic treatment and dental epidemiology. More information on accessing this service is explained under question 9 below.

- **The Emergency Dental Service** (EDS) provides out-of-hours emergency dental treatment. Clinics are located at various dental practices or sites across Kent and are accessed on an appointment basis.

6. What information can be provided on the state of children's oral health in your PCT, and how this has changed over time?

The NHS Dental Epidemiology Programme for England - Oral Health Survey of 12 year old Children 2008 / 2009 has recently been published (Appendix B). This report has been written using data from the North West Public Health Observatory and it's Dental Observatory. A more detailed summary is available from their web-site [1].

NHS West Kent takes part in national epidemiological surveys. These highlight that we have some of the lowest levels of oral disease in the country. However, we are aware of pockets of deprivation in West Kent where the oral health of children is below the national average.

At present, 10% of the worst (most deprived) schools are screened by West Kent Primary Care Dental Service and offered treatment. West Kent Primary Care Dental Service also provides oral health promotion programmes.

7. What plans are there to develop children's dental health and dental health services?

Child Heath is an important element in the new White Paper and the PCT will be looking to see how we can work with the new local authority public health Joint Strategic Needs Assessment to ensure improvement in child oral health is recognised as part of the strategy.

The PCT are currently re-commissioning its salaried dental service. This presents us with an opportunity to redefine the health promotion programmes within the service agreement.

The Department of Health has recently completed a consultation exercise and are due to pilot a new dental contract, which focuses on improving quality, achieving good dental health and increasing access to NHS dentistry, with an additional focus on the oral health of schoolchildren.

[1] http://www.nwph.net/nwpho/

It is also worth noting that the oral health of children in NHS West Kent is very good compared with national data and that 62.8% of resident children are accessing NHS dental care – see table 3. Furthermore, the orthodontic service discussed in question 8 below, is predominantly a specialist service for children, notwithstanding the fact that it is available to all patient categories.

8. Regarding orthodontic services:

a) How many orthodontic courses of treatment are provided on the NHS to residents of your PCT area?

The following table (no 5) shows the Units of Orthodontic Activity (UOA) as at 30th September 2010 commissioned by NHS West Kent along with the number of patients treated. A full course of treatment for each patient typically utilises 21 UOA's.

Table 5 – UOA as at 30th September 2010

	units of orthodontic activity	**number of patients treated**
Assess and accept/start treatment	64,577.00	3,119
Assess and Review	5,495.00	5,375
Assess and Refuse	1,044.00	1,045
Treatment Completed	0	1,685
Treatment Abandoned	0	84
Treatment Discontinued	0	109
Repairs	0.8	1
Regulation 11 appliances	0	15
Total for PCT	**71,116.80**	**10,835**

b) How are orthodontic services accessed by patients?

Patients are referred by their General Dental Practitioner (GDP) to an orthodontist using The Kent Orthodontic Referral Pro-forma (Appendix C). The referral pro-forma has a guide to help the GDP decide which patient needs a referral for NHS orthodontic treatment and which provider is the most suitable. All NHS referrals must be on this form, although the GDP may attach a letter providing further details if they wish. This pro-forma assesses the "need" of the patient for orthodontic treatment. All patients referred for orthodontic treatment should firstly be dentally fit and have good oral hygiene.

c) How are providers of NHS orthodontic services remunerated and what decisions are being made around commissioning orthodontic services after March 2011?

Dental contractors get paid a monthly sum in line with contract values. The PCT then performance manages the provider with regard to the value of activity delivered against contract plan. The dental providers, as independent contractors, determine

how much they, and the staff they employ, receive in terms of salaries, taking into account the expenses incurred in running their business.

The orthodontic practices contracts for Personal Dental Service (PDS) in April 2006 were for a period of three years with an option to extend this for a further 24 months. These contracts will therefore come to an end 31st March 2011. NHS West Kent has a total of 7 Personal Dental Services (PDS) contracts that come to an end on 31st March 2011.

The Department of Health (DH) recently published guidance to PCTs on how to approach the review and re-commissioning of existing orthodontic contracts which are due to expire at the end of March 2011. In order to maintain continued access to services for patients the DH guidance suggested four options when reviewing these contracts. The four options are:

1) Existing agreement/contract expires and services not re-commissioned. This action would be appropriate if, from the PCT's needs assessment, the service is no longer required in the current location or there are concerns regarding service performance or quality.

2) Award an agreement/contract under a "Single Tender Waiver" to current provider for defined transition period. This action allows for a more clearly planned transition to a longer term solution in-line with future policy for dental services. This would only be appropriate if quality and performance of the service already provided was adequate.

3) Award a "Single Tender Waiver" with enhanced provisions for a defined period of time. This action allows the PCT the opportunity to explicitly implement performance management and quality standards. This would be appropriate if there was room for improvement in the quality and/or performance of the service already being provided.

4) Use open procurement for services. This allows the PCT to test the market for value for money solution. It may also allow the PCT to secure provision in areas where there has been no previous service and has been identified as a need.

A paper is currently being prepared within NHS West Kent outlining the options on a per contract basis for discussion and decision in early 2011.

9. Who provides out of hours dental services and how do patients access these?

DentaLine is commissioned by NHS West Kent to provide an out-of-hours dental service. DentaLine is part of community dental services (also referred to as salaried services) and is hosted by Medway Community Health Care (provider arm of NHS Medway). This service is provided at a number of designated dental access centres by booked appointment. Patients need to telephone the Kent DentaLine on 01634 890300 and will be given an appointment slot at a centre if urgent treatment is considered necessary.

All dental practices holding NHS contracts are required to display their out-of-hours arrangements including telephone numbers in their waiting rooms. This information should also be visible from the outside of the practice, a fact that is reviewed during practice inspections. In addition information about out-of-hours arrangements must be made clear on practices answer phone messages.

Practices opting out of out-of-hours are required to signpost patients to the arrangements with DentaLine which are outlined below.

This service is available between 7.00PM - 10.30PM during weekdays and between 09.30AM and 11.00AM. DentaLine treat patients who:

- are bleeding heavily (haemorrhaging) from the mouth
- have an injury to their teeth or mouth
- have severe facial swelling
- are in pain that started suddenly and cannot be eased by pain killers

NHS charges apply to all out-of-hours dental services.

10. What is the patient pathway for those with advanced oral health needs (such as cancer, and/or courses of treatment involving referral to a consultant)?

The GDP refers the patient to secondary care services following standard protocols. The specialties referred to are maxillo-facial and/or oral surgery. Our main secondary care providers are:

- Maidstone and Tunbridge Wells NHS Trust
- Dartford and Gravesham NHS Trust
- The Queen Victoria NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust.

11. Are there any particular geographical areas where there are issues around commissioning adequate dental provision?

Commissioning priorities are aligned to objective data, public health needs assessment findings and local intelligence. In line with this information, NHS West Kent has made a significant investment of an additional £3million into improving access to NHS dentistry in the last year. We anticipate this will enable 40,000 more people to regularly see an NHS dentist. Improvements include new surgeries in Tonbridge and Swanley and more NHS appointments available at a range of other surgeries throughout West Kent.

NHS West Kent has no plans to make further investment in NHS dentistry during the remainder of this financial year, but will consider future decisions on investment according to the priorities and needs of the local population, and taking account of the PCT's overall financial position as well as other priorities.

The Oral Health Needs Assessment for GDS Procurement led by colleagues in Dental Public Health, published in January 2010 which informed much of the most

recent commissioning activity is available to view. Please see footnote[2]. This assessment documented:

- The oral health status of the West Kent population and, where possible, its distribution geographically and by socio-economic backgrounds.

- The estimated level of dental activity needed to meet the demand for NHS dental services by 2011, and

- The wards most likely to need further investment in development of dental services.

In addition, NHS West Kent Directorate of Strategy and Communications, undertook a social marketing exercise. This has provided a clear and localised understanding of the perceived barriers which exist for potential patients in accessing NHS dentistry. This information will be used in conjunction with our needs assessment work to shape any future commissioning of dental activity.

12. Are there any particular times of year where there are issues around commissioning adequate dental provision?

The PCT is still unaware of any seasonal issues relating to the demand for dental care. The supply side could however be affected by significant outbreaks of seasonal flu etc. However with over 100 providers of NHS dental care across West Kent this risk is considered to be small and to date we have not experienced any seasonal related issues.

13. What are the challenges faced by PCTs in commissioning adequate dental provision and what plans does the PCT have to develop dental services in the future and what will be the impact of the NHS White Paper proposals?

The key challenges faced by PCTs in commissioning adequate dental provision are:

- Disproportionately low level of funding allocation from DH as identified in question 3 above.
- The PCT has recently had its Tier 2 Vital Sign target relating to the number of Unique Patients Seen over the 24 month period ending March 2011 increased from 320,000 to 352,000.
- Raising public awareness of oral health and dentistry and stimulating the demand for dentistry and highlighting its essential role in primary prevention.
- The timescales associated with full tendering processes are lengthy and can take almost a year before contracts are signed and new services mobilised.

To a great extent all future plans will be restricted to the level of funding provided for NHS dentistry by DH. However, in terms of prioritising how the existing budget is spent, there is a Dental Steering Group made up of representatives from Dental Public Health, the Local Dental Committee, the Dental Practice Advisors and the PCT's Dental Team. The priorities identified by members of this group in January 2010 were:

[2] http://www.kmpho.nhs.uk/geographical-areas/primary-care-trusts/west-kent-pct/?assetdetesctl1877284=99224

- Improving access to domiciliary care.
- Improving access to primary care dentistry.
- Improving access to restorative, endodontic and periodontal services.
- Promoting smoking cessation.

Progress has been made in all of the above areas and priority areas and results will continue to be reviewed by the Dental Steering Group at regular intervals. These reviews will also include consideration of the latest dental needs assessment and findings of the social marketing campaign.

The intention of the proposals set out in the NHS White paper is to improve quality, achieving good dental health and increasing access to NHS dentistry, with an additional focus on the oral health of schoolchildren[3]. To achieve these intentions, three types of new contracts are being piloted to assess the potential impact before deciding, in consultation, on the final dental contract which is hoped to be introduced fully in April 2014, subject to approval of Parliament. The full impact of the NHS White Paper proposals will therefore depend upon the findings of the pilots which are expected to last one year. However, the three contracts being piloted have been designed to test safety, clinical outcomes and effectiveness and patient experience. In addition, the proposed new national contract will be based on registration, capitation and quality. For the latest information available on this please see DH's NHS Dental Contract: Proposals for Pilots, December 2010[4] and letter from the Chief Dental Officer – England at DH (Appendix D).

14. What actions are you taking to ensure dental care is provided to groups with a traditionally low take up?

The needs assessment identified areas with a low take up of dental services and linked to this, our recent social marketing campaign identified barriers patients perceive which may prevent them from accessing NHS dental care. To address some of these barriers the PCT is currently organising a poster campaign in selected GP surgeries to raise awareness of the dental services available.

The PCT has also made contact with representatives of local traveller sites to encourage attendance with an NHS dentist in the area. In addition, the PCT promotes the location of NHS dental providers within local borough council magazines distributed to the public.

15. Is there any mobile dentistry provision within your PCT area, and is this something you have considered?

3 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

4 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122789.pdf

The PCT dental commissioning team has considered mobile dental units and as a result obtained some projected costs and specifications. However, on further investigation, this model of dentistry was not pursued because the PCT received advice from NHS Primary Care Commissioning that both they and the DH felt these units were only suitable in extremely remote areas. This is because the units have proven very difficult to manage in many areas, not least with matters of waste disposal and decontamination, which might ultimately present unnecessary risks to patients.

16. What powers of prescription do dentists have and how much prescribing is carried out by them?

Dentists can only prescribe items listed in the Dental Prescribing Formulary (Part XVIIA of the Drug Tariff) and are prescribed on Form FP10 (D). Although the Dental Formulary displays products by their generic titles and dentists are strongly encouraged to prescribe generically, a product may be ordered on Form FP10 (D) by its brand name providing that the brand is not listed in Part XVIIIA of the Drug Tariff (the blacklist).

Relevant information is attached in the links below:
http://www.psnc.org.uk/pages/prescribing_rights.html
http://www.psnc.org.uk/pages/introduction_to_the_drug_tariff.html
http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/Drug_Tariff_Guidance_Notes.doc

How much prescribing is carried out by them?

Dental data is only available at a national (England) level as the prescription forms do not identify the Primary Care Trust (PCT) of the prescriber or the patient and therefore the prescriptions cannot be attributed.

Relevant information is attached in the links below:
http://www.ic.nhs.uk/webfiles/publications/PrescribingDentists08/Prescribing%20by%20Dentists%202008.pdf

17. Please provide the following information relating to customer services (including information from PALS)

- ***a) How many enquiries are received each quarter relating to dental services and what trends can be identified regarding the nature of these enquiries?***
- ***b) How many complaints/compliments/comments have been received about accessing dental services?***
- ***c) How many complaints/compliments/comments have been received about the quality of the services?***
- ***d) How has information from customer services about dentistry informed service development?***

Table 6 - Total enquiries, including complaints, received by NHS West Kent Customer Services in quarterly periods from July 2007 to end of September 2010.

	2007/08			2008/09				2009/10				2010/11	
Period	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Queries													
Accessing NHS dentist	285	158	1024	1075	1317	749	652	1015	1063	584	964	597	841
Domiciliary visit	0	0	2	2	2	2	5	14	12	31	25	39	32
Waiting list for new practices following procurement							45	10	3	5			
Emergency dental services											68	91	51
Patients being told NHS unavailable												172	110
Complaints													
Dental Charges	1		2	2	1	3	6	12	11	10		21	15
Treatment/ diagnosis	1		3	2	4	8	15	13	13	12			
Attitude/ Communication				1		1	1	5	5	4			
Referrals					2	1			2	2			
Orthodontic						1	1		1	2			
Wheelchair access							1						
Miscellaneous							5	6	8	13			
Total Dental Queries	**287**	**158**	**1031**	**1082**	**1326**	**765**	**731**	**1075**	**1118**	**663**	**1057**	**920**	**1049**

Please note: The above data across the periods shown is not comparable due to a revised data collection and analysis process and changes in software systems .

The information is more useful for performance review and management as it relates to existing services rather than the lack of service.

The information is used primarily for two main purposes. Firstly to identify any issues that relate to individual dental contractors or dental practitioners which the PCT will then investigate and manage accordingly. Secondly we use the intelligence to inform service development and specifically future procurements. In this respect, the information that underpins some of the data in Table 6 will be used as part of the refreshed dental needs assessment through which the PCT will determine where to place further additional contracts and capacity.

18. What part is your organisation playing in the development of a new dental contract following the Steele Review?

The new dental contract is being developed nationally with a small working group including Professor Steele. Proposals to roll out the pilot of this new contract are expected to be announced in December 2010.

The current CEO of NHS West Kent is a member of the national working group.

APPENDIX A

Primary Dental Services
Indicative 2010-2011 non recurrent allocations

Primary Dental Services
Indicative 2010-11 non-recurrent allocations

SHA code	PCT code	PCT	Primary Dental Services Net Allocation £000s	Total £000s	Resident population (000s) - ONS mid 2008	Registered population (000s) - attribution data set Mar 09	Allocation per patient (resident)	Allocation per patient (registered)
Q33	5ET	Bassetlaw PCT	3,976	3,976	111	111	£36	£36
Q36	5M6	Richmond and Twickenham PCT	4,741	4,741	187	198	£25	£24
Q30	5D9	Hartlepool PCT	4,745	4,745	91	95	£52	£50
Q36	5LA	Kensington and Chelsea PCT	4,896	4,896	171	186	£29	£26
Q36	5A5	Kingston PCT	5,000	5,000	165	190	£30	£26
Q38	5QT	Isle of Wight NHS PCT	5,585	5,585	140	140	£40	£40
Q32	5EF	North Lincolnshire PCT	5,745	5,745	157	167	£37	£34
Q30	5J9	Darlington PCT	5,907	5,907	100	106	£59	£56
Q31	5HP	Blackpool PCT	6,237	6,237	141	152	£44	£41
Q39	TAL	Torbay Care Trust	6,386	6,386	134	145	£48	£44
Q30	5QR	Redcar and Cleveland PCT	6,620	6,620	138	136	£48	£49
Q32	TAN	North East Lincolnshire Care Trust Plus	6,622	6,622	159	170	£42	£39
Q39	5K3	Swindon PCT	6,625	6,625	201	213	£33	£31
Q37	5P8	Hastings and Rother PCT	6,768	6,768	178	182	£38	£37
Q34	TAM	Solihull Care Trust	6,930	6,930	204	221	£34	£31
Q30	5D8	North Tyneside PCT	6,951	6,951	196	214	£35	£32
Q31	5J4	Knowsley PCT	7,057	7,057	150	159	£47	£44
Q34	5PH	North Staffordshire PCT	7,390	7,390	212	210	£35	£35
Q36	TAK	Bexley Care Trust	7,640	7,640	225	227	£34	£34
Q39	5M8	North Somerset PCT	7,950	7,950	207	207	£38	£38
Q30	5KF	Gateshead PCT	7,992	7,992	190	205	£42	£39
Q39	5FL	Bath and North East Somerset PCT	8,230	8,230	177	196	£46	£42
Q30	5KG	South Tyneside PCT	8,352	8,352	151	155	£55	£54
Q34	5MK	Telford and Wrekin PCT	8,448	8,448	162	170	£52	£50
Q36	5K6	Harrow PCT	8,484	8,484	225	234	£38	£36
Q36	5K8	Islington PCT	8,543	8,543	189	211	£45	£41
Q31	5NQ	Heywood, Middleton and Rochdale PCT	8,560	8,560	204	222	£42	£39
Q30	5KM	Middlesbrough PCT	8,570	8,570	140	153	£61	£56
Q31	5CC	Blackburn with Darwen PCT	8,587	8,587	139	166	£62	£52
Q36	5AT	Hillingdon PCT	8,618	8,618	258	269	£33	£32
Q38	5FE	Portsmouth City Teaching PCT	8,670	8,670	199	209	£43	£41
Q36	5C2	Barking and Dagenham PCT	8,814	8,814	172	181	£51	£49
Q31	5JX	Bury PCT	8,969	8,969	182	194	£49	£46
Q38	5L1	Southampton City PCT	8,983	8,983	234	260	£38	£35
Q30	5E1	Stockton-on-Tees Teaching PCT	9,057	9,057	190	192	£48	£47
Q32	5J6	Calderdale PCT	9,066	9,066	200	209	£45	£43

Q31	5J2	Warrington PCT	9,239	9,239	196	204	£47	£45
Q34	5CN	Herefordshire PCT	9,268	9,268	179	180	£52	£51
Q35	5GC	Luton PCT	9,311	9,311	191	207	£49	£45
Q34	5PJ	Stoke on Trent PCT	9,342	9,342	247	279	£38	£33
Q33	5N7	Derby City PCT	9,373	9,373	243	291	£39	£32
Q36	5K7	Camden PCT	9,383	9,383	227	238	£41	£39
Q35	5PN	Peterborough PCT	9,503	9,503	170	175	£56	£54
Q32	5H8	Rotherham PCT	9,547	9,547	253	255	£38	£37
Q36	5C3	City and Hackney Teaching PCT	9,663	9,663	224	269	£43	£36
Q34	5M3	Walsall Teaching PCT	9,792	9,792	255	269	£38	£36
Q31	5J5	Oldham PCT	9,840	9,840	218	237	£45	£41
Q36	5H1	Hammersmith and Fulham PCT	9,898	9,898	169	188	£59	£53
Q36	5NC	Waltham Forest PCT	10,111	10,111	221	271	£46	£37
Q39	5A3	South Gloucestershire PCT	10,265	10,265	260	255	£39	£40
Q35	5PV	West Essex PCT	10,413	10,413	280	285	£37	£37
Q32	5JE	Barnsley PCT	10,416	10,416	225	243	£46	£43
Q38	5CQ	Milton Keynes PCT	10,429	10,429	238	253	£44	£41
Q31	5HQ	Bolton PCT	10,432	10,432	264	289	£40	£36
Q36	5A4	Havering PCT	10,458	10,458	232	252	£45	£41
Q31	5NR	Trafford PCT	10,530	10,530	214	231	£49	£46
Q34	5MV	Wolverhampton City PCT	10,591	10,591	238	260	£44	£41
Q36	5A7	Bromley PCT	10,769	10,769	308	325	£35	£33
Q32	5NW	East Riding of Yorkshire PCT	10,789	10,789	336	314	£32	£34
Q35	5PR	Great Yarmouth and Waveney PCT	11,027	11,027	214	230	£52	£48
Q36	5LG	Wandsworth PCT	11,435	11,435	284	355	£40	£32
Q30	TAC	Northumberland Care Trust	11,448	11,448	311	321	£37	£36
Q34	5PE	Dudley PCT	11,604	11,604	306	315	£38	£37
Q36	5A8	Greenwich Teaching PCT	11,633	11,633	224	264	£52	£44
Q31	5LH	Tameside and Glossop PCT	11,752	11,752	248	238	£47	£49
Q34	5M2	Shropshire County PCT	11,824	11,824	291	296	£41	£40
Q39	5F1	Plymouth Teaching PCT	12,121	12,121	256	272	£47	£45
Q31	5NN	Western Cheshire PCT	12,151	12,151	233	259	£52	£47
Q31	5NF	North Lancashire Teaching PCT	12,152	12,152	326	338	£37	£36
Q37	5LQ	Brighton and Hove City PCT	12,392	12,392	254	299	£49	£41
Q37	5P7	East Sussex Downs and Weald PCT	12,766	12,766	333	346	£38	£37
Q36	5C1	Enfield PCT	12,846	12,846	289	300	£44	£43
Q36	5LC	Westminster PCT	12,855	12,855	247	245	£52	£53
Q30	5D7	Newcastle PCT	12,864	12,864	278	280	£46	£46
Q36	5LD	Lambeth PCT	13,146	13,146	281	370	£47	£36
Q31	5F5	Salford PCT	13,200	13,200	223	240	£59	£55
Q36	5HY	Hounslow PCT	13,227	13,227	230	251	£57	£53
Q30	5KL	Sunderland Teaching PCT	13,233	13,233	281	284	£47	£47
Q35	5PW	North East Essex PCT	13,316	13,316	322	322	£41	£41
Q36	5C4	Tower Hamlets PCT	13,318	13,318	227	245	£59	£54
Q36	5NA	Redbridge PCT	13,342	13,342	264	263	£51	£51
Q37	5L3	Medway PCT	13,442	13,442	254	279	£53	£48
Q39	5QM	Dorset PCT	13,556	13,556	406	399	£33	£34
Q31	5NM	Halton and St Helens PCT	13,564	13,564	295	319	£46	£43
Q31	5F7	Stockport PCT	13,583	13,583	283	297	£48	£46
Q33	5PC	Leicester City PCT	13,760	13,760	304	355	£45	£39
Q34	5MD	Coventry Teaching PCT	13,765	13,765	311	356	£44	£39
Q31	5NJ	Sefton PCT	13,933	13,933	274	280	£51	£50
Q35	5P1	South East Essex PCT	13,955	13,955	335	361	£42	£39
Q36	5K5	Brent Teaching PCT	14,038	14,038	255	353	£55	£40

Q39	5QN	Bournemouth and Poole Teaching PCT	14,064	14,064	305	361	£46	£39
Q36	5M7	Sutton and Merton PCT	14,338	14,338	392	396	£37	£36
Q38	5QG	Berkshire East PCT	14,360	14,360	394	416	£36	£34
Q36	5LF	Lewisham PCT	14,399	14,399	262	298	£55	£48
Q34	5MX	Heart of Birmingham Teaching PCT	14,548	14,548	274	315	£53	£46
Q36	5A9	Barnet PCT	14,583	14,583	338	357	£43	£41
Q36	5C9	Haringey Teaching PCT	14,834	14,834	225	275	£66	£54
Q35	5PX	Mid Essex PCT	14,892	14,892	368	375	£40	£40
Q31	5HG	Ashton, Leigh and Wigan PCT	14,944	14,944	305	318	£49	£47
Q36	5LE	Southwark PCT	15,058	15,058	283	311	£53	£48
Q36	5K9	Croydon PCT	15,090	15,090	341	377	£44	£40
Q36	5C5	Newham PCT	15,239	15,239	242	327	£63	£47
Q32	5NX	Hull Teaching PCT	15,423	15,423	261	288	£59	£54
Q34	5PG	Birmingham East and North PCT	15,764	15,764	405	442	£39	£36
Q31	5NK	Wirral PCT	15,835	15,835	309	332	£51	£48
Q35	5P2	Bedfordshire PCT	16,022	16,022	409	429	£39	£37
Q32	5N3	Wakefield District PCT	16,037	16,037	323	351	£50	£46
Q33	5EM	Nottingham City PCT	16,304	16,304	297	331	£55	£49
Q39	5QK	Wiltshire PCT	16,341	16,341	454	457	£36	£36
Q34	5M1	South Birmingham PCT	16,386	16,386	340	386	£48	£42
Q34	5PF	Sandwell PCT	16,754	16,754	289	336	£58	£50
Q35	5PY	South West Essex PCT	16,857	16,857	401	422	£42	£40
Q32	5N5	Doncaster PCT	16,870	16,870	289	308	£58	£55
Q36	5HX	Ealing PCT	17,330	17,330	312	359	£56	£48
Q31	5NH	East Lancashire Teaching PCT	17,718	17,718	381	388	£47	£46
Q32	5N2	Kirklees PCT	18,678	18,678	404	418	£46	£45
Q38	5QD	Buckinghamshire PCT	18,727	18,727	505	527	£37	£36
Q38	5QF	Berkshire West PCT	19,625	19,625	460	496	£43	£40
Q39	5QJ	Bristol PCT	19,647	19,647	426	458	£46	£43
Q31	5NE	Cumbria Teaching PCT	19,768	19,768	496	519	£40	£38
Q35	5PT	Suffolk PCT	19,793	19,793	593	611	£33	£32
Q30	5ND	County Durham PCT	20,303	20,303	505	530	£40	£38
Q34	5PK	South Staffordshire PCT	20,344	20,344	607	616	£33	£33
Q31	5NP	Central and Eastern Cheshire PCT	20,541	20,541	456	467	£45	£44
Q35	5PP	Cambridgeshire PCT	21,124	21,124	601	612	£35	£34
Q34	5PL	Worcestershire PCT	21,541	21,541	555	573	£39	£38
Q32	5NY	Bradford and Airedale Teaching PCT	21,543	21,543	501	542	£43	£40
Q31	5NG	Central Lancashire PCT	21,761	21,761	458	468	£48	£46
Q33	5PA	Leicestershire County and Rutland PCT	21,915	21,915	680	672	£32	£33
Q39	5QH	Gloucestershire PCT	21,977	21,977	586	608	£37	£36
Q33	5N9	Lincolnshire Teaching PCT	22,841	22,841	698	740	£33	£31
Q39	5QP	Cornwall and Isles of Scilly PCT	22,873	22,873	532	545	£43	£42
Q39	5QL	Somerset PCT	22,937	22,937	524	536	£44	£43
Q33	5N8	Nottinghamshire County Teaching PCT	22,977	22,977	662	664	£35	£35
Q37	5P9	West Kent PCT	23,112	23,112	674	699	£34	£33
Q31	5NL	Liverpool PCT	23,351	23,351	441	484	£53	£48
Q34	5PM	Warwickshire PCT	23,775	23,775	533	546	£45	£44
Q38	5QE	Oxfordshire PCT	23,907	23,907	611	675	£39	£35
Q31	5NT	Manchester PCT	24,432	24,432	473	538	£52	£45
Q35	5P4	West Hertfordshire PCT	24,565	24,565	543	584	£45	£42
Q35	5P3	East and North Hertfordshire PCT	24,663	24,663	541	582	£46	£42
Q32	5N4	Sheffield PCT	25,812	25,812	540	562	£48	£46
Q37	5QA	Eastern and Coastal Kent PCT	25,944	25,944	728	762	£36	£34
Q33	5PD	Northamptonshire Teaching PCT	26,304	26,304	679	698	£39	£38

Q35	5PQ	Norfolk PCT	27,856	27,856	751	747	£37	£37
Q33	5N6	Derbyshire County PCT	28,796	28,796	724	711	£40	£40
Q32	5NV	North Yorkshire and York PCT	31,429	31,429	788	794	£40	£40
Q39	5QQ	Devon PCT	31,893	31,893	747	758	£43	£42
Q32	5N1	Leeds PCT	32,428	32,428	779	804	£42	£40
Q37	5P6	West Sussex PCT	32,717	32,717	789	816	£41	£40
Q37	5P5	Surrey PCT	37,102	37,102	1,089	1,155	£34	£32
Q38	5QC	Hampshire PCT	46,085	46,085	1,284	1,309	£36	£35

Appendix B

NHS Dental Epidemiology Programme for England
Oral Health Survey of 12 year old Children 2008 / 2009

Introduction
This report has been written using data from the North West Public Health Observatory and its Dental Observatory[5]. A more detailed summary is available from that web site [6]. Details are given here of the oral health of 12 year old children surveyed in the school year 2008/9 nationally, regionally and for the PCTs in the South East Coast (SEC) SHA Region.

Methods
The sampling frame was children attending mainstream schools who were aged 12 years at the time of the survey. Trained and calibrated examiners collected data, which involved visual-only detection of missing teeth, filled teeth and teeth with obvious dentinal decay. The primary sampling unit was Local Authority (LA) but the methodology allowed for representative PCT samples. Positive consent was received for the children examined. Data cleaning and quality checks were undertaken before the data was transferred to the NWPHO for analysis.

Results
In total, 140 PCTs out of 152 took part in the survey covering 299 out of 326 local authorities (configurations as of April 2009). A total of 89,442 clinical examinations were included in the final analysis. This represented 15% of the population of this age cohort attending mainstream state schools. The overall response rate of pupils examined as a proportion of those sampled was 74%.

Experience of dental decay at age 12
At a national level 33.4% of pupils were found to have experience of caries, having one or more teeth that were decayed to dentinal level, extracted or filled because of caries. The remaining 66.6% were free from visually obvious dental decay. At a PCT level however there are wide variations ranging from Southwark where only 12.9% have experience in dental decay to Knowsley where 56.1% were affected. Figure 1 shows the differences across the country at strategic health authority (SHA) level. Within SEC SHA the caries experience ranges from 17.5% in Brighton and Hove City to 34% in Hastings and Rother. Figure 2 shows the values for the PCTs in the SEC SHA and Table 1 gives the percentages for the individual PCTs.

[5] www.nwph.net/dentalhealth, www.dental-observatory.nhs.uk

[6] **Summary of caries prevalence and severity results**
E Rooney, G Davies, J Neville, M Robinson, C Perkins, M A Bellis
November 2010

Figure 1 : Percentage of 12 year old children with decay experience ($D_3MFT > 0$) including 95% confidence limits. Strategic Health Authorities, 2008/09.

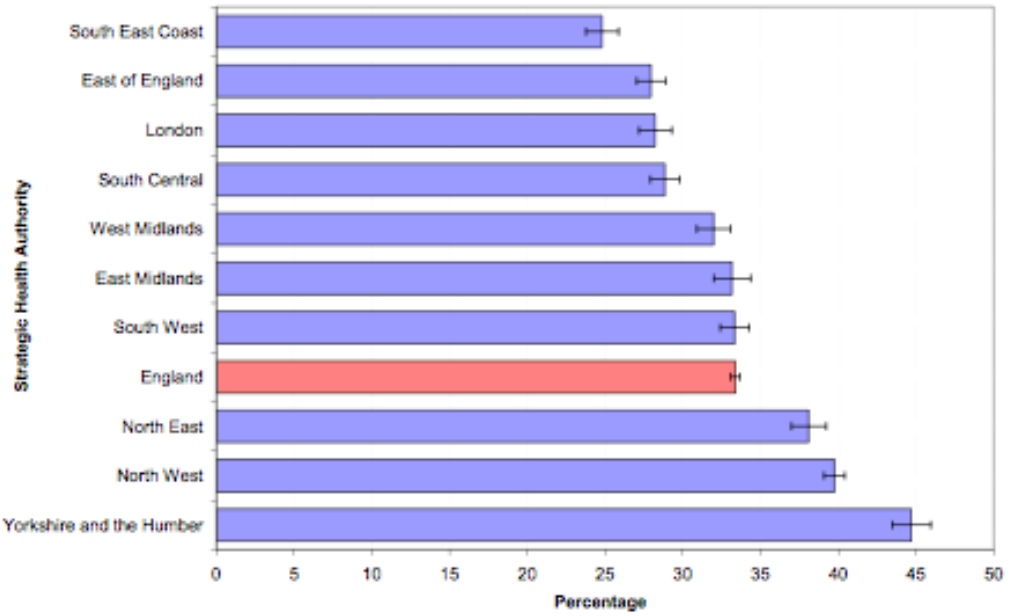


Figure 2: Percentage of 12 year old children with decay experience ($D_3MFT > 0$) including 95% confidence limits. SEC Primary Care Trusts, 2008/09.

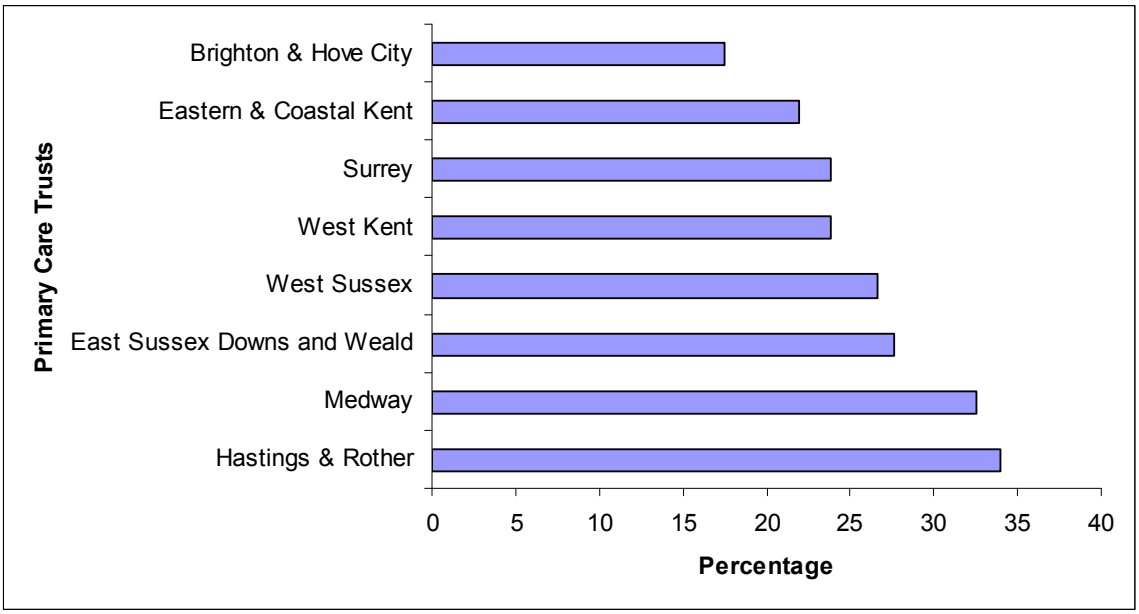


Table 1 : Percentage of 12 year old children with decay experience ($D_3MFT > 0$). SEC Primary Care Trusts, 2008/09.

PCT Name	% $D_3MFT > 0$
Brighton and Hove City	17.5%
East Sussex Downs and Weald	27.6%
Eastern and Coastal Kent	21.9%
Hastings and Rother	34.0%

Medway	32.5%
Surrey	23.8%
West Kent	23.8%
West Sussex	26.6%

Severity of dental decay at age 12

Across the whole of the population examined the average number of dentinally decayed, missing or filled teeth (D3MFT) per child is 0.74. Figure 3 shows the differences across the country by SHA. This ranges from 0.23 in Southwark to 1.48 in Ashton, Leigh and Wigan. Within the SEC SHA these values range from 0.27 in Brighton and Hove City to 0.77 in Medway. Figure 4 and Table 2 show these values for the PCTs.

Figure 3 : Average number of dentinally Decayed, Missing (due to decay) and Filled Teeth (D3MFT) in 12 year old children including 95% confidence limits. Strategic Health Authorities, 2008/09.

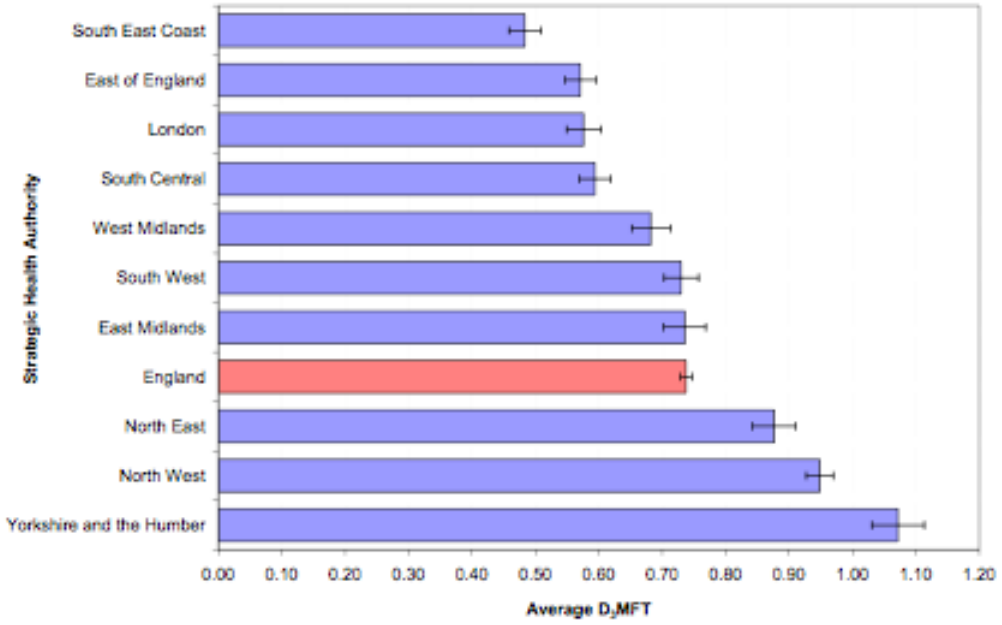


Figure 4 : Average number of dentinally Decayed, Missing (due to decay) and Filled Teeth (D3MFT) in 12 year old children. SEC Primary Care Trusts, 2008/09.

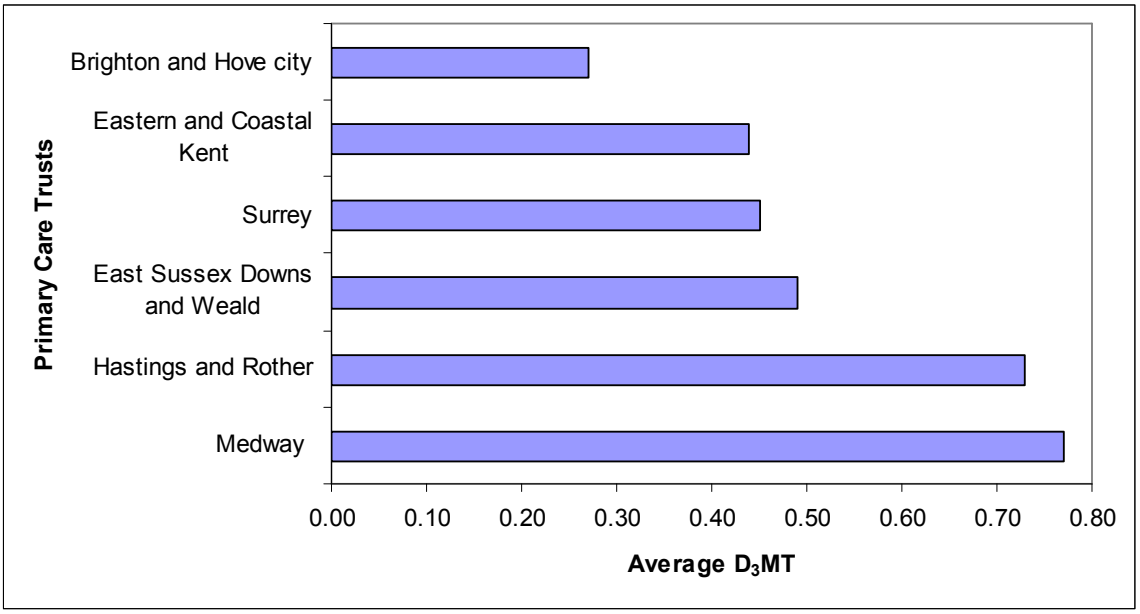
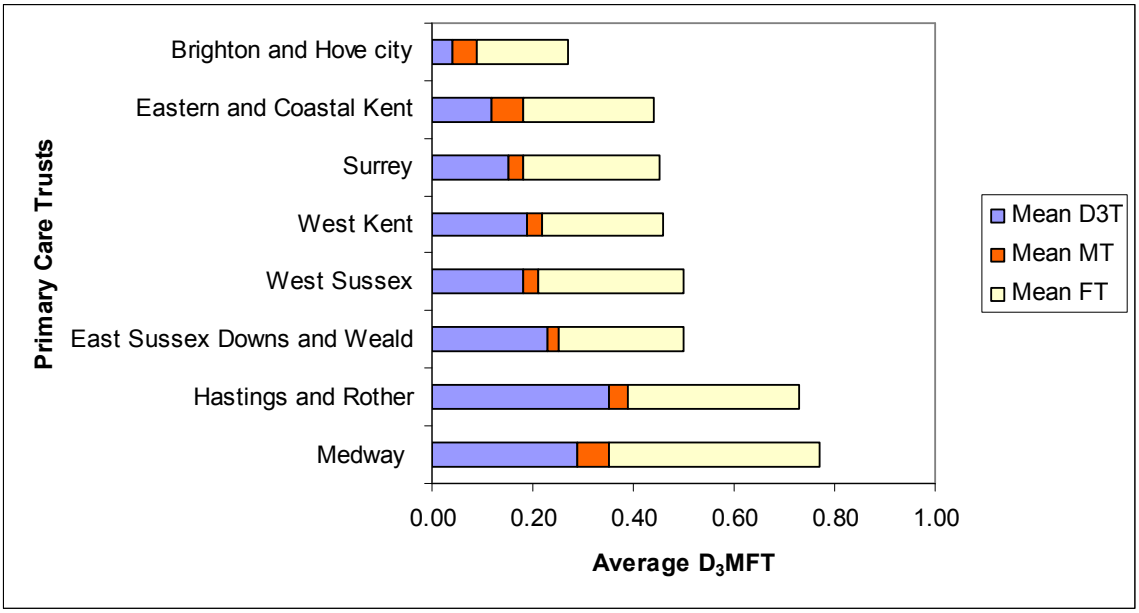


Table 2 : Average number of dentinally Decayed, Missing (due to decay) and Filled Teeth (D3MFT) and components in 12 year old children. SEC PCTs, 2008/09.

PCT Name	Mean D_3MFT	Mean D_3T	Mean MT	Mean FT
Brighton and Hove City	0.27	0.04	0.05	0.18
East Sussex Downs and Weald	0.49	0.23	0.02	0.25
Eastern and Coastal Kent	0.44	0.12	0.06	0.26
Hastings and Rother	0.73	0.35	0.04	0.34
Medway	0.77	0.29	0.06	0.42
Surrey	0.45	0.15	0.03	0.27
West Kent	0.46	0.19	0.03	0.24
West Sussex	0.50	0.18	0.03	0.29

The number of decayed, filled and missing teeth (due to dental decay) at age 12
The number of decayed and filled teeth makes a similar contribution to the total D3MFT index present in 12 year old children and missing teeth a far smaller portion. The combined components of the D3MFT index are shown for each PCT in the SEC SHA in Figure 5 and Table 2.

Figure 5 : Components of D3MFT (number of dentinally Decayed, Missing (due to decay) and Filled Teeth) in 12 year old children. SEC Primary Care Teusts, 2008/009



The care index

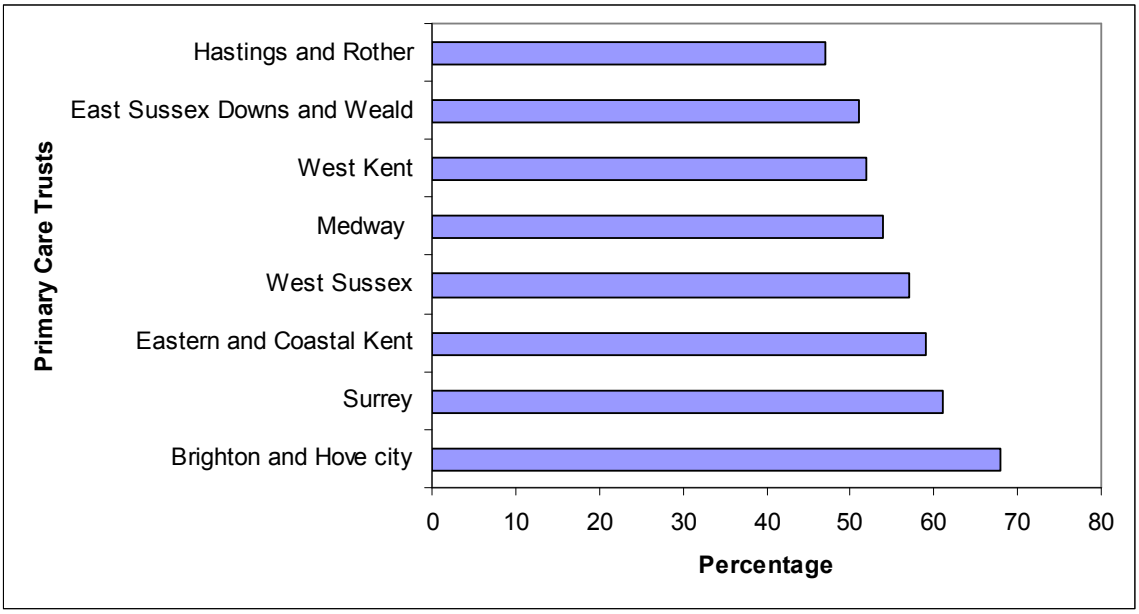
The care index is the proportion of teeth with caries experience which have been filled, derived by taking the number of filled teeth and dividing by the total number of dentinally decayed, missing and filled teeth and converting to a percentage (FT/D3MFT).

The care index is 47% across England as a whole and varies between SHAs from 42% in the North East to 58% in London, with South East Coast at 50%. The care index should be interpreted alongside other intelligence such as levels of deprivation, disease prevalence and the provision of dental services. Table 3 and figure 6 show the care index for he SEC PCTs.

Table 3: Care index (FT/ D3MFT) in 12 year old children. SEC Primary Care Trusts, 2008/09

PCT Name	Care Index %
Brighton and Hove City	68%
East Sussex Downs and Weald	51%
Eastern and Coastal Kent	59%
Hastings and Rother	47%
Medway	54%
Surrey	61%
West Kent	52%
West Sussex	57%

Figure 6: Care index (FT/ D3MFT) in 12 year old children. SEC Primary Care Trusts, 2008/09



Discussion

The positive consent now required for epidemiological surveys appears to have had little impact so the data can be used for comparison.

Approximately 12% of sampled schools declined to co-operate when asked by fieldwork teams. Only a small proportion of parents (7.3%) actively withdrew their children and only 6.7% of pupils declined the request to take part. Absenteeism on the day of examination accounted for loss of 11.8% of children. There was potential for any or all of these reasons for non-participation to bias the results. This proved not to be the case as weighting the results using quintiles of socio-economic deprivation had almost no effect on the unweighted results and this suggests that the samples were representative of the populations from which they were drawn, at a socio-economic level. This would suggest that withdrawal of co-operation by schools, parents or pupils was not associated with socio-economic measures.

In previous surveys the response rates of 75.0% and above have been achieved and considered by BASCD to provide sufficient confidence to enable publication and comparison with the results of previous surveys. In England during 2008/09, the response rate was 74.1% and therefore national level comparisons with previous surveys can be made with reasonable confidence.

The results showing reducing levels of disease are in alignment with those found in previous years. The geographic distribution of disease levels is also consistent with previous surveys. The northern SHAs, Yorkshire and The Humber, North West and North East show higher prevalence and severity of disease than SHAs in the Midlands and the South West. The more southern and easterly SHAs, South Central, South East Coast and London, along with East of England, have the lowest levels of disease.

APPENDIX C

Kent Orthodontic Referral Proforma

Date: ……

Insert Address of Orthodontist Here:

Referring Practitioner

Name:…….

Address**:**……

……

Contact No:…….

Fax No: …….

Patient Details IN BLOCK CAPITAL LETTERS please **Patient has been given information letter** ☐

Name……..... Male/Female

Address……

…….. NHS No.....….

Postcode (Essential)…….. Date of Birth……

Telephone Number (Daytime).....(Mobile)……..

GDP (If not referrer) Name……..
Practice…….....

GP Name……..
Practice……

Please tick one or more reason(s) below for your referral. Then check your selection overleaf to

decide the most suitable provider. Further descriptions for each reason are available overleaf.

Non palpable, unerrupted, permanent canines in patient aged 10 years *(see note 9)* ☐

1) Overjet >6mm <10mm	☐	>10mm ☐	8) Presence of supernumerary teeth	☐
2) Reverse overjet -1mm	☐	>-1mm ☐	9) Impacted teeth inc canines	☐
3) Traumatic overbite		☐	10) Submerged deciduous teeth	☐
4) Open bites > 4mm		☐	11) Aesthetic impairment	☐
5) Ant/Post x-bite with displacement		☐	12) Possible surgical case	☐
6) Crowded / Malaligned teeth		☐	13) GDP would like an opinion	☐
7) Missing teeth		☐	14) Over 18 for private assessment	☐

Relevant Medical History……..
.....
Additional Comments/Information……
…….

……
…….....

Please send relevant radiographs and models if available

FOR DATA PROTECTION PURPOSES, ELECTRONIC REFERRALS MUST BE SENT TO AND FROM SECURE NHS.NET ACCOUNTS ONLY. IF NHS.NET UNAVAILABLE, PLEASE SEND BY POST

NHS Orthodontic Referral Guidelines

This orthodontic referral proforma is to help you decide which patient needs a referral for NHS orthodontic treatment and which provider is the most suitable. All NHS referrals must be on this form, although you may attach a letter providing further details if you wish. This proforma is based around the "need" of the patient for orthodontic treatment.

S = Specialist practice (may include DwSI**)** **H = Hospital service** (see provider sheet)

1) **Overjet**: measured from the most prominent of the four incisors.
Action- if >6mm but <10mm, refer to **S.** If >10mm refer to **S** or **H**

2 **Reverse overjet:**
Action - Edge to edge to -1mm refer to **S**. If > -1mm, refer to **H**

3) **Traumatic overbite:** increased complete overbite with signs of trauma to the labial or palatal tissues.
Action- refer to **S** or **H**

4) **Open bites Ant/Post:** >4m.
Action - if linked to a digit habit refer to **S.** If not, refer to **H**

5) **Ant/ Post X bite with displacement**: mandibular displacement from RCP to ICP greater than 2mm.
Action - refer to **S**

6) **Crowded / Malaligned Teeth:**
Action - refer to **S**

7) **Missing teeth**: this relates to:
a) Hypodontia congenitally absent teeth commonly, upper laterals or second premolars (third molars do not count)
b) Avulsed teeth or inappropriate extractions (eg space remaining due to early loss of one or more first molars)
Action - refer to **S** unless severe hypodontia, then refer to **H**

8) **Presence of supernumerary teeth**: Extra teeth causing a problem.

Action - refer to **S** or **H**

9) **Impacted teeth:** a) simple tipped teeth causing food packing b) moderate /severe impactions,
including impeded eruption – not enough room for a tooth to erupt c) impacted or palatal canines - if
the maxillary canines cannot be palpated in the buccal sulcus by age 9-10 years, they may be ectopic
and further investigations should be carried out.
Action - if a) refer to **S**, if b) refer to **S** or **H,** if c) refer to **S** or **H**

10) **Submerged deciduous teeth:** adjacent teeth grossly tipped towards each other, premolar impacted
or missing.
Action - refer to **S**

11) **Aesthetic impairment:** in a select number of cases treatment may be justifiable on grounds of
"aesthetic impairment". If you feel this is the case then the patient should be referred for a specialist
opinion, but warned that treatment may not be available on the NHS.
Action - refer to **S**

12) **Possible surgical case**: for severe skeletal discrepancy, defects of cleft lip palate, craniofacial
anomalies.
Action - refer to **H**

13) **GDP opinion**: where a GDP has real concerns regarding an individual patient then a referral for a
specialist opinion remains entirely appropriate.
Action- refer to **S**

14) **Patient over 18** :-
Action - for orthodontics only refer to **S** (private**)** or if for (9b), (12) above then refer to

H (NHS).
In addition, patients referred for orthodontic treatment should be dentally fit and have good oral hygiene.

APPENDIX D

Gateway Number: 15285

New King's Beam House
22 Upper Ground
London
SE1 9BW

Tel: 02076334144
Fax: 02076334665

16 December 2010

Dear Colleague,

Piloting Reform of the NHS Dental Contract in England

You will be aware that the Government is committed to reforming the NHS dental contract.

Recent national surveys show that two-thirds of adults and children are now free of visible tooth decay; they deserve a dental service that helps them maintain good oral health, not one that is focused on treatment only.

The Government wants to enable dentists to exercise their professional judgment in working with patients to decide what care will be best to prevent ill-health and promote good oral health, whilst being accountable for the quality of the services they provide.

The Government wishes to put in place an NHS dental service delivering high quality clinically appropriate preventative, routine and complex care for those who choose it. As such, it plans to develop a new national contract based on registration, capitation and quality. It has said that it will develop the new contract in consultation with representatives of the profession, patients, and NHS management. It has said that it will pilot any changes before implementing them.

In September the Government announced the formation of a national steering group to advise it on the reforms. The group includes representatives of the BDA, and Professor Jimmy Steele, who led last year's independent review of NHS dentistry.

Ministers have today announced their proposals for piloting contract reforms. I am writing to explain the proposals in outline.

The Government intends to run three simultaneous sets of pilots. In all of the pilots, dentists will no longer have to carry out a given number of UDAs. All pilots will be required to adhere to a quality and outcomes framework. The three types of pilot are:

- Type 1 – a simulation model.
- Type 2 – a weighted capitation and quality model
- Type 3 – a weighted capitation and quality model, with a separately-identified budget for higher cost treatments within the overall contract value

Under the type 1 model, dentists will receive the same contract sum as they currently do. They will be expected to adhere to evidence-based clinical pathways, and will be eligible for payment according to performance against the quality and outcomes framework. They will be expected to provide care for a specified number of people. But otherwise they will be free to provide clinical care as they judge appropriate.

In the type 2 pilots the practices will receive a capitation payment to cover all care (preventative, routine and complex), and will be eligible for payment according to performance against the quality and outcomes framework. The pilots will more realistically explore whether the factors used in the weighted capitation model reflect the needs of patients across different practices and the response where the needs of individual patients differ from the average.

The type 3 pilots will also receive a weighted capitation payment. But it will cover only routine care and treatment. There will be a separately identified payment to cover more expensive and complex care. They will again be eligible for payment according to performance against the quality and outcomes framework.

The pilots will help us to test a Quality Outcomes Framework (QOF) in dental practice, and to develop and refine the systems, which we can use to monitor quality and outcomes. Quality covers three domains:

- Safety
- Clinical outcomes and effectiveness, and
- The patient experience

Work on quality indicators, and in particular outcome indicators, is relatively new in the NHS and even more so in dentistry. The quality framework itself will therefore need to continue to be developed over time. The pilots give us the opportunity to test and shape it in practice.

The QOF will be underpinned by the development of a comprehensive set of accredited clinical pathways. The importance of using clinical protocols using available evidence and professional consensus is a pillar of Government policy, and in the context of dentistry has been highlighted by clinicians who are already pioneering quality frameworks.

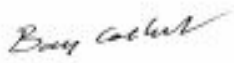
The plan is to launch the pilots at the start of the next financial year (2011/12). We will select the pilot sites from among the dental practices that apply, with the support of their local primary care trust (PCT). Guidance on how to apply to take part in the pilots, and detailed eligibility criteria will be published on the Primary Care Commissioning website very shortly.

The pilots will present us with the opportunity to see how the new system might work in practice, and to develop and refine systems for recording patients' oral health and clinical effectiveness and outcomes indicators.

The Government will assess the lessons of the pilots after a year, but will consider allowing their extension until the substantive new contract is implemented. After a year, the Government will consult on proposals for the new contract, and for reforms to the patient charging system to fit in with the new contract. The changes will require legislation, and so it will then introduce them to Parliament in a Bill. Subject to the approval of Parliament, we would expect to implement the new contract in April 2014.

The announcement of the Government 's proposals marks a great opportunity for NHS dentistry to move from being a treatment based service to a national dental health service. I know many of you will be keen to take part. Unfortunately we will have to place a limit on the number of pilots to about 50-60 nationally, in order to give the pilots the close scrutiny and evaluation they need to ensure we learn the lessons from them. But ultimately we, and the patients we care for, all stand to gain from the proposed reforms.

Yours sincerely,



Barry Cockcroft
Chief Dental Officer - England
Commissioning and Systems Management

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 7 January 2011

Subject: Draft Forward Work Programme.

---

1. Background.

(1) The Forward Work Programme has been revised to reflect the ongoing developments with the health sector.

(2) The following item has been agreed at an earlier meeting:-

(a) 4 February

1) The Future Shape of Community Service Provision

a) Strategic Questions for above item:

1. How can first class community health services best be provided for the people of Kent?

2. What are the challenges to realising this provision?

(2) The proposed new Forward Work Programme is outlined below:-

(a) 25 March

1) NHS Financial Sustainability. Part 1: Commissioning.

a) Strategic Questions for above item:

1. What are the challenges to ensuring the NHS in Kent is financially sustainable?

2. Are there any implications for the range and quality of health services available to the people of Kent as a result of any measures being taken to achieve or maintain financial sustainability?

(b) 19 April

1) NHS Financial Sustainability. Part 2: Providers: Acute Trusts.

a) Strategic questions as above.

(c) 10 June

1) NHS Financial Sustainability. Part 3: Providers: Mental Health and Community Services.

a) Strategic questions as above.

(3) The meeting dates for the rest of the year are as follows:

1. 22 July
2. 9 September
3. 14 October
4. 25 November

2. Recommendations

The Committee is asked to approve the revised Forward Work Programme.

Item 7 – Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update.

By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 7 January 2011

Subject: Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust: Update.

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1. Background

(a) At the meeting of this Committee of 26 November 2010, the following resolution was passed:

RESOLVED that a Freedom of Information Act request be made to the Secretary of State to ask him to release to the Committee a copy of the report he had commissioned to be prepared by the South East Coast Strategic Health Authority on the reconfiguration of Women's and Children's Services within the Maidstone and Tunbridge Wells NHS Trust.

(b) The subsequent correspondence is attached.

2. Recommendations

(a) The Committee is asked to note the attached correspondence.

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Members' Suite
Sessions House
County Hall
Maidstone
Kent ME14 1XQ
Tel: 01622 694434
Fax: 01622 694212
E-mail: members.desk@kent.gov.uk

Mr A Lansley,
Secretary of State for Health,
Department of Health,
Richmond House
79 Whitehall,
LONDON
SW1A 2NS

30 November 2010

Dear Mr Lansley

FREEDOM OF INFORMATION ACT REQUEST

On Friday 26 November the Health Overview and Scrutiny Committee of Kent County Council resolved to invoke the Freedom of Information Act legislation and ask for a copy of the report you commissioned from the South East Coast Strategic Health Authority concerning Women's and Children's Services within the Maidstone and Tunbridge Wells NHS Trust which was to be presented to you by 30 September 2010.

As the body which exercised its statutory right to refer the reconfiguration of Women's and Children's Services at Maidstone and Tunbridge Wells NHS Trust to you for determination, the Health Overview and Scrutiny Committee would like to see the report you commissioned on which you will base your decision.

I look forward to hearing from you.

Yours sincerely,

Bryan Cope
Vice-Chairman, Health Overview and Scrutiny Committee

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Mr A Lansley
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
LONDON
SW1A 2NS

Date: 17 December 2010

Dear Mr Lansley

FREEDOM OF INFORMATION ACT REQUEST

I refer to my letter dated 30 November 2010 (a copy of which is attached for your ease of reference).

The next meeting of the County Council's Health Overview and Scrutiny Committee is on 7 January 2011 and it would be helpful to inform the Committee of your response at this meeting.

I look forward to hearing from you

Yours sincerely,

pp Paul Wickenden

Bryan Cope
Vice-Chairman of the Health 0verview and Scrutiny Committee

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By: Paul Wickenden, Overview, Scrutiny and Localism Manager

To: Health Overview and Scrutiny Committee – 7 January 2011.

Subject: Committee Topic Discussion.

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1. Background

(1) In previous discussions that the Committee has had about different ways to restructure and refocus the Health Overview and Scrutiny Committee, one of the recurring themes has been that the Committee's meetings should be more focused on the outcomes it would like to achieve.

(2) This section of the meeting is to allow Members to discuss what they had heard and decide whether the outcomes for each main agenda item had been achieved, or whether there was a need for further information to be requested, and from whom.

2. Recommendations

(a) The Committee is asked to assess whether the outcomes for this meeting have been achieved or if further information on any topic is required by the Committee.

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