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:

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[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?

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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.

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[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.

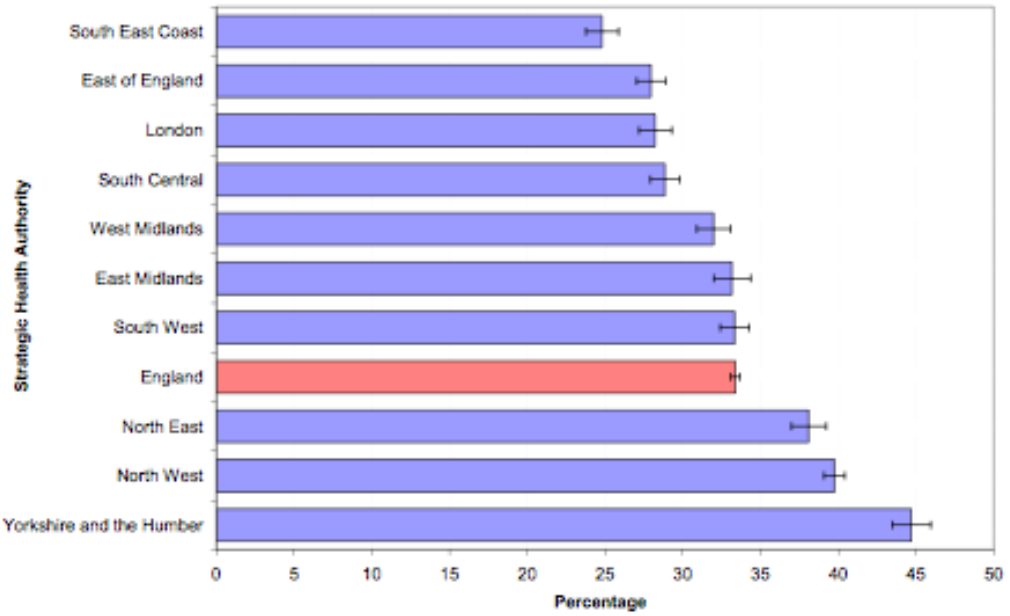


Figure 2: Percentage of 12 year old children with decay experience ($D_3MFT > 0$) including 95% confidence limits. SEC Primary Care Trusts, 2008/09.

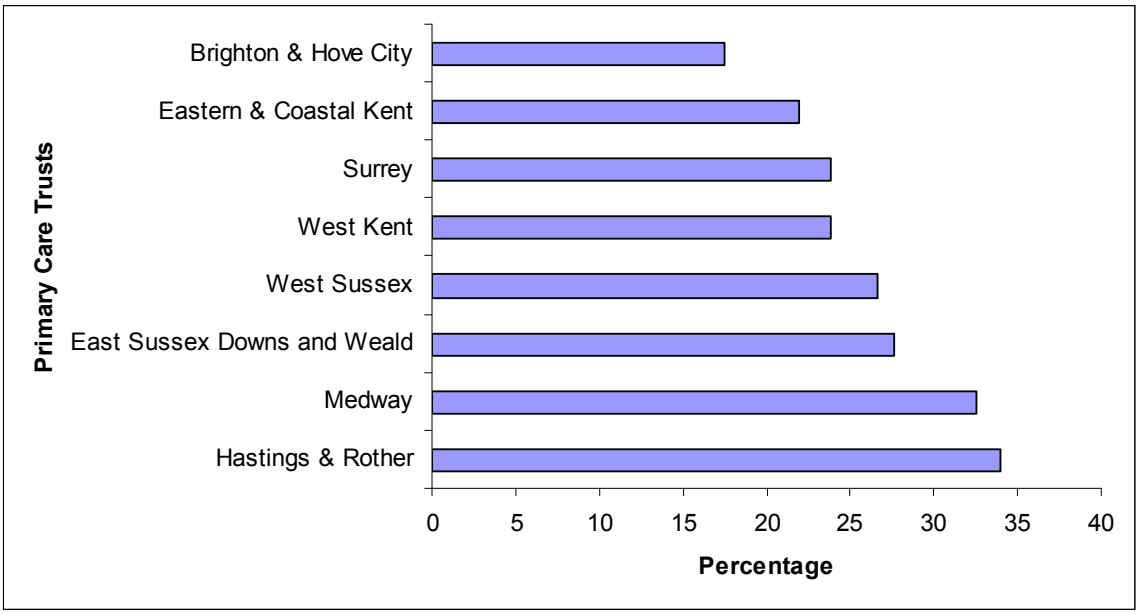


Table 1 : Percentage of 12 year old children with decay experience ($D_3MFT > 0$). SEC Primary Care Trusts, 2008/09.

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.

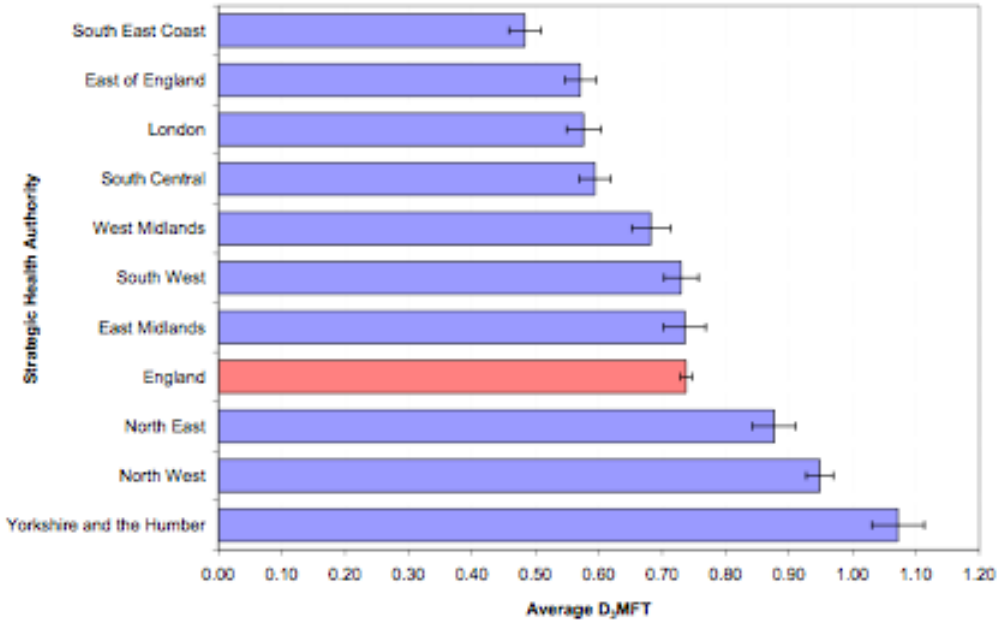


Figure 4 : Average number of dentinally Decayed, Missing (due to decay) and Filled Teeth (D3MFT) in 12 year old children. SEC Primary Care Trusts, 2008/09.

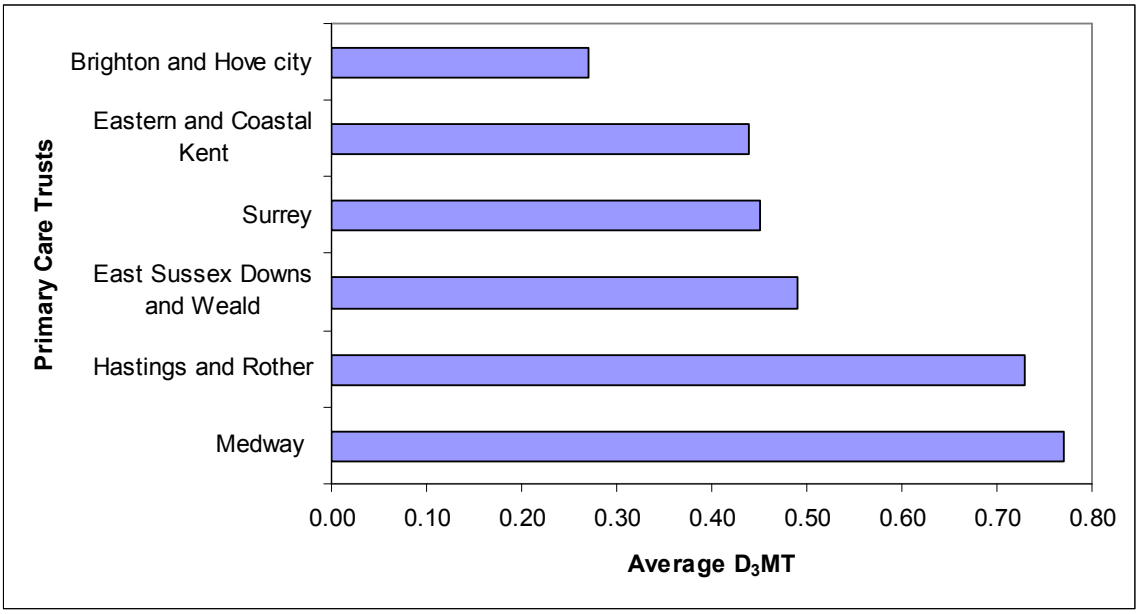
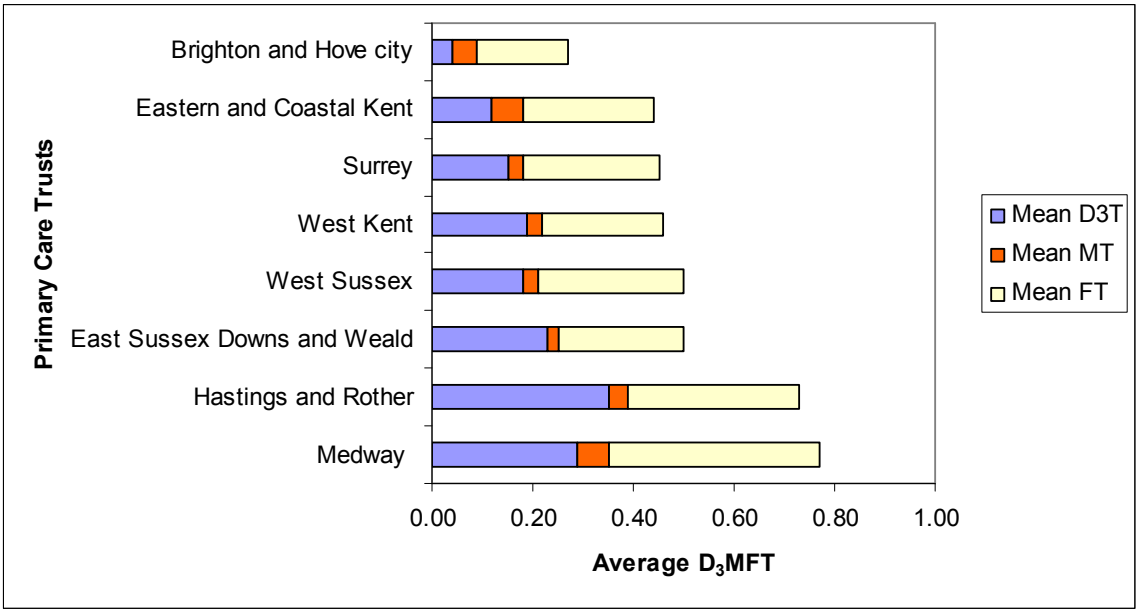


Table 2 : Average number of dentinally Decayed, Missing (due to decay) and Filled Teeth (D3MFT) and components in 12 year old children. SEC PCTs, 2008/09.

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

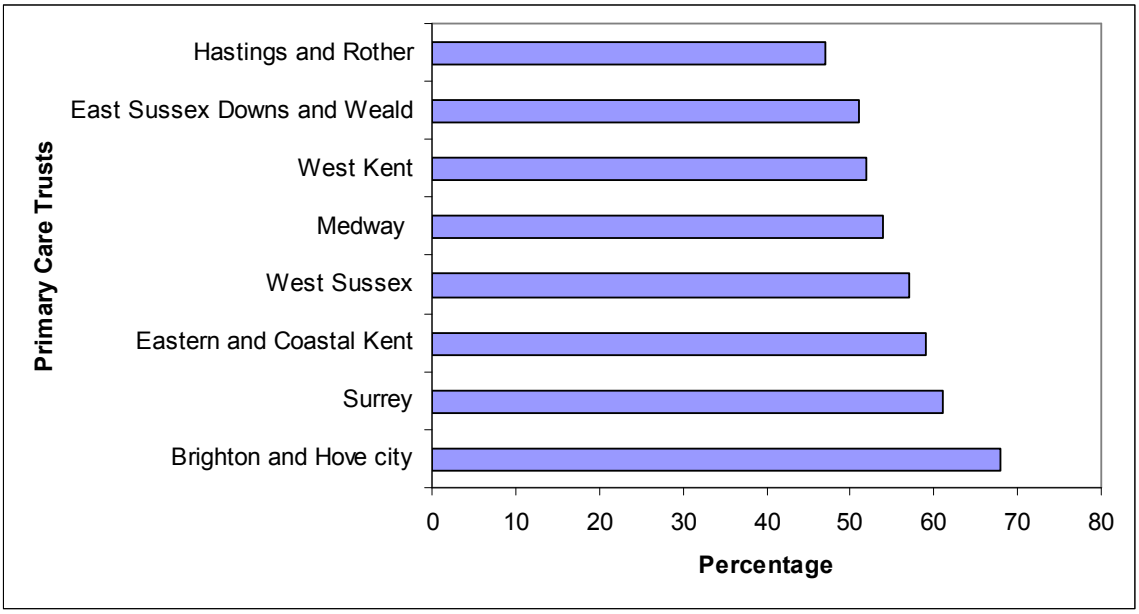
The care index is the proportion of teeth with caries experience which have been filled, derived by taking the number of filled teeth and dividing by the total number of dentinally decayed, missing and filled teeth and converting to a percentage (FT/D3MFT).

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

DH Department of Health

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

Tel: 02076334144
Fax: 02076334665

Gateway Number: 15285

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.

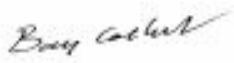
The plan is to launch the pilots at the start of the next financial year (2011/12). We will select the pilot sites from among the dental practices that apply, with the support of their local primary care trust (PCT). Guidance on how to apply to take part in the pilots, and detailed eligibility criteria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



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