CDO UPDATE
DH Department of Health
MARCH 2008
A COMMUNICATION TO THE DENTAL TEAM FROM THE CHIEF DENTAL OFFICER

CDO Foreword

Welcome to the latest edition of *CDO Update*. With everything that is happening in dentistry at the moment – not least its inclusion in the new NHS operating framework – I thought this was an opportune time to relaunch the CDO's regular bulletins to the profession.

The operating framework is a very significant document; not only does it make increased access to NHS dentistry a national priority for the next three years, but it also carries details of the indicative allocations to primary care trusts (PCTs) for delivering their dental services next year. There is a very significant increase in the dental allocations to PCTs – most will receive a 9% increase, with strategic health authorities (SHAs) receiving a further 2% to use within their own area where it can be most beneficial. This is unprecedented growth in funding and is a clear sign of the Government's commitment to grow and improve dental services. You can read more about the framework and where to access it online on page 2.

Now that it is 18 months since I was appointed, I find myself reflecting on both how far we have come and how much more we have to do. Many changes for the better are now evident: a significantly improved workforce situation; the positive outlook for the development of new fluoridation schemes; and the considerable number of new practices opening. It has been interesting to visit practices that are working with the NHS to expand their services and I have been very pleased to open new services across the country. In short, things are looking a lot brighter than they did a couple of years ago – but there is clearly much more to do.

This *CDO Update* includes articles both on the above and on a number of other important issues that are currently coming to the fore. These include the implications of 2009, the latest on the new salaried services contract, developments in pay and pensions and the likely impact of the 18 weeks target.

Barry Cockcroft

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THE IMPLICATIONS OF THE NEW OPERATING FRAMEWORK – LOOKING AHEAD TO THE NEXT THREE YEARS

On 13 December 2007, the Department of Health (DH) published *The NHS in England: The operating framework for 2008/09*. This document sets out the specific business and financial arrangements and describes the priorities for the next three years. Dentistry is featured significantly in paragraph 2.35:

'PCTs also need to ensure robust commissioning strategies for primary dental services, based on assessments of local needs and with the objective of ensuring year-on-year improvements in the number of patients accessing NHS dental services (as measured by quarterly data published by the Information Centre on the number of people receiving primary dental services within the most recent two year period.)'

Additionally, paragraph 1.10 specifically states: '2008/09 is the start of the next three-year planning round. In this context, we are clarifying the priorities for the next three years.'

The framework also refers to the fact that there is an overall increase in dental allocations, with each PCT receiving, on average, 9% and each SHA receiving an additional 2% with which to target specific issues or local areas under pressure.

Together, these statements clearly position the provision of dental services as a key priority over the longer term, placing dentistry where it belongs – in the mainstream NHS.

Barry Cockcroft

To read *The NHS in England: The operating framework for 2008/09*, see: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

2009 AND ALL THAT

Prior to the introduction of the new contractual arrangements in April 2006, much was made of various surveys that suggested that large numbers of dentists would reject contracts at around the time of the transition from the old system to the new. In reality, only about 3.6% of services were lost and, despite all the difficulties, PCTs were successful in recommissioning this lost activity.

Almost immediately following the April 2006 transition, the next perceived disaster scenario was set for 2009, when dentistry is apparently due to cease to become an NHS priority and when PCTs will divest themselves of dental services.

Clearly, this is never actually going to happen – the new legislation gives PCTs a statutory duty to provide primary dental care services and, as Ann Keen, Parliamentary Under Secretary of State for Health Services, stated on September 2007 at a seminar for PCTs, 'that statutory duty is not going away, either now, in 2009 or in the future'. This is exactly what I have been saying at every meeting I attend.

The one thing that does change in April 2009 is that the gross income guarantee to dentists will be removed. This does not mean that all practices will have their contracts renegotiated downwards – but it does give

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PCTs an opportunity to tackle areas where delivery on contract (and in the guaranteed income that people have been receiving) has not been consistent over the intervening three years. The Government has a robust commitment to growing NHS dental services, as demonstrated in the 2008/09 operating framework.

Many PCTs have engaged really well over the last two years in expanding dental services but there are still areas that are not developing as they should. Inclusion in the operating framework provides a very strong indication to the NHS that this is something it should be focusing on.

To reinforce the Government's commitment to the provision of NHS dentistry and its future development, DH launched new guidance in January 2008 entitled *Commissioning NHS primary care dental services: meeting the NHS operating framework objectives*.

Launched by Ann Keen, the new guidance sets out:

- the Government's commitment to maintaining and expanding NHS dental services and the expectations on the NHS to deliver year-on-year increases in access, as set out in the NHS operating framework for 2008/09
- more detail on what this means for commissioners and providers in developing dental services locally, including managing the 2009 transition.

This high-level guidance will be followed by a series of detailed briefing notes to support PCTs and providers of dental services in ensuring year-on-year improvements in the number of patients accessing NHS dental services, by means of robust commissioning based on assessments of local oral health and access needs.

Barry Cockcroft

To read *Commissioning NHS primary care dental services: meeting the NHS operating framework objectives*, see: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082104

WORKFORCE UPDATE

When we published our *Primary Care Dental Workforce Review* in 2004 there was a clearly identified gap between the need for dental services and the workforce available.

At the time, we initiated a well publicised recruitment drive involving increasing the NHS contribution from existing dentists but also focusing on international recruitment. The process was successful and we increased the number of dentists in the system very significantly. At the same time, we initiated a programme of expansion of undergraduate training in dental schools, including expansion to a critical mass of 75 places within existing dental schools and the creation of two new schools, in Plymouth and Preston.

I had the pleasure of opening the dental school in Preston (see page 11) and of meeting these new graduate entrants who are committed to learning how to provide high-quality dental services. The model of education whereby all clinical teaching takes place within the primary care sector is innovative and surely appropriate, given that the vast majority of dental graduates will provide their services in primary care throughout their practising life.

The new school in Plymouth is based on a similar model. It has been one of the great pleasures of my job to visit both new developments and existing dental schools that are successfully developing innovative outreach facilities with the capital we allocated to them for modernisation purposes.

Barry Cockcroft

TONY JENNER'S COLUMN

We have made it clear in our national oral health strategy, *Choosing Better Oral Health*, published in 2005, that the key focus for dentistry must be on effective prevention. Payment schemes such as 'fee per item' and the old Statement of Dental Remuneration did not support this but the new contractual arrangements have the potential to do so. For the first time, we have been able to include preventive items on the new FP17 in use from April 2008.

Choosing Better Oral Health was published at the height of the work leading to the new contractual arrangements in 2006 and so at the time didn't receive the attention that it deserved. However, I'm delighted that, despite this, many PCTs have or are developing excellent local strategies based on our key themes. With the publication of *Delivering Better Oral Health: An evidence-based toolkit for prevention,* in September 2007, we have identified how dental practices can make a real difference to improving oral health and reducing the oral health inequalities that still remain. We have also produced documents outlining how dentists can contribute to supporting patients who want to quit smoking (*Smokefree and Smiling,* May 2007*)* and how we can help to improve oral health in high-need children and adults with disabilities (*Valuing People's Oral Health*, November 2007*).* This year we will also be publishing guidance on supporting improvements in oral health in the black and minority ethnic communities, including economic migrants from Eastern Europe, who have – in many cases – much higher oral health needs.

To finish on a really positive note, oral health in England is improving and we should all be proud of that. Our older children in particular have some of the best teeth in Europe, which runs counter to popular belief about the state of the nation's oral health. However, we still have work to do. There are still inequalities across the country, which we must reduce, and we must do more to improve the oral health of our younger children. Fluoridation will play a big part in this (see page 7). Those of us who are in the postwar 'baby boomers' age group, or older, carry most of the country's dental restorations in our mouths; as these wear out and we keep our teeth longer, we will continue to need strong support from the dental profession. However, as successive age cohorts feed through the system, the whole nature of dentistry will change as there will be less and less active decay to treat. Indeed, if our dental public health preventive strategy is successful, then it is estimated that in 30 years' time or so dental caries in England will cease to be a public health issue.

Thank you for your support in improving our nation's oral health.

Tony Jenner
Deputy Chief Dental Officer
Head of Oral Health Policy

Useful links:
Choosing Better Oral Health www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251
Delivering Better Oral Health www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078742
Smokefree and Smiling www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074970
Valuing People's Oral Health www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080918

18 WEEK CLOCK RULES AND DENTAL SPECIALTIES

The underlying principle of the 18 week patient pathway is that patients should receive excellent care without unnecessary delay. The target covers pathways that involve, or could potentially involve, care led by a medical, dental or surgical consultant. It sets a maximum time of 18 weeks from the point of initial referral up to the start of any necessary treatment.

The 18 week target has to be achieved by the end of 2008. As a milestone, by March 2008 patients should begin treatment within 18 weeks for 90% of non-admitted referrals and 85% of admitted referrals.

A 'consultant-led' dental service is one where the consultant retains overall clinical responsibility for the care provided by the team, but may not necessarily be present for each of the patient's appointments. The 18 week target will therefore primarily include referrals to consultant-led hospital dental services, but may also include referrals to consultant-led dental services provided in the primary care setting, where the consultant has overall responsibility for the patient.

Many PCTs are currently looking at patient pathways and treatment patterns across primary and secondary care and considering opportunities to redesign services and referrals to meet the new targets.

Further details about 18 week clock rules and dental specialties can be found on in the dentistry section of the 18 weeks website: www.18weeks.nhs.uk/public/default.aspx?load=ArticleViewer&ArticleId=1026

Natasha Dogmetchi
Special Adviser, NHS PCC

IMPLEMENTING THE NEW SALARIED SERVICES CONTRACT

Left to right: John Langford, Janet Clarke, Andy Coombe, Eric Rooney and Barry Cockcroft.

Following overwhelming acceptance of the proposals in the recent ballot, the DH dental team is working closely with NHS Primary Care Contracting (PCC) to develop a programme of support for PCTs. This was launched with three one-day implementation learning events for PCT managers in London, Birmingham and Manchester. The event sets out to:

- position the review in the overall context of the local commissioning of primary care dentistry
- outline the benefits of the new system for both clinical staff and patients
- summarise the changes being introduced
- explain the HR and financial implications for PCTs – who will have to do what, by when
- launch the implementation toolkit for PCTs
- help PCTs devise their own implementation action plan on the day via a hands-on tuition session.

Opened by Barry Cockcroft, the morning sessions looked at what the new contract entails from an HR perspective and its implications for both dentists and commissioners. The other keynote speakers were:

- Janet Clarke, Chair of the Committee for Community and Public Health Dentistry (CCPHD), British Dental Association
- Eric Rooney, NHS Employers
- John Langford, Senior Dental Adviser/ Consultant in Dental Public Health, DH
- Andy Coombe, MD, Kairos Consultancy.

The afternoons consisted of three interactive workshops on appraisals and job planning, staff development and putting together an implementation programme. They were followed by a plenary session with all delegates returning to the larger group for a round-up of the afternoon's sessions, Q & A and closing. Presentations from all the events, Q & As and a step-by-step implementation toolkit are available on the PCC website at: www.primarycarecontracting.nhs.uk/248.php

The new contract is being introduced as direct a result of responses received to a DH consultation launched in December 2004 called 'Creating the future: Modernising careers for salaried primary care dentists'.

To read the original consultation, see: www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4108023

To read the analysis of consultation responses issued in March 2006, see: www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_4131379

To keep up to date with developments on the new contract, see the Salaried Services page on the PCC website on: www.primarycarecontracting.nhs.uk/248.php

For more information about the structure of the new contract and to access the core documents produced to support the ballot, see: www.nhsemployers.org/pay-conditions/primary-1071.cfm

Julia Battersby
Communications Lead, Dentistry
NHS PCC

FLUORIDATION – THE FACTS

The Water Act of 2003 means that new fluoridation schemes can now be developed where there is agreement to do so following widespread local consultation. This process can be highly controversial, with people making wild claims about so-called dangers. These claims are totally unfounded and I think it is interesting to note that 70% of the US and over 60% of the Australian population already drink fluoridated water. Furthermore, the 2003 York Review considered 700 articles on fluoridation and found no evidence of health risks. While we need to update the evidence base, we also know that fluoridation reduces tooth decay. Just look at the example of Manchester where there is three times the level of tooth decay as there is in Birmingham, where water is fluoridated.

Having worked and lived in a fluoridated area for over 20 years, I have personally seen the benefits this measure brings to improving oral health and wholly endorse it, as does Alan Johnson, Secretary of State for Health, who I am delighted to see has reinforced the Government's commitment to fluoridation in a number of key announcements to the NHS.

In the coming year, as we see consultations going forward, I hope to see dentists playing an active role in conveying positive messages to patients and the public about fluoridation.

Barry Cockcroft

Useful links:
DH guidance:
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_082666

National Fluoridation Information website:
www.fluorideinformation.com/default1.aspx

THE DARZI REVIEW AND DENTISTRY

As many of you will know, Lord Darzi has been invited to lead a wide-ranging review of the NHS to ensure that a properly resourced NHS is clinically led, patient-centred and locally accountable. The NHS Review will directly engage patients, NHS staff, the public and the voluntary sector. It focuses on three over-arching themes:

- quality and safety
- access
- reducing inequalities.

The review looks at eight patient pathways that aim to focus on NHS care from the cradle to the grave. To ensure that it is locally 'fit for purpose' and accountable, it is being driven by SHAs.

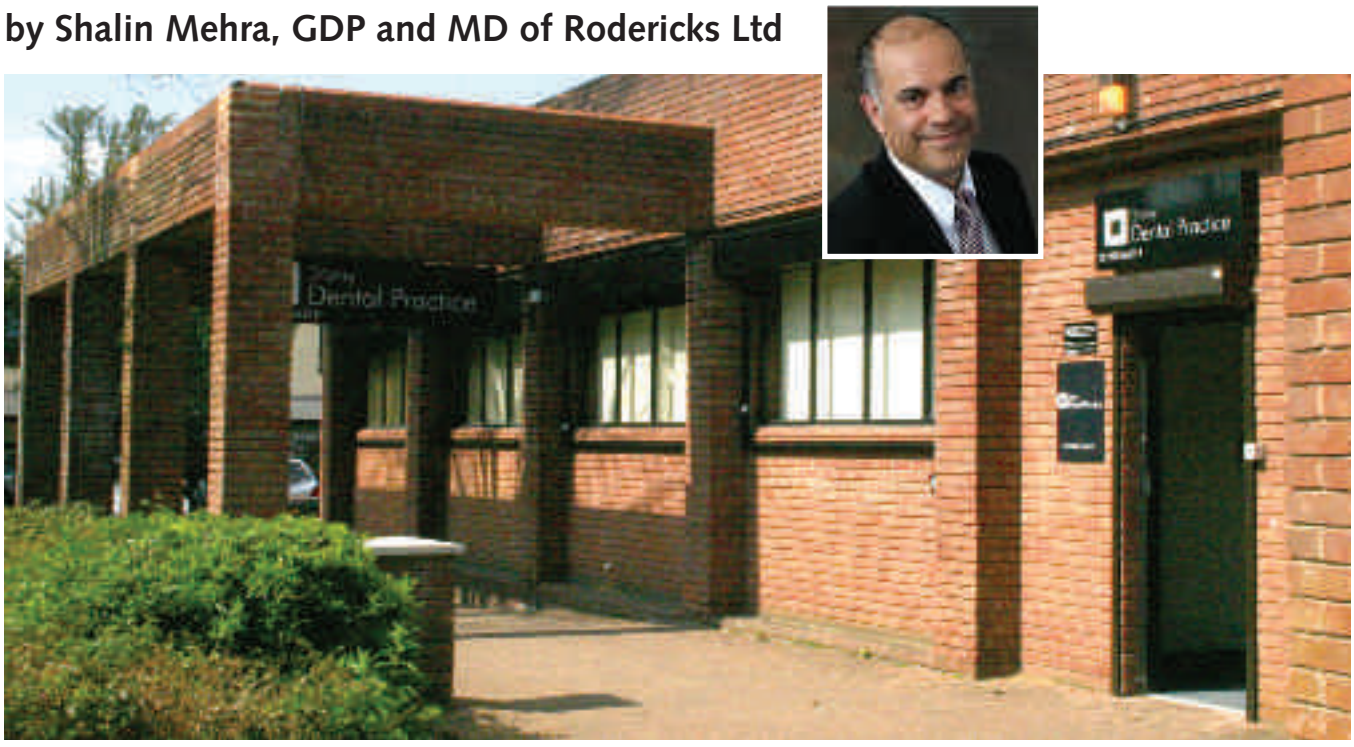
Obviously, dentistry is an integral part of the NHS and Lord Darzi has invited a dentist to provide clinical input to the Review Board. I am delighted that the dentist in question – John Milne from Yorkshire – has accepted and am confident, having known John for many years, that he will not be slow in making his presence felt.

Barry Cockcroft

For more information about the Darzi review, see www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_079077

NEW CONTRACTUAL ARRANGEMENTS – A PROVIDER'S PERSPECTIVE

by Shalin Mehra, GDP and MD of Rodericks Ltd



Shalin Mehra's NHS premises – Stony Dental Practice, Stony Stratford, Buckinghamshire, part of Rodericks Ltd.

It is over four years since the Government produced its first framework document for consultation on modernising NHS dental services. The intervening period has been a rollercoaster ride of information, misinformation, controversy, hints of opportunity and, ultimately, of opportunity realised.

From the outset, the profession was clearly concerned and initially did not understand the new arrangements. Possibly even more worrying, most PCTs knew little about dentistry. There were also many myths that emerged as pseudo-facts, such as: dentists would not be allowed to mix NHS and private treatment; child-only contracts were to be closed down; and there would be a contractual duty to treat every patient who presented at your door, come what may.

Latterly, when 2006 passed, 2009 became the 'big issue'. According to the rumours, NHS dentistry is to be 'asset stripped', 'all contract values are going to be reduced' and NHS dentistry is going to be allowed 'to wither on the vine'.

The reality is that things are settling down. PCTs have reorganised and their understanding of dentistry and local population needs is improving. In essence, 'dentists need PCTs, and PCTs need dentists'. Clearly, providers need to have a good, positive working relationship with their PCT, and providers, performers and PCTs will need to have common goals, with the ultimate aim of providing high-quality dental care to patients.

To this end, providers want openness, honesty, transparency, trustworthiness and good channels of communication with their PCTs and to cement a long-term working relationship. I have personal experience of seeing all these values at work in my dealings with Oxfordshire, Northampton and Derbyshire County PCTs – and they certainly make for positive and productive partnerships.

Working better by working together – embracing the tendering process

Tendering is another new element in the practitioner/PCT relationship and is an entirely new concept for dentists. In the past, when a dentist reduced his or her NHS commitment, it meant a loss of access for patients to NHS dentistry in that area – it rarely led to a new NHS practice opening in the vicinity to accommodate these patients. However, as funding remains in the PCT budget, a competitive tendering process should be undertaken to replace this lost provision and an increasing number of PCTs are now embarking upon this route.

Keith Mann, Derbyshire County PCT

Derbyshire County PCT has worked closely with Rodericks since they were appointed preferred providers for NHS dental services in Swadlincote, Swanwick and Belper. The emphasis has been on establishing the services in new premises as soon as possible, and keep to a tight timescale for delivery. The PCT is also working with the practice to establish patient forum groups at each practice to obtain first-hand feedback about the new services from the opening day. Any issues about access and services generally can then be dealt with very quickly.

Other circumstances in which tendering occurs include when a PCT identifies an area of need and sets out to commission new services to directly meet this need. I've witnessed this in action recently with tenders in Milton Keynes, Thame in Buckinghamshire and Belper, Swanwick and Swadlincote in Derbyshire. The PCTs concerned were targeting healthcare inequalities previously identified and, particularly in Derbyshire, new methods of working to meet specific local needs were encouraged. The tendering process is a daunting one, but there are plenty of workshops and courses on how best to handle it – and our Milton Keynes experience is documented as a case study in good practice on the PCC website. See: www.primarycarecontracting.nhs.uk/uploads/Dentistry/may_07/briefing_note__opening_a_new_practice.pdf

Diane Fenton, Northampton PCT

The PCT has worked collaboratively with Shalin Mehra and his partners over a number of years. For example, the practice worked with the PCT and community services to set up a paedodontic pilot, which entailed school visits and the treatment of those patients in deprived areas who were not registered with a dentist. The pilot is now an established service and the practice has enabled it to expand and deliver high-quality preventive care and treatment services to children in the whole town.The PCT has continued to maintain a productive relationship with the providers, having links with Shalin through his deanery work and with Steve Brooks, Clinical Director as an ex PCT-employed dental adviser. These associations have, we believe, helped to improve the quality of dental care within Northampton and we look forward to developing this further in the future.

Generally speaking, tenders go as follows: the location and site are approved by the PCT and then the provider is set a very challenging timescale in which to set up a practice. Once set up, patients need to be recruited via very sensitively tuned methods to prioritise those people with high levels of need. Often this process is undertaken in cooperation with and – where required – with additional help from

the PCT. For example, in one of the cases I mention above, the PCT operated a waiting list, the provider contacted people on it and offered priority appointments.

Nicky Wadeley, Oxfordshire PCT

Oxfordshire has a history of working closely with local dentists to develop improvements in access to NHS dentistry. Included within our 119 dental providers are nine vocational training practices, three of which have enhanced training status, and the PCT team is involved in the selection of training practices in association with the dental deanery. We also have a progressive salaried dental service providing additional specialist services including minor oral surgery and restorative services in primary care; these have recently relocated to a new five-surgery, state-of-the-art clinic part of the PCT Local Improvement Finance Trust scheme in East Oxford.

In the period prior to the introduction of the new dental contract, a strong network was established with local dentists who demonstrated a commitment to work with the PCT to provide high-quality accessible NHS dental care – one such dentist is Shalin Mehra, with whom we have an excellent working relationship. The PCT dental commissioning team is always open to discussion with local practitioners about changes to enhance access and quality of care for the local population either at workshops or practice meetings or on an individual basis. This has proved invaluable when facing some of the challenges of provision to a diverse population across a wide geographical area.

The waiting room area, Stony Dental Practice.

Looking ahead

The first year of meeting UDA (units of dental activity) levels was very challenging; however, our PCT was very understanding about the issue. There is no doubt that, as a currency, UDA is here to stay but as both providers and commissioners begin to understand the opportunities that the new contracts offer, I am sure more flexibility will develop. I think 2009 will come and go, and providers and performers will realise that the status quo will remain. Their contracts won't be removed and given to someone else who will do it cheaper. Their values won't be reduced at will.

For the future, as dentists and PCTs start to understand the potential of the new contract and to start to share emerging innovative schemes, I'm sure we'll see a much greater focus on prevention. The NHS is here to stay but there may be treatments that are quite rightly out of the scope of the NHS; I'd expect to see patients receiving healthcare from the NHS and those seeking purely cosmetic treatment to receive it outside the NHS, but probably from the same practitioner.

The last few years have been really difficult for the dental profession and the culture change has been enormous. But for us, where we have developed a good working relationship with the PCT, the change is starting to work as envisaged.

Shalin Mehra

A hints and tips paper on procurement is shortly be available on the PCC website at: www.pcc.nhs.uk/162_php

PRESTON DENTAL SCHOOL OPENS FOR BUSINESS

Reproduced with kind permission of UCLan

Left to right: Professor Lawrence Mair, Head of the School of Dentistry; Eileen Martin, Dean, Faculty of Health; Malcolm McVicar, Vice-Chancellor; and Barry Cockcroft, Chief Dental Officer (England).

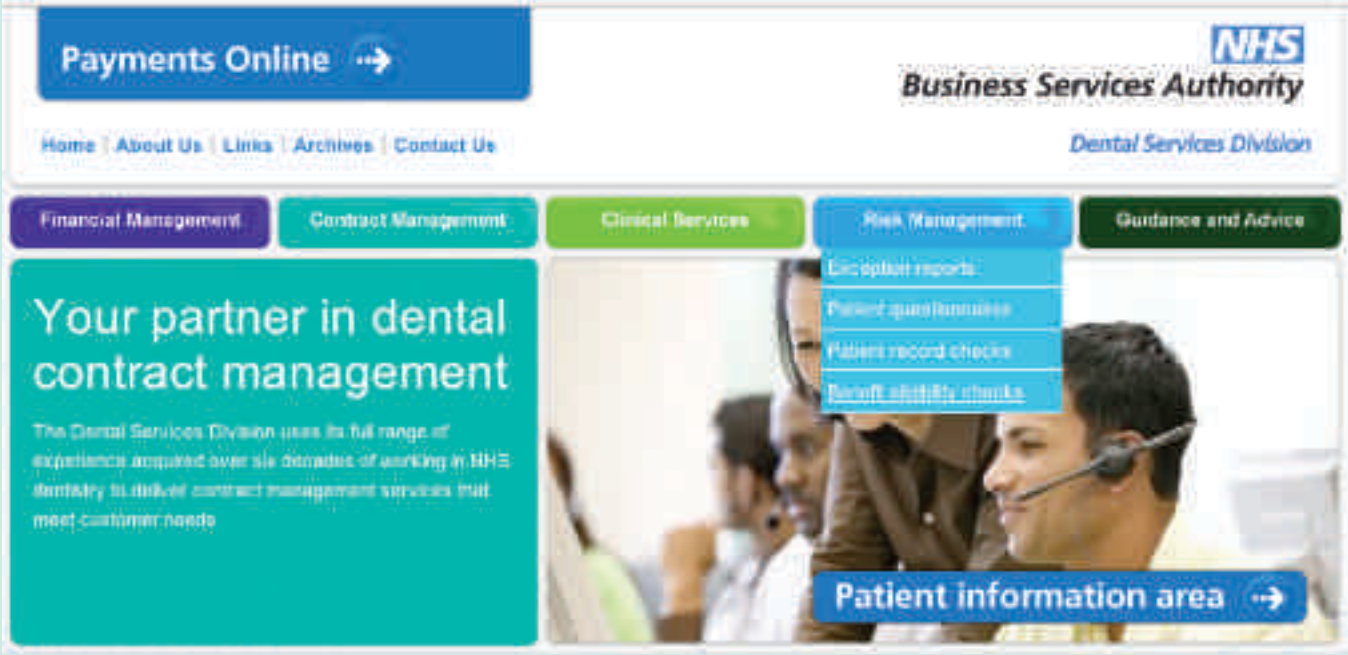
Towards the end of last year, Barry Cockcroft visited Preston to officially open Europe's newest dental school at the University of Central Lancashire (UCLan). Costing £5.25 million it is probably the first new dental school to be built in Britain for over a century.

Providing world-class teaching facilities and aiming to set new standards in dentists' training, the school incorporates a range of state-of-the-art technologies. Its creation is the result of work undertaken by the Cumbria and Lancashire Medical and Dental Education Consortium, a joint venture between UCLan and the Universities of Liverpool, Lancaster and Cumbria. They, together with the North West SHA and local PCTs, responded to government figures identifying the need for more qualified dentists in the North West and were awarded funding from the Higher Education Funding Council to train an additional 32 students per year in the North West. Liverpool University has provided the curriculum and UCLan will be responsible for its delivery, supported by Liverpool University and the other Consortium members.

The new four-year graduate entry course offers a balance of theoretical study and practical training, and will provide a new core of qualified dentists across the region. Students will spend their first year studying on campus in the new school at UCLan, before relocating for three years' clinical training at one of four newly-established dental education centres (DECs) in Accrington, Blackpool, Carlisle and Morecambe Bay. The DECs will be clinical training centres where students will treat patients, under supervision, and gain first-hand experience within the communities they are most likely to serve after graduation.

'This new school is very different from the established schools in that we have four clinical education centres distributed around the North West rather than being confined to one location. This allows our students to gain experience in the local communities. Four years may seem a long time before these first cohorts qualify but, even while they are training, they will be providing treatment in the local areas.'

Hew Mathewson, President of the General Dental Council, also welcomed the new facility, saying, 'We are delighted that through the University of Central Lancashire's Dental School there will be a new opportunity for graduates in other disciplines to study dentistry in the UK by joining an innovative and exciting-looking new course. As the UK dental regulator, one of the General Dental Council's key roles is setting educational standards. We will work closely with the school to ensure that high standards are reached and maintained.'



CONFIRMATION OF PENSION CONTRIBUTIONS 2006/07

The Business Services Authority Dental Services Division (DSD) has now sent out SD86Cs to all practitioners detailing contributions paid in 2006/07 to the NHS Pension Scheme. If you feel these figures are incorrect please contact the provider of each contract you perform on, to discuss your concerns with them before you seek clarification from the DSD or your PCT. The provider is responsible for the notification of the net pensionable earnings on which these contributions are based. If your provider did not complete the net pensionable earnings declaration, we have used the default position when processing your contributions, which uses the estimated net pensionable pay entered on Payments Online to calculate the contributions. See: www.dpb.nhs.uk/contract_management/payments_online/

You should also be aware that the changes to the NHS Pension Scheme from April 2008 mean you will be allocated to a contribution rate tier based on the signed declaration of net pensionable earnings, plus contributions deducted from your previous GDS or PDS number processed after April 2006. The contribution tiers are explained in *Your NHS Pension Scheme is Changing, a* leaflet sent out by DSD in November, and are as follows:

Annual pensionable pay (full-time equivalent)	Current contribution	New contribution
Up to and including £19,165	5% (manuals) or 6%	5.0%
£19,166–£63,416	5% (manuals) or 6%	6.5%
£63,417–£99,999	6%	7.5%
£100,000 plus	6%	8.5%

For more details about pensions, please see the 'Pensions administration' page of the DSD website at: www.dpb.nhs.uk/financial_management/pensions_administration/

THE FP17 – NEW INFORMATION REQUIREMENTS FOR EXTENDED DATA SETS FROM 1 APRIL 2008

One of the principles of the new contractual framework was to reduce the large amount of bureaucracy involved in the 'Items of Service' remuneration system and the Statement of Dental Remuneration.

With a move away from collecting every single item of treatment to a system based on completed courses of treatment, a much slimmer database was conceived and implemented together with the new contract in April 2006.

Dentists, however, told us that the slimmed-down database did not fully reflect the work that they did and PCTs told us that it did not provide enough information to monitor contracts as part of the local commissioning process.

From 1 April 2008, practices will therefore be required to complete a new enhanced clinical data set which asks for additional information on the range of treatment being provided within each of the three treatment bands without returning to payment for individual items. This is being introduced with a revised new FP17 and electronic equivalent. For the first time, we are also introducing data boxes to demonstrate that evidence-based preventive care has been undertaken in line with the recommendations of the preventive toolkit *Delivering Better Oral Health* which all dental practices should be using as a basis for their preventive care. Dentists will be able to indicate whether fluoride varnish and fissure sealants have been provided for individual patients, these being the two preventive procedures with evidence of the highest level of effectiveness.

We are also introducing a separate FP17O for orthodontic treatment generating additional information, including IOTN and whether PAR scoring has been applied to that case.

We have consulted with stakeholders on the new data set and the view is that this will provide better and more comprehensive information for both dentists and NHS management without producing information overload. Please note: we are not going back to the item of service system. Dental system suppliers have also been advised of the changes and will be providing their existing customers with the necessary upgrades for their systems to record the additional data.

We will of course be reviewing the outcomes from the new data set and its implementation. The DSD will shortly be issuing guidance on how to complete the new forms.

Tony Jenner

PARTNERSHIP IN PRACTICE

How the DH dental team and NHS PCC are working together to support the NHS

Who we are

Previously part of the Modernisation Agency, NHS PCC has been established for three years. A non profit making organisation, NHS PCC offers an essential national service to commissioners comprising:

- Advice and resources for managing commissioning and contracting
- Support for implementation of national policy
- Help to develop in-house commissioning capability.

Our team of regional primary contracting advisors (PCCAs) works in partnership with PCT managers and clinicians to deliver locally-tailored programmes.

We have a wide range of commissioning and contracting expertise and specialist and technical knowledge. This is supplemented by a network of associates, many of whom are national experts in their field.

What we do

We enable commissioners to improve services for patients and users through our:

- Responsive service shaped by local priorities
- High quality expertise and skills
- Established NHS track record
- Value-for-money focus
- Access to the national direction-of-travel
- Wealth of practical support.

Working closely with the Department of Health on a comprehensive work programme, over the past 12 months the PCC dental team has generated briefing papers, guidance, case studies and updates on:

– Specialist commissioning
– Salaried services
– Delivering better oral health in practice
– Handling disputes, suspensions and suspected fraud
– Out of hours
– 2009 and beyond
– Patient and public involvement
– Dentists with Special Interests

A dedicated dental helpdesk for PCTs, local and national learning events and regional workshops have helped to reinforce this work. Additionally, we have provided tailored, local one to one support via PCCAs.

Forthcoming changes to NHS PCC's services

From April 1st 2008, PCC's services will be available for the first time to PCTs as an annual subscription service rather than a centrally procured one.

2008/9 outline programme

Our outline programme for 2008-09 has been shaped by our recent PCT focus groups and will continue to be informed throughout the year by local steering groups upon which all subscribers will have a representative.

If you are a PCT and would like to subscribe to our new services, or find out more about how we can help you, please contact your local PCCA or email Roy Greenhalgh on: RoyGreenhalgh@pcc.nhs.uk

For more information about PCC, see: www.pcc.nhs.uk where you can also register to receive our regular weekly update bulletin, New@PCC.

Helen Northall
Programme Lead, NHS PCC

MEET THE TEAM

Barry Cockcroft, Chief Dental Officer

Barry took up the post of CDO in July 2006, having been Deputy CDO for almost four years. He qualified from Birmingham Dental School in 1973. Before joining DH as Deputy CDO he served on the Warwickshire Local Dental Committee (LDC) as chairman and secretary. He was chairman of the West Midlands Association of LDCs, and was elected to the General Dental Services Committee (GDSC) of the British Dental Association in 1990. Barry also served on many subcommittees and working groups of the GDSC before being elected vice-chairman in 2000. Away from dental politics, Barry was the clinical lead in developing and running a first-wave personal dental service (PDS) in Rugby which was based on capitation as a method of remuneration in NHS general practice. In November 2007 Barry was awarded an Honorary Fellowship in Dental Surgery from the Royal College of Surgeons.

David Lye, Head of Dental and Eye Care Division

David began working at DH in 1985. Before joining the dental team, he was project manager for the implementation of the Mental Health Act 2007, and for the production of the revised Code of Practice. Prior to this, he was Director of Performance Management in the West Midlands NHS Region from 1993 to 1998, and then seconded to the Lord Chancellor's Department in 1999. From 2001 to 2004, he was the first chief executive of the Public Guardianship Office.

Tony Jenner, Deputy Chief Dental Officer

A consultant in dental public health, Tony has been Head of Oral Health Policy in DH since 2003 and Deputy CDO since 2006. He leads on prison dentistry at DH and was also responsible for launching the Government's oral health strategy for England, *Choosing Better Oral Health*, in 2005. Tony has since launched *Delivering Better Oral Health* – the preventive toolkit, *Valuing People's Oral Health* and *Smokefree and Smiling*. Other policy areas include research and development, dental IT, 18 week pathways and Dentists with a Special Interest (DwSIs). Tony is a fellow of both the Faculty of Public Health and the Faculty of General Dental Practice (UK) by election, and an Honorary Visiting Professor at the University of Liverpool.

Serbjit Kaur, Head of Quality and Standards

Serbjit joined the DH dental team in January 2008. While her main area of work at the moment is decontamination, her remit extends to prescribing, pandemic influenza, CJD and dentistry, dental amalgam, tooth whitening and other issues. Ongoing developments across these areas will appear in future issues of *CDO Update*. Prior to joining DH, Serbjit had extensive experience as an NHS practitioner. Qualifying from Birmingham Dental School in 1984, she went into general practice in Birmingham – first as an associate and then as principal. She then joined the salaried services. Whilst continuing to be a principal in a predominantly NHS dental practice. During this time, she became a member of the Professional Executive Committee of Eastern Leicester PCT and then Leicester PCT. She has also served on the LDC in Leicester.

NEWS IN BRIEF

Antibiotic prophylaxis

Many of you will have seen that the National Institute for health and Clinical Excellence (NICE) has produced new draft guidelines regarding antibiotic prophylaxis and infective endocarditis. These draft guidelines are currently out for consultation but we are expecting them to be published on 26 March. I will be writing to alert the profession as soon as possible after the guidance is published, explaining the new recommendations and why we are making these changes.

To read the NICE draft guidelines, see: www.nice.org.uk/guidance/index.jsp?action=byID&o=11656

Barry Cockcroft

Pandemic influenza and dentistry

When pandemic influenza arrives in the UK, it will be a major issue, not least for the dental services. We are working closely with the British Dental Association and the NHS to produce guidance for both dentists and the NHS. We will particularly be looking to ensure that patients requiring treatment in this period will be able to access it, and also that the financial viability of NHS practices is maintained through a period which will inevitably see disruption to services. The guidance will also be suggesting how dentists could best be utilised in supporting the response to an influenza pandemic within their locality.

Tony Jenner

Barry Cockcroft opening the Dean Road dental practice in South Shields on 17 September 2007. The practice is now believed to be the second largest dental surgery in the country, thanks to a £1 million surgery expansion, and delivers dental services to approximately 28,000 NHS patients. Barry is pictured with Matthew Gill and Paul Blaylock, both partners at the practice.

Vocational training

The expansion of undergraduate training, which was implemented in 2005, will mean an increased number of dental graduates from 2009 – with the optimum increase taking effect from 2010. I have asked the postgraduate dental deans to start identifying areas where we could develop new vocational training schemes so that all new graduates will continue to have the opportunity to take part in such training.

Barry Cockcroft

286081 1p 30k Mar 08 Gateway ref: 9503

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