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In July the Government published the NHS Plan, the most far reaching programme of reform in the history of the National Health Service. The Plan sets out how we intend to redesign the NHS around patients and deliver fast, accessible care. “Modernising NHS Dentistry” shares that vision and makes sure that the development of dental services in England will be consistent with, and a core part of, the NHS Plan.

Many of us see our dentist more often than we see our doctor. Yet in the past it has been too easy for dentistry to be overlooked among all the other big health issues competing for attention, so that there seemed to be an imbalance between the importance of dentistry to people and its importance to Government.

The general election of 1997 marked the beginning of a real change. The new Government immediately began to tackle the long-standing problems of access to NHS dentistry. Those initiatives have already made a difference and they are still bearing fruit. The work will continue until we have made NHS dentistry a truly national service again, fulfilling the commitment first made last year by the Prime Minister and reaffirmed in the NHS Plan – that by September 2001 anyone will be able to find an NHS dentist simply by calling NHS Direct. This strategy describes what has been achieved so far and what more will be done.
Improving access is our top priority for NHS dentistry, but it is far from the only one. The NHS is already modernising, providing better services in better ways, and we set out here how we expect dentistry to play its part in that programme of change. This Government has given a whole new emphasis to public health, and we also set out what can be done to build on the great improvements to oral health – especially for children – since the NHS was founded over fifty years ago.

This strategy provides a firm foundation for NHS dentistry for the next fifty years. It details the programme of investment that is needed to modernise NHS dentistry in the 21st century.

ALAN MILBURN
15 September 2000
Summary

Just like the rest of the National Health Service, NHS dentistry has served the country well for over fifty years. Just like the rest of the NHS, it now needs to modernise and improve the service it gives to patients.

This strategy sets out what is working well, what isn’t working well and what more needs to be done. It is built on the principle that good, accessible NHS dentistry and better oral health are important to the Government’s plans for a healthier nation.

Its key features are:

1. Making sure that by September 2001 everyone can get NHS dentistry if and when they need it —
   — fulfilling the commitment made by the Prime Minister in September 1999 and making NHS dentistry available to millions more people.

2. Expanding the role of NHS Direct —
   — so that it can act as a gateway to all NHS dentistry, advising callers on where they can find an NHS dentist and on NHS dental services.
3. A modernised and more accessible General Dental Service —
   — including:
   
   • up to £4 million in 2000/01 for a Dental Care Development Fund, allowing
dental practices to grow and treat more patients;
   
   • up to £35 million in 2001/02 to modernise NHS dental practices, providing
a better experience for patients and staff alike; and
   
   • £18 million a year to reward dentists’ commitment to the NHS.

4. New alternatives to the General Dental Service where it is failing to deliver
   for patients —
   — including:
   
   • projects running around fifty Dental Access Centres by March 2001, where
patients who are not registered with a dentist can get the full range of
NHS dental care. In the year 2001/02 access centres are expected to treat
up to half a million patients;
   
   • radical new ways for local Health Authorities to improve the availability
of NHS dentistry by entering into contracts with NHS Primary Care Trusts,
independent organisations or individual dentists; and
   
   • better access to urgent out of hours treatment.

5. Moving dentistry up the NHS agenda —
   — by giving Health Authorities powerful and flexible new tools for improving
access to NHS dentistry, and monitoring their performance.
6. Improving the high quality of dental care in the NHS —
— by:

- introducing clinical governance to NHS dentistry, supported by £2 million for individual dental practices and further funding for continuing professional development, clinical audit and peer review;

- giving patients easier access to better information on the full range, quality and cost of NHS treatments, and making sure that they are clear about any proposals for private treatment; and

7. Improving oral health —
— by providing good advice and information on how to prevent disease, and by reducing inequalities through proactive local schemes aimed at children in particular.

8. About £100 million for investment in improved access to better services across 2000/01–2001/02 —
— making a real difference for patients and the whole dental team. The investment and reforms will make improved NHS dental services available to another two million patients a year by September 2001. The spending on treatment for these extra patients will mean another £80 million a year going into NHS dentistry by 2001/02.
Introduction

1.1 Since it was elected in 1997 the Government has been building the NHS’s future. It has set tough new targets for improving the health of the nation. With the NHS Plan it has launched the most far reaching programme of reform in the NHS’s history. It is creating a new kind of service, fit for the new century and there for people when they need it.

1.2 Like the rest of the NHS, dentistry needs to adapt and modernise. It should share the ten core principles that the NHS Plan spelled out:

- a universal service based on clinical need;
- a comprehensive range of services;
- services shaped around patients’ needs;
- responsiveness to the needs of different populations;
- continuous improvement of services;
- support for staff;
- public funds devoted to NHS patients;
- co-operation with others;
- work to reduce health inequalities; and
- open access to information about services and treatments.
1.3 This document takes the values of the NHS Plan, the Plan’s analysis of the problems and its approach to solving those problems and applies them to NHS dentistry. Many of the main themes that emerged in the Plan are echoed here – including the importance of convenient access for patients, more flexible working practices, better quality services and new sorts of contracts between the NHS and health professionals.

1.4 The NHS is changing, and primary care – which means all the services provided in the community rather than in a hospital setting (like general medical services, pharmacy, district nursing and community physiotherapy, as well as dentistry) – is changing the fastest. The introduction of NHS Direct, easier access to services and higher quality of care are all making a real difference to millions of people’s experience of the NHS.

1.5 NHS dentistry has an important role within that programme of modernisation. Over the last decade it has actually become more difficult for many people to get NHS dental treatment. That situation is unacceptable and has to be reversed, but the traditional ways of providing dentistry may not always be able to deliver that change.

1.6 The commitment of dentists and other dental professionals is central to the future of NHS dentistry. The number of dentists has risen year on year but so has the amount of time they devote to private practice. The consequence has been a lack of stability and predictability in NHS primary care dentistry, making it difficult for patients to know what they can expect, and where and when.

1.7 Oral health in England has improved enormously over the last fifty years but there are still inequalities. Not everyone has benefited from the general progress because poor oral health is still linked too closely to deprivation and social exclusion. This too is unacceptable, and the strategy sets out plans for continuing the overall improvement and ending the inequalities.

1.8 The Government can only meet its objectives through a committed, flexible workforce and by forging new partnerships between the NHS, individuals and other agencies. We will make the best use of resources and people to help everyone to get more from NHS dentistry.
Improved Oral Health

2.1 Since the NHS was founded over fifty years ago there has been a real and sustained improvement in oral health. The numbers of adults with no natural teeth, and of children with decayed, missing or filled teeth, have fallen dramatically.

2.2 Better diet, fluoride toothpaste and the fluoridation of water (where it has happened) have all helped, along with the contribution of dentists working in the NHS.

2.3 The biggest improvement has been in the oral health of children – since 1973 the number of decayed, missing or filled teeth has fallen by over 50 per cent for 5 year olds and by 75 per cent for 12 and 15 year olds. In 1943 over 60 per cent of the...
children examined in a survey needed extractions and dentures. The most recent figures show that now over 60 per cent of 5 year olds have no experience of tooth decay at all.

**Figure 1: The average number of decayed, missing or filled teeth per child in England**

![Graph showing the average number of decayed, missing, or filled teeth per child in England for 5 year olds, 12 year olds, and 15 year olds.](image)

*Figures are for the average number of decayed, missing and filled deciduous teeth for 5 year olds and the average number of decayed, missing and filled permanent teeth in 12 and 15 year olds. Figures taken from the National Children's Dental Health Survey, last carried out in 1993.*

2.4 Adult oral health has also improved. Since the 1960s the proportion of adults with no natural teeth has fallen by 65 per cent, and adults with natural teeth now have on average 14 per cent more.

**Figure 2: Percentage of adults with no teeth (England)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>1968</td>
<td>37%</td>
</tr>
<tr>
<td>1978</td>
<td>28%</td>
</tr>
<tr>
<td>1988</td>
<td>20%</td>
</tr>
<tr>
<td>1998</td>
<td>12%</td>
</tr>
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</table>

*Figures taken from the Adult Dental Health Survey. 1968 figure is for England and Wales.*
**Figure 3: Average number of teeth per adult with some natural teeth (England)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1968</td>
<td>21.9</td>
</tr>
<tr>
<td>1978</td>
<td>23.3</td>
</tr>
<tr>
<td>1988</td>
<td>24.4</td>
</tr>
<tr>
<td>1998</td>
<td>24.9</td>
</tr>
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</table>

Figures taken from the Adult Dental Health Survey. 1968 average is for England and Wales.

2.5 Adults, especially older ones, may still need complex dental treatment. Elderly patients are now less likely to have full dentures, but that means they are more likely to have crowns or large numbers of fillings. Nearly 90 per cent of people aged over 65 show signs of gum disease compared with 14 per cent of 16 – 24 year olds.

2.6 Despite the improvements oral health still varies across the country. Adults in the north of England are twice as likely to have no natural teeth as those in the south and, as Figure 4 shows, there are wide differences in the oral health of five year olds between the different regions.

**Figure 4: Average number of decayed, missing or filled teeth in five year olds: 1997/98 BASCD survey**
2.7 Differences in oral health across the country are rooted in a number of factors – including fluoridation – and there are equally wide variations within individual regions. Economic deprivation, social exclusion and some cultural differences can all help to create an environment where oral health suffers, but the evidence suggests that fluoridation can help to bring oral health in a deprived area up to around the level of a more affluent area. Figure 5 highlights the link between social class and the numbers of decayed, missing and filled teeth in 12 and 15 year olds.

**Figure 5: Average number of decayed, missing or filled teeth in the UK by social class: 1993**

![Graph showing average number of decayed, missing or filled teeth in 12 and 15 year olds by social class.](image)

Figures taken from the National Children’s Dental Health Survey, last carried out in 1993.

2.8 Oral health in black and minority ethnic groups can be worse than the national average, for a number of reasons. Cultural differences in feeding, weaning and diet can affect levels of tooth decay among children. So can poor access to dental services, which in turn is made worse by language and communication barriers. A study in Birmingham showed that only 28 per cent of Asian children were registered with a dentist compared with 68 per cent of white children. On average Asian children had 2.9 decayed teeth while white children had an average of 1.6.

2.9 The inequalities that exist throughout England and across ethnic groups show that there is no single cause of poor oral health but a range of factors including unemployment, poverty, social deprivation and life style. Chapter Five sets out how the Government intends to reduce inequalities and build on the general improvements in oral health, paying particular attention to children.
The Contribution of the Dental Profession

2.10 The whole dental team plays a role in improving oral health, by educating and advising patients as well as by treating them. Dentists’ rigorous training, the regulation of the profession by the General Dental Council and the overall NHS framework for dental services make a solid foundation for high quality care, but there is still room for improvement. For example, there has been no systematic approach to reviewing treatments and treatment practices, or for checking that dentists are continuing their professional development. Patients often do not know, and have difficulty finding out, their rights and what they can expect under the NHS. Chapter Four describes how the Government will guarantee better services and make sure that dental patients are better informed about their treatment.

2.11 Most NHS dentistry is delivered to patients through the General Dental Service (GDS – the traditional, high street NHS dentists) which in the past has been largely successful in getting it to those who want it. The number of dentists working in the GDS has risen consistently and in June 2000 there were 17,692 – over 400 more than the year before.

Figure 6: Number of dentists in the GDS per head of population

2.12 Although the number of dentists has risen, the amount of time they spend treating NHS patients has dropped. This is because, on average, dentists have increased the amount of time that they devote to private practice and more are working part-time.
2.13 The Government has commissioned a study into the career aspirations and working patterns of women dentists. We need to identify barriers that can make it difficult for women to make the fullest contribution so that we can improve employment opportunities for women in NHS dentistry. The study will produce a report and recommendations by next April.

2.14 After dentists have left university they undertake another year’s training before they can treat their own list of NHS patients. The nature of this vocational training (VT) scheme affects the recruitment and retention of dentists in the NHS. Vacancies on VT schemes can attract new graduates to parts of the country where there are too few NHS dentists, and dentists often settle at, or close to, their training practice. The Government will fund four extra VT schemes and make sure they support dentistry in the NHS.

2.15 The shift of dentists towards private work has been slow but steady. Although probably only about five hundred dentists (under 3 per cent of the total) do no NHS work at all, the amount of time that the rest devote to the NHS has fallen. In a 1993 British Dental Association survey, 75 per cent of General Dental Service dentists said they received at least three quarters of their earnings from the NHS and just 12 per cent received less than one quarter. By 1999 those figures had changed to 58 per cent and 18 per cent respectively.

2.16 As a result of this shift the service has become patchy and unreliable and some people have found it difficult to get NHS dentistry. In many areas dentists’ lists have remained open and anyone who wants NHS treatment can get it, but nationally about a third of Health Authorities report serious problems in finding dentists for at least some of their residents.

2.17 The most reasonable estimate of the level of unmet demand for NHS dentistry is around 2 million people, comprising:

- the fall (or the part of it not due to administrative or technical factors) in the number of adults registered with a dentist since its peak in 1993 – 1 million; plus

- half the rise since 1993 in the number of adults with natural teeth in the population (assuming half would be registered at any one time) – 0.75 million; plus

- others who are prompted to seek NHS dentistry by the access and oral health promotion measures in this strategy – 0.25 million.
2.18 Many of the people who are not registered with dentists do not want to be. Even at the 1993 peak only about half of the adult population was registered. This need not be a problem as long as people can get NHS dentistry when they need it (including routine care as well as urgent treatment). It is a problem when they can’t. It is also a cause for concern when people who want NHS dentistry cannot easily find out where to get it.

2.19 Chapter Three sets out what the Government is doing to make effective, appropriate and high quality NHS dentistry available to all who need it. The Government is also making dentistry available in new ways, so that patients no longer have to be registered to get the full range of high quality NHS care. While most people will carry on getting NHS dentistry in the traditional way, the changes mean that the number registered is no longer the most reliable measure of availability – patients who are not registered will also be able to get the full range of NHS dentistry when they need it.

Conclusion

2.20 Oral health has improved but there are still significant variations across the country. Poor oral health is associated with economic deprivation and social exclusion. We need further action to continue the general improvement and tackle the inequalities that persist.

2.21 NHS dentistry has worked well for decades, and thousands of dentists are still working hard to deliver the best care to their patients. However, both dentists and patients are making new demands on the system and access to NHS dentistry is difficult in some parts of the country. The Government is strengthening NHS dentistry so that in the new millennium it can continue to deliver the best possible oral health care.
Target

By September 2001 everybody who needs NHS dentistry will be a phone call away from finding it. Information for patients about dentistry will be better and easier to get.

Many people believe that it is now virtually impossible to get NHS dental care and that the only way to see a dentist is to pay for private treatment. The Government believes that view is too pessimistic and will challenge it – for example, in a recent dental health survey almost four out of five adults said they had their most recent course of dental treatment under the NHS.

Nevertheless, and despite the steps taken by the Government since 1997, there are still too many parts of the country where it is too difficult to find an NHS dentist. No matter how many dentists there are, the job of finding one can be difficult, time consuming and off-putting.

The Government will make NHS dentistry a truly national service again. Across the two years 2000/01 and 2001/02 it will invest a total of up to £93 million on:

- more Dental Access Centres, caring for up to half a million people not registered with a dentist;
- building on the role of NHS Direct so that it can guide anyone to an NHS dentist;
Chapter Two described how, and why, some people still have a problem getting NHS dentistry. About a third of Health Authorities have reported serious availability problems and the situation is worst in the south and west of the country. Whether or not local dentists are available, getting information about NHS dentistry can be difficult and relies too heavily on knowing the system.

The General Dental Service works on a national contract and until recently there have been too few ways for local Health Authorities to arrange better access to dentistry for their residents. Consequently Health Authorities have tended to give higher priority to issues over which they have more control.

That national contract has fixed the current shape of dental services. Before 1990 access to dentistry was informal, but many patients built relationships with individual dentists over time. In 1990 a new contract introduced a system of patient registration which formalised the relationship between patient and dentist. From then on access to dentistry depended heavily on registration with a General Dental Service dentist. Although registration was meant to encourage regular attendance and continuing care for patients, a side effect was that the number registered came to be seen as the benchmark of access to NHS dentistry and therefore an end in itself.

The registration system still can benefit oral health. It can promote continuing care, strengthen the relationship between patient and dentist and encourage regular visits. Despite that many people do not visit a dentist regularly and never have done. If they leave a gap of more than fifteen months between visits their registration will lapse, and if their dentist won't then re-register them they can be isolated from NHS dentistry. Clearly registration does not work for this group. What really matters is that everyone can get NHS dental care when they need it, not that everyone is registered.
3.5 The 1990 contract was introduced without fully piloting many of the changes it contained. The results were mixed. There were some very real drawbacks for oral health, expenditure and NHS dentistry overall. Many dentists began to spend less time doing NHS work and more time in the private sector.

3.6 The Government will continue to sustain and improve the General Dental Service, but recognises that in some parts of the country the GDS is failing many NHS patients. Turning access problems around and making NHS dentistry a genuinely national service again calls for an approach which:

- provides better and more easily available information about how to find and use NHS dentistry;
- gives the General Dental Service incentives to modernise and treat more patients; and
- opens up flexible new approaches to NHS dental treatment, taking proper account of how patients want to use NHS dentistry, allowing local problems to be dealt with locally and giving Health Authorities the tools they need to do their job.

The Proposals

Better information – NHS Direct

3.7 However many dentists provide NHS treatment, patients can’t benefit unless they know where the dentists are and what services they provide. NHS Direct is already an effective and popular way of sharing reliable information on a range of health issues. The Government will expand NHS Direct so that it can advise and inform dental patients too.

3.8 Finding out about NHS dental services is not always easy and can be hard for people who do not know their way around the system. That is true for finding an NHS dentist in the first place, getting urgent treatment outside normal working hours and getting information on patients’ rights. If dentistry really is to be open to all again, the NHS must improve both the quality of the information and the ways it provides it.

3.9 NHS Direct now covers 65 per cent of the population and will cover the whole country by the end of October this year. It has already begun to fulfil its enormous potential for providing easily accessible and up to date information about health and health services.
3.10 NHS Direct’s role will grow to include four key aspects of dental care and services, transforming the quantity and quality of the information available. NHS Direct staff will get extra training and information so that in 2001 everybody will be able to contact NHS Direct (or NHS Direct Online) and quickly get good, accurate advice on:

- dental health problems and how to cope with them;
- patients’ rights, including information on charges;
- where to find an NHS dentist; and
- how to get services outside normal working hours.

Incentives for the GDS – the Dental Care Development Fund

3.11 The Investing in Dentistry scheme gave grants to dentists so they could either increase their own commitment to the NHS or start a new practice in an area with poor access. In return for the grant the dentist guaranteed acceptance of extra registered patients. Between 1997 and 1999 over £10 million was offered in 370 locations. IID schemes are already providing services for around 400,000 people and that figure is expected to rise to about two thirds of a million.

3.12 The Government is ready to press ahead now with more action to improve the availability of dentistry. In the current financial year it will implement a new Dental Care Development Fund of up to £4 million, in consultation with Health Authorities and the dental profession. The DCDF will allow the Health Authorities furthest from the Government’s target for access to work up and deliver plans for expanding the GDS locally and delivering NHS treatment to people who cannot get it now – for example, by paying for new equipment or extended premises so that dentists can treat more patients. The £4 million will mean that up to 250,000 more people can get NHS treatment, but the Government will monitor the outcome carefully and determine whether more is needed in 2001/02.

Incentives for the GDS – rewarding commitment to the NHS

3.13 Dentists are free to decide whether or not to provide NHS services, who to provide them to and what level of service to give. The Government believes it is right to encourage and reward those dentists who have shown a long term, high level of commitment to the NHS. This will help patients too, by maintaining and strengthening the General Dental Service.
3.14 The Government will implement a scheme rewarding commitment and quality of service, again in consultation with the dental profession. We will make about £18 million available each year in England to reward and encourage continued commitment to the NHS and quality of treatment. This should help up to a third of a million people to get NHS dentistry. The scheme is consistent with the recent recommendation of the Review Body on Doctors’ and Dentists’ Remuneration, and will deliver up to £4,500 a year extra for dentists with the first payments made this October and November. The average earnings of dentists aged over 45 working five days a week in the NHS will be nearly £60,000 a year (before tax but after deducting practice expenses).

Incentives for the GDS – modernising NHS dental practices

3.15 NHS dental patients are entitled to expect treatment with up to date and clinically effective materials and equipment in pleasant, modern surroundings. NHS dentists and their staff need a better working environment. The Government intends to deal directly with both these issues.

3.16 In the financial year beginning in April 2001 the Government will make available up to £35 million for Health Authorities to plan and implement improvements to the practices of significantly committed NHS dentists. This will make a real difference to patients’ experience of NHS dentistry and make commitment to the NHS even more worthwhile for dentists. The Government will discuss the detail of the scheme with the dental profession and the dental trade, but will require the dentists who benefit to show that they are maintaining or increasing their level of NHS work over a set period.

New approaches – NHS Dental Access Centres

3.17 Dental Access Centres have an important part to play in solving the access problem. They help to plug gaps in the service and bring NHS dentistry to everyone who needs it. So far there have been two waves of projects tackling the worst local access problems and a third wave will be up and running by March 2001. The eight existing projects have already succeeded in providing NHS dentistry for thousands of patients.

3.18 The centres provide a complete range of services, including routine as well as urgent care. People do not need to register to see a dentist in an access centre, and the centres are open at times when patients can get to them. Patients can call a centre directly to make an appointment, and soon they will be able to call NHS Direct which will refer them either to a GDS dentist or a Dental Access Centre.
3.19 By next April there will be projects running around fifty Dental Access Centres in the Health Authorities where they are needed most. By 2002 they will be treating up to half a million patients a year. The centres will be conveniently located, and co-located with primary care walk-in centres where appropriate.

3.20 All of them will improve access to dentistry and some will be sited where there is poor oral health but no tradition of regular visits to a dentist. These centres will need to link up with other health care professionals, including oral health educators, community nurses and health visitors to make sure that people who need dental care get it. The centres will be judged on their success in achieving that.

3.21 Any future investment in improved access, on top of the centres already planned, will be focused within the 500 new one-stop primary care centres which were announced in the NHS Plan, helping to integrate a whole range of front line health services.

3.22 Costs in 2000/01 will be up to £10 million, with up to £13 million on capital from the Government’s Capital Modernisation Fund. In 2001/02 the costs will rise to £25 million with another £7 million capital.

**New approaches – new partnerships**

3.23 Although NHS Direct, the Government’s support for the GDS and Dental Access Centres will all make a huge difference, the NHS and the profession still need new ways of working together to guarantee a route to NHS dentistry which doesn’t depend on registration with a dentist or a conveniently located access centre.

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**Cornwall Dental Access Centre**

The Cornwall Dental Access Centre operates through a network of twenty sites across the county, complementing the service provided by local GDS dentists so that there is always a genuine option of NHS dental treatment for Cornwall residents. In a survey 97 per cent of patients said they were either ‘very happy’ or ‘satisfied’ with the service they received.

**Shropshire Dental Access Centre**

The Shropshire Dental Access Centre opened early in 1999 and works from two sites, Shrewsbury and Donnington. The centres provide high quality NHS treatment to people who cannot find a dentist to register with. The pilot is making full use of the whole dental team, especially dental therapists.
In many areas the traditional system has failed NHS patients. We need to recognise that and find new systems that work.

3.24 That calls for action and new partnerships between Health Authorities and potential providers of dentistry. Those providers could be:

- **individual GDS dentists** –
  who enter into contracts with HAs to set aside time for unregistered patients who have called NHS Direct looking for treatment. These sessions would be flexible in frequency and length, depending on the level of demand, and could make every dental practice in the country a potential access centre.

- **local groups of dentists** –
  when dentists co-operate it can generate benefits for dentists and patients alike. Dentists can share the costs of things like computer systems and administrative staff, and negotiate bulk discounts on materials. Patients gain from the security of access to NHS dentistry in efficiently run practices, where the dentists can concentrate on providing treatment. Some groups are already operating successfully but might benefit from the flexibility offered within Personal Dental Services projects.

- **Primary Care NHS Trusts** –
  developing their existing roles as providers of salaried services, including some Dental Access Centres. Wherever problems with access to NHS dentistry persist, HAs and Primary Care Trusts should be discussing whether they can work together to improve things. The role of the Salaried Dental Service is described in paragraphs 3.32-3.34.

- **independent organisations** –
  including private companies – who have the expertise and resources to expand into dentistry in areas of unmet demand. Like Trusts they have the potential to provide services across a wide area. They could use the existing framework for corporate bodies in dentistry (and the Government will consider removing the existing limits on numbers if that is necessary) or work within the Personal Dental Service initiative. Contracts would specify that the full range of NHS treatment would be available to anyone who cannot find a dentist to register with.

3.25 Health Authorities need to assess what is necessary in their area and make contracts which meet the demand for the whole range of high quality NHS dental services, bringing back stability and reliability to NHS dentistry. In future all the potential providers will be able to operate from the new one-stop primary care
centres described in the NHS Plan, adding convenience and accessibility to the reliability offered by the new partnerships.

**New approaches – Personal Dental Services**

**3.26** As well as the Dental Access Centres, almost forty other Personal Dental Services pilot projects have been set up in two waves and a further fourteen will be set up during 2000/01. These projects represent new systems for the local development and commissioning of primary care dentistry. Many of them explore new ways of providing dentistry for people who cannot easily or conveniently use existing services, while others provide NHS dentistry through combined Community Dental Service and other salaried dentist services. The projects include mobile surgeries tackling the problems of homeless people or of people in sparsely populated areas, care for housebound people and using extra dental therapists to free up dentists’ time. Other projects are testing alternative methods of remuneration for dentists, making sure that the system can be constantly reviewed and kept up to date. All the projects will be evaluated carefully after three years.

**East London and the City Health Authority Personal Dental Services**

This PDS pilot is testing the use of dental therapists in general practice in an area of unmet dental need, low levels of dental manpower and a population of socially deprived, mobile, and ethnically diverse people. The project aims to improve access and to address oral health inequalities, with an emphasis on improving the oral health of children.

**Warwickshire Health Authority Personal Dental Services**

The Warwickshire project is expanding primary dental care in the Rugby area, where the availability of NHS dental services has worsened over recent years. The pilot is operating a new remuneration system designed to encourage dentists to work within the NHS and to encourage the registration and treatment of new adult patients. Four dental practices are involved.

**3.27** Although each Personal Dental Services project is being evaluated over three years the Government believes firmly that the PDS is likely to represent a valuable long term partner for the General Dental Service and has already announced proposals for a fourth round of pilots.

**3.28** The PDS already offers a whole range of powerful tools for delivering access to dentistry, including the sort of new contractual arrangement already outlined. So far HAs haven’t been able to exploit this fully, mainly because they have not been encouraged to use their own resources. The Government expects that to change,
especially where patients cannot find an NHS dentist, and will help to guide HAs and providers towards new solutions.

**New approaches – the Community Dental Service**

3.29 For some people access to NHS dentistry depends on more than the every day, high street services that most people use. Health Authorities are responsible for making arrangements with NHS Trusts (including Primary Care Trusts) so that those who may not otherwise seek or get care within the GDS, such as people with learning disabilities, can still get NHS dentistry. The Community Dental Service has a range of objectives including dental health promotion, oral screening for children in schools and epidemiological fieldwork for use in planning local services.

3.30 The CDS also provides facilities for a full range of treatment to patients who have difficulty getting treatment in the GDS, and treatment on referral which is not generally available in the GDS.

3.31 The Community Dental Service has built up considerable expertise in providing a full range of treatment to a wide range of patients. HAs need to consider how the service can be modernised to become a uniformly effective, cohesive and district-wide service, so that it can play its full part in the new NHS.

**New approaches – the Salaried Dental Service**

3.32 In some circumstances Health Authorities have been able to supplement the local CDS by employing salaried dentists on GDS terms. Given the alternatives now available and Health Authorities’ more strategic role, it is no longer appropriate for HAs to employ the staff and provide services directly. The effective management of salaried dentists is a distraction and often gets too low a priority. While salaried dentists will play an important part in the new partnerships described in 3.24, the Government expects Health Authorities to stop providing salaried dental services themselves.

3.33 Taken together, salaried primary dental care services do important work and account for considerable amounts of NHS funding. So far they have remained outside the normal NHS Performance Assessment Framework and are not funded or managed consistently across the country. The way these services are organised needs to benefit from the same sort of modernisation happening in other kinds of primary care so that all the services work coherently together and are easily understood and used by patients.
3.34 Health Authorities need to consider the existing CDS, the need to stop employing salaried dentists themselves and the potential of Personal Dental Services contracts.

### Moving Dentistry up the NHS Agenda

3.35 In the past HAs' influence over dentistry has been limited, but the initiatives described in this chapter have allowed them to begin building consistent and accessible local NHS dental services. The Government will take this further by creating an environment where NHS dentistry can become a more active part of the local health service, and be supported by it, and where HAs will be better equipped to improve local services.

3.36 In the future HAs and Primary Care NHS Trusts will tackle the need for accessible NHS dentistry, whether through new partnerships or through salaried services. Primary Care Groups and Trusts should seek out professional dental public health advice to help hospital and community dental services meet local people's needs.

3.37 For the first time, improving the availability of dentistry is a clear priority for the NHS. The Government will monitor Health Authorities' progress closely and provide support and advice while managing their performance. Each HA will be accountable for the delivery of the strategy in its own area.

3.38 HAs can now also ensure that Health Improvement Programmes take proper account of wider oral health issues. Health Improvement Programmes are local strategies for health and health care and open up significant new possibilities for innovative local action on better oral health and NHS dentistry. Their structure encourages working between local partners including the wider NHS, local authorities, the Prison Service and voluntary organisations.

3.39 The new developments in NHS dentistry need to fit with the other modernising strategies for the NHS, especially those for information technology. Health Authorities and other local agencies need to make sure that all their information management and technology needs, including those of dentistry, are addressed in their Local Implementation Strategies for Information for Health, the Government’s information strategy for the NHS.

3.40 For all these kinds of change the Government’s National Priorities Guidance for the NHS will reinforce the need for high standards, and HAs will be held to account for their performance through the Performance Assessment Framework.
Out of Hours & Emergency Dental Services

3.41 People also need quick access to NHS dentistry for emergency treatment. Patients who are registered with a General Dental Service dentist can turn to them in an emergency, whenever it arises. Whether or not they are registered, patients will be able to call NHS Direct for help.

3.42 In the past unregistered people have depended on the Emergency Dental Service, where different approaches have developed in different areas. Although the number of Emergency Dental Service sessions has grown considerably – from 6,700 dealing with 44,000 patients in 1991/92 to 27,700 sessions and 189,700 patients in 1999/2000 – services are patchy and incoherent and it is hard to find out how to get dental treatment outside normal surgery hours.

3.43 The Government, the profession and the NHS are working together to improve emergency dental care and make sure that the right services are available for people who are not registered with a dentist but need treatment. The overriding responsibility of all dentists for the patients they are treating will not change, but in future emergency dental services will be:

- more consistent;
- better value for money; and
- more easily understandable and accessible.

3.44 We will find ways of linking emergency treatment with other out of hours arrangements where that’s practical, and extend existing pilot exercises that offer a co-ordinated approach through NHS Direct. The plans will be published with a target implementation date of April 2001.

3.45 NHS Direct in Newcastle and North Tyneside has already extended its service to include information on out of hours dentistry and points the way for future developments.
Conclusion

3.46 The Government will continue to respond firmly and effectively where NHS dentistry is failing to deliver the service that patients should expect. The Personal Dental Services and Investing in Dentistry initiatives have proved that access and availability problems can be beaten. Now it is time for Health Authorities to work more effectively with the dental service in their areas, and use the potential of the Personal Dental Services to develop a system which is more responsive to patients’ needs and which delivers best value.

3.47 HAs now have the tools and resources to do this effectively, and with those goes the responsibility for making change happen. The combined effect of the proposals described in this chapter will be significant and real. They should deliver NHS dentistry to millions. The Government will monitor the effects closely and continue working to make sure that by September 2001 everyone is within a phone call of finding an NHS dentist, no matter where they live.

Newcastle upon Tyne out of hours service

Newcastle and North Tyneside Health Authority have worked with the local dental profession to establish an innovative out of hours scheme based on NHS Direct.

Patients who are in pain out of normal surgery hours call NHS Direct and talk to trained nurses to establish how serious the problem is. Patients are given self-help advice if that is appropriate. If the problem is more serious, information about the patient is sent to a central emergency dental clinic in Newcastle. An on-call dentist there will then speak to the patient, and either give further self-help advice or see the patient at the emergency clinic. The clinic is easily accessible and near public transport routes.

The scheme has been running for over a year and both patients and dentists are satisfied with the way it is working.
Improving Quality

Target

NHS dental services will be more clinically effective and more cost effective; patients will be better informed about dental treatment; the skills of the whole dental team will be maximised and used to the full; self-regulation of the dental profession will be more effective.

The combination of the UK’s rigorous training for dentists, professional regulation by the General Dental Council and the NHS framework for dental services provides a solid foundation for high quality care. This Chapter describes how the Government will build on that foundation to root out poor performance more effectively and ensure better services for better informed patients.

The Government will:

- provide better, clearer information for patients about NHS dental treatment and patients’ rights;
- strengthen the self regulation of the dental profession so that it is easier to deal with poor performance before serious harm is done;
- implement clinical governance in NHS dentistry and encourage dentists to continue to develop throughout their career, helping dentists to provide the best possible care and prevent poor performance;
The Issues

4.1 Wherever and however it is provided NHS dentistry must provide a high quality service, defined by:

- safe, appropriate, clinically effective and cost effective services, backed up by a new approach to quality which guarantees consistently high standards;

- a system of professional self-regulation which commands the confidence of both the profession and the public;

- patients who know, or can easily find out, their rights in relation to NHS treatment and what they can expect of their dentist; and

- the best use of the skills available in dentistry and opportunities for individuals to improve those skills.

4.2 Many of the ingredients of that sort of service are already in place, making a sound foundation for improvements. Dentists who qualify in this country have rigorous training and can be proud of their skills and professional standards. In the NHS those standards, backed by the General Dental Council which regulates dentists, dental therapists and dental hygienists, are supplemented by:

- clear guidance on the appropriateness of different treatments and the standards those treatments should meet, and a system of prior approval by the Dental Practice Board for more complex, expensive work. The quality of the materials used during treatment is also guaranteed;

- provide £2 million to support the introduction of clinical governance in NHS dentistry and further funding for continuing professional development, clinical audit and peer review;

- publish clear new guidance for dentists on complex treatments;

- reform orthodontic treatment to encourage the best and most appropriate treatment for patients;

- consider professional opinion on modernising working patterns, for example the appropriate intervals between dental check-ups;

- continue to tackle fraud in NHS dentistry; and

- allow the whole dental team, not just dentists, to give their best to NHS dentistry.
• the Dental Reference Service, which regularly reviews the work of every NHS dentist;

• a formal system for making and investigating complaints, and a process for excluding dentists from the NHS if necessary; and

• support for continuing training and education, led by the National Centre for Continuing Professional Education of Dentists.

4.3 Despite all this there are still some areas where the quality of the service, and the ways of guaranteeing that quality, need strengthening:

• there is currently no systematic approach to reviewing treatments and treatment practices, or for checking that dentists are continuing their professional development;

• in a few cases treatment can still be unsafe, ineffective or bad value for money;

• the system for getting prior approval for complex work is often clinically ineffective;

• patients may not know, and may have difficulty finding out, their rights and what they can expect from the NHS;

• recent fraud cases have shown that not only did the taxpayer and the NHS lose financially, but also that the patients involved got a poor service and that those responsible for protecting them did not react quickly enough;

• the NHS is not using the whole range of skills potentially available to it; and

• the framework for professional regulation can make it difficult to deal with poor performance before serious harm is done.

The Proposals

4.4 These issues need to be tackled by the Government, the NHS and the professions together. Some positive action has already been taken. For example, the NHS Plan sets out how the NHS Tribunal will be abolished and the power to remove dentists from Health Authorities' lists devolved to HAs themselves. The Government will reinforce that and do more, guaranteeing the quality of NHS dental care and protecting and empowering dental patients.
Empowering Patients

4.5 Too many people are uncertain about exactly what they can expect from NHS dentistry. In the worst cases this can lead to patients suffering pain and disease by going without dental care altogether, or to paying for private work without realising that the NHS could have met their needs. It is also possible for patients to be left unsure about whether they are getting NHS or private treatment. The Government will work with the dental profession, patient organisations and the NHS to make sure that patients are better informed about the full range and quality of treatment that they are entitled to expect from the NHS.

4.6 Chapter Three explains how NHS Direct will play a big part in providing information about NHS dental care. With one call people will be able to:

- get advice on dental problems;
- find out about their nearest NHS dentists;
- find out about out of hours dental services; and
- get advice on the range of NHS treatment, including information on charges.

4.7 Patients also need to be better informed when they are in the surgery. The Government will ensure that before they are treated patients can get clear, comprehensive and up to date information about:

- the range of treatments available from the NHS;
- the charges payable for their treatment;
- the arrangements their dentist has made for urgent, out of hours treatment; and
- whether their dentist is suggesting any private treatment.

4.8 This information will be supplemented by personal estimates of what a treatment plan will involve and cost, and receipts showing patients exactly what they have paid.
**Estimate and receipts**

Dentists will be required to provide NHS patients with a fully costed estimate of what is proposed before starting anything but a relatively simple course of treatment.

The estimate will indicate all the treatment that the dentist thinks is necessary and how much it will cost. If it is necessary to change the treatment plan or the charges the dentist must tell the patient and discuss the changes before going ahead.

There will also be a clear distinction between NHS work and private work. If a patient would prefer private dental work for all or part of a course of treatment, he or she must sign to show agreement to having the treatment carried out privately.

The Annex at the back of this document indicates what the form will look like and the sort of information it will contain.

4.9 Better estimates and receipts will help patients to know exactly what treatment they are getting and whether it is being provided by the NHS or privately. Some other aspects of the relationship between NHS dental care and the private sector have also prompted complaints from patients. For example, some dentists will provide NHS treatment to children only if the parents agree to be treated privately. The Government understands the issues around this, including patients’ concerns, and will consider whether it represents a significant barrier to NHS treatment for all.

4.10 Like NHS patients, people having private treatment should be able to expect high quality treatment, good information and an overall package of care that meets their needs. They lack access to an effective complaints system, and the Government and profession will discuss how to put a new system in place.

4.11 There are three main ways in which the NHS can safeguard NHS patients and their rights:

- the NHS complaints procedure. This will be strengthened and improved under the NHS Plan but currently begins with an individual practice’s complaints manager, who should respond to the patient within two weeks;

- through the Dental Reference Service, which reviews the treatment provided by every dentist. This helps to make sure that dentists are acting properly, that their decisions about what treatment to give are right and that the quality of that treatment is high. Dentists can expect the DRS to examine at least two of their patients every year; and
through indemnity cover. Although most treatment is successful and appropriate, in a few cases things go wrong and the patient seeks compensation from their dentist. When that happens it is in everybody’s interest for the dentist to have proper indemnity cover. All NHS dentists will now be required to hold adequate cover, so that their patients are guaranteed proper compensation on the rare occasions when it is needed.

Clinical Governance

4.12 Clinical governance is a programme aimed at changing the culture of the whole NHS and improving the quality of its services. It means:

- clear lines of responsibility for the quality of clinical care;
- a comprehensive programme of activity which improves quality;
- clear policies for managing risk; and
- procedures for all health care professionals to identify and remedy poor performance.

4.13 NHS dentistry will adopt clinical governance, and the Government has already consulted and developed plans for bringing the benefits to dentists and their patients.

4.14 Clinical governance is not just a matter for the NHS. It is a professional issue that must be led by the profession, and it should include all aspects of care and treatment and be embraced by the whole dental team.

4.15 Implementation in the General Dental Service requires a five to ten year development programme. That programme began in April 2000, when the Government rolled out its proposals to “pioneers” among the profession. There are now about 250 practices engaged in clinical governance, including clinical audit, peer review and continuing professional development. These components of clinical governance are all described in more detail below.

4.16 This initial exercise will help to establish how best to roll out clinical governance in a mandatory programme for all practices from April 2001. The Government will make £2 million available for dental practices in England to help with the costs of implementing clinical governance.
4.17 The British Dental Association understands the value of the principles of clinical governance. Its guidance to its members recognises that it should be about self-driven improvement, but that some problems are too serious and practices need systems for dealing with poor performance which cover all possibilities.

Clinical audit and peer review

4.18 Many dental practitioners have already willingly adopted clinical audit and peer review. As things stand the results of an audit remain confidential to the individual who undertook it, but peer review is a group undertaking. They could be brought together to form a clearer demonstration of quality by sharing the results of audit and learning from the performance of colleagues.

4.19 The Government will also encourage dental professionals to learn more from experience, so that they can look in a more structured way at what went well, what didn’t, and why. That should improve dental prescribing and the way clinical procedures are carried out, as well as the cost effectiveness, clinical effectiveness and appropriateness of NHS dental services.

Continuing professional development

4.20 In 2001/02 the Government will fund a revised scheme which will be fair to dentists undertaking NHS work and contribute to re-certification requirements. The payments will be in proportion to dentists’ commitment to the NHS.

Strengthened self regulation

4.21 Just as for other professions in the NHS, the legal framework for the regulation of the dental profession needs modernising. The General Dental Council can only investigate complaints and sanction dentists in cases of “serious professional misconduct”. Dentists whose standards of practice are inadequate but fall short of serious misconduct cannot be made to improve before patients are put at risk.

4.22 The GDC has consulted on a package of measures designed to modernise regulation and has asked for amendments to the Dentists Act 1984 allowing them to:

- amend their constitution to provide for more lay members;
- make continued registration as a dentist dependent on the dentist taking part in continuing education, requiring re-certification; and
- investigate possible poor performance which does not amount to serious professional misconduct and, when appropriate, to require dentists to undertake remedial training to demonstrate their fitness to practise.
4.23 The Government is firmly committed to eliminating poor performance across the NHS, including NHS dentistry. It will consult on the GDC’s proposals and the necessary legislation.

4.24 The profession itself is already taking a lead. In East Lancashire, the Local Dental Committee has co-operated with the Health Authority to identify and help dentists whose performance is causing concern. The Performance and Assessment Group has been accepted by all the dentists in the area and has already helped to resolve some local problems.

Safe and Clinically Effective Treatments

4.25 Patients have the right to expect treatment that is safe, clinically effective and appropriate to their needs.

NICE

4.26 The National Institute for Clinical Excellence will develop clear guidelines improving both the clinical effectiveness and cost effectiveness of dental treatment. One of the first treatments NICE looked at was the extraction of wisdom teeth, and its guidance for the profession should mean better treatment for patients. NICE recommended that disease-free impacted wisdom teeth should not be operated on, partly because there is no reliable research suggesting that it benefits patients, and partly because patients who do have disease-free wisdom teeth removed are exposed to the risks associated with any type of surgery.

NICE

The National Institute for Clinical Excellence (NICE) is a Special Health Authority, set up to give advice on best clinical practice to NHS clinicians, to those commissioning NHS services (Health Authorities and Primary Care Groups and Trusts), and to patients and their carers. It is a key aspect of the Government’s agenda for quality in the new NHS. NICE is part of a new partnership between the Government, the NHS, clinical professionals and patients. In establishing NICE the Government has acted to clarify, for patients and professionals alike, which treatments work best for which patients.

4.27 NICE’s work around dentistry will be supplemented in four important ways:

General Anaesthesia

4.28 In July the Chief Medical Officer and Chief Dental Officer for England published a review of the use of general anaesthesia and conscious sedation for dental treatment. The number of deaths associated with general anaesthesia in dental
practice is small – eight between 1996 and 1999 – but each one is a tragedy, and
the Government has acted to reduce the risk as far as is possible.

4.29 After 31 December next year general anaesthesia for dental treatment will only
take place in hospitals, where emergency facilities and experienced staff are
available immediately should anything go wrong. Until then dental practices that
administer general anaesthesia will be regulated more closely – premises will be
registered and inspected, systems will be put in place for life support and transfer
to hospital, and patients will be better informed.

Prior Approval for Treatment

4.30 Before dentists carry out courses of treatment which would cost more than £230
they must submit their plans to the Dental Practice Board for approval. Despite
this, and because of a lack of clear clinical guidelines, advanced or complicated
treatments are sometimes given when they are not justified. This can mean
patients having treatment that is both difficult for them and expensive for the
NHS, even though it might not have been the most clinically effective thing to do.

4.31 New clinically-based criteria will help to make sure that this sort of treatment is
only given when the evidence suggests that it will be effective, and will provide
dentists with a clear reference point for exercising their own clinical judgement.
The first step is to prepare and publish those criteria in consultation with the
profession. The Government can then assess the effect the criteria are having
on treatment and submissions for prior approval.

Orthodontics

4.32 The Government will propose new ways for orthodontic services to be provided
and paid for.

4.33 The cost of orthodontic services has nearly doubled over the last five years and
now stands at over £80 million a year. The current fee scale for dentists neither
reflects the most up to date approaches nor encourages the most appropriate
choices about who to treat. There is evidence of some inappropriate and
ineffective treatment, and even abuse of the system by some dentists.

4.34 To the public the availability of NHS orthodontics seems patchy, with long
waiting lists for treatment. The Government will make sure that dentists can
identify appropriate cases for treatment, use the most clinically effective and cost
effective approach and maintain high standards of probity. This will concentrate
valuable NHS resources more on the cases of greatest clinical need and less on
purely cosmetic work.
The Government will also take account of the different approach being piloted in the Bedfordshire Personal Dental Services project, which is currently being evaluated. This scheme uses the Index of Orthodontic Treatment Need (IOTN) which is already used widely in the rest of the NHS. It is a scale running from 1 to 5 assessing the health need for orthodontic treatment as well as the appearance of the teeth. Patients with an IOTN rating of 3 (with an aesthetic component of 6 or more), 4 or 5 are offered treatment.

Reforms will be introduced next year.

Modernising Working Patterns

The idea that everyone should visit their dentist every six months for a check up is a familiar one – many people were taught it by their dentists or their parents. Oral health has improved greatly over the years, and although regular dental examinations are still important there is a growing body of expert opinion suggesting that many patients could get a more appropriate programme of care by seeing a dentist about once a year.

About half of all adult courses of treatment consist of the patient having nothing more than an examination, scale and polish. There must be real doubt over whether all the thirteen million scale and polishes done in England in 1999/2000 (at a gross cost to the NHS of £122 million) were necessary on clinical grounds. It is possible that this treatment could be provided more clinically effectively and cost effectively – and both patients’ and dentists’ time better spent – by recalling patients at intervals which match their individual needs more closely.

This approach is already being tried in the Warwickshire Personal Dental Services pilot project. The Government will discuss with the dental profession what else might be needed to assess the effects of different working patterns on oral health and the NHS. Those discussions will cover the question of how to make the best use of time freed up – for example by treating more new patients – and whether other changes to working patterns could benefit patients.

Tackling Fraud

Patients rightly expect that NHS funds will be used to pay for their treatment, and not siphoned off through fraud. They expect high standards of probity from their dentists, and we all owe the NHS an obligation to use its services properly. The Government is acting to prevent fraud through:

- establishing the Directorate of Counter Fraud Services in the NHS Executive; and
new powers under the Health Act 1999 allowing the NHS Tribunal to deal with fraudulent dentists, and creating a new penalty charge and criminal offence for patients who evade NHS dental charges.

Making the Best Use of Professional Skills

4.41 A modern health service must make the most of the talents of its entire workforce. We can improve the quality and cost effectiveness of dental care by improving team working and developing the skills of everyone involved. That should also mean more job satisfaction for those working in NHS dentistry.

4.42 Dental therapists already contribute directly to patient care in the areas of the profession where they can work – the Community Dental Service, some Personal Dental Services pilots and the Defence Medical Services. Dental hygienists’ valuable contribution to oral health is also well recognised.

Dental Therapists

Working under the direction of a registered dentist, dental therapists can extract deciduous teeth, do simple fillings, clean, scale & polish teeth, apply preventative materials and give some local anaesthetics. Long standing regulations, which are currently being reviewed, prevent therapists working in general practice within the General Dental Service, but they can work in the Community Dental Service and Personal Dental Services pilot projects.

Dental Hygienists

Again working under a dentist’s direction, dental hygienists clean, scale and polish teeth and apply preventative materials. They can work in any area of dentistry.

4.43 There is now the potential to develop skills and opportunities for the professions complementary to dentistry if:

- training is made more widely available and is matched to the extended duties;
- the professions are properly regulated; and
- dentists’ overall accountability for the performance of their teams remains clear.
Currently only dental therapists and dental hygienists have to be enrolled with the General Dental Council. The GDC has proposed that:

- dental nurses, dental technicians, maxillofacial prosthetists and maxillofacial technologists should be statutorily registered with the GDC;
- dental therapists should be able to work in all areas of dentistry;
- a new class of PCD – clinical dental technician (CDT) – should be created and registered. The GDC envisages that CDTs could fit as well as make dentures after a dentist had confirmed that the treatment was appropriate; and
- another new class of PCD – orthodontic assistant – should be created to carry out orthodontic work to the prescription of a dentist.

The GDC has also proposed extending the permitted duties of therapists and hygienists to include more kinds of local analgesics, re-fixing crowns and taking impressions. The Government supports the principles behind these proposals.

The proposals for dental therapists in general practice have far reaching implications but would be a powerful boost to team working. The Government will consult on the detail of those implications. It would, of course, be necessary to keep the principal general dental practitioner’s overall accountability for the work of the whole team. It would also be necessary to work within the limits of how many therapists are available and how quickly the numbers in training could be increased.

There is also scope for making better use of the skills of qualified dentists themselves, in particular those who would like to return after a career break or those working part time who would like to work full time. The Government will explore ways of promoting supportive and family-friendly policies in NHS dentistry to help dentists have the working patterns that they want.
Conclusion

4.48 The range of proposals described in this Chapter will affect everyone involved in
dental treatment – dentists, other dental professionals and patients. They will
encourage and help the whole dental team to provide the best possible services to
their patients, who will be better informed about their dental treatment than they
have ever been.
Target

By 2003, five year-old children should have on average no more than one decayed, missing or filled primary tooth; and seventy per cent of five year-olds should have no experience of tooth decay.

The Government will tackle the inequalities in oral health that Chapter Two describes. It will focus on children, helping to give the next generation a healthier start that will benefit them throughout their lives.

The Government will do this by:

- promoting oral health in new ways – Health Authorities will extend their role, Health Action Zones and Healthy Living Centres will be encouraged to build oral health into their activity;
- reviewing the Early Years Initiative to encourage dental registration of children in deprived areas;
- encouraging Health Authorities to address black and minority ethnic oral health issues locally;
- widening public health measures, including campaigns against tobacco and alcohol misuse; and
- reviewing fluoridation of the water supply.
The Issues

5.1 Oral health is central to healthy living and contributes to the well being of us all. Improving oral health is a part of the Government’s wider public health strategy. That strategy – published in Saving Lives: Our Healthier Nation – has two fundamental aims:

- to improve both the length of people’s lives and the number of years they spend free from illness; and
- to improve the health of the worst off in society and to narrow the health gap.

5.2 Chapter Two describes the long term trend towards better oral health. Children have shared in that improvement, and the most recent figures show that five year-olds now have on average 1.5 decayed, missing or filled teeth and that 61 per cent have no experience of tooth decay.

5.3 The overall improvement disguises some persistent problems:

- inequalities between more and less deprived areas;
- particular problems faced by some black and minority ethnic groups; and
- oral cancer, which kills about 1,500 people every year. Smoking and alcohol misuse, especially when combined, are significant causes of poor oral health in general and oral cancer in particular.

5.4 The Government is addressing these issues and, in line with the NHS Plan commitment to narrow the gap in child morbidity between socio-economic groups, is focusing on the oral health of children. This is for good reasons – there is a strong correlation between tooth decay and deprivation, and good oral health depends largely on good oral hygiene and diet, which are both habits usually formed in early childhood.

5.5 We know that:

- children who start brushing their teeth in infancy are less likely to experience tooth decay than those who start brushing later;
- using fluoride toothpaste is an effective way of preventing decay; and
- children from deprived communities (and some black and minority ethnic communities) are less likely to visit a dentist regularly.
5.6 The Government’s targets are that, by 2003:

- on average, five year-old children should have no more than one decayed, missing or filled primary tooth; and
- seventy per cent of five year-old children should have no experience of tooth decay.

5.7 The Government intends to set new, challenging, targets:

- for children’s decayed, missing or filled primary teeth in 2013 (when ten-yearly data becomes available), which will be set in the light of the outcome of the 2003 target and concentrate on improving oral health in the Health Authorities furthest from the target; and
- another for adults, again focused on targets for Health Authorities. More details of this will be announced over the coming twelve months.

The Proposals

Fluoridation

5.8 The evidence shows that fluoridation of the water supply can reduce tooth decay in children by between a third and a half. The water supply in Sandwell was fluoridated in 1986 and over the next ten years tooth decay in local children fell by more than half. During the same period the oral health of children in Bolton, an area with a similar population mix but without fluoridated water, changed very little.

5.9 Once a health authority has established that there is strong local support for doing so, it can ask a water company to fluoridate the water supply. So far over fifty Health Authorities have asked water companies to fluoridate but none have agreed. The reluctance of the companies to take that step means there have been no new fluoridation schemes since 1986.

5.10 The White Paper Saving Lives: Our Healthier Nation indicated that the Government wanted in principle to extend fluoridation but also wanted to confirm the scientific basis of the benefits. It announced an expert scientific review of fluoride and health. The review is being carried out by the NHS Centre for Reviews and Dissemination and a report will be published soon.
Oral health in early childhood

5.11 We will help and encourage Health Authorities, Health Action Zones and Healthy Living Centres to develop new schemes making sure that more children use toothbrushes and fluoride toothpaste and visit a dentist regularly.

5.12 These schemes are known to work. Programmes in Manchester, East Lancashire and St Helens & Knowsley have cost an average of £35,000 each, concentrating on 20,000 to 30,000 deprived children in each area. Oral health advisers, working in dental practices with other health professionals, can significantly increase dental registrations of young children.

The MANCIT Project

The MANCIT project is targeted at 5,000 children in central Manchester. Health visitors who have had extra training in oral health promotion first see the children with their parents at the eight-month visit to the child health clinic. The parents are given a feeder cup to substitute for a bottle and a leaflet, available in seven languages, on oral hygiene. At the eighteen month visit the health visitor gives each child a tube of fluoride toothpaste and a toothbrush and demonstrates how to use them properly. A new toothbrush and another tube of toothpaste are given to the children at three years and again at the school entry check.

5.13 In this financial year the Government plans to spend about £0.5 million helping the Health Authorities furthest from its targets for decayed, missing and filled teeth to set up their own schemes. The schemes will be evaluated to make sure they are working as well as they should and are providing good value for money.

Early Years Initiative

5.14 The Early Years Initiative was launched in 1998 to improve the dental health of children from deprived areas. It gives higher payments to dentists to encourage more deprived children to register with them and costs about £3 million a year. The Government will work with the profession to evaluate the initiative and decide whether it represents the best possible value for money.

School Dental Screening

5.15 Schools are the ideal arena for encouraging and establishing good oral health in childhood. The Community Dental Service provides dental screening to all children in state funded schools three times in each child’s school life, but the system is not working at its best throughout the country. There are particular
problems with following up school screening – many children who are identified as needing further treatment do not get it.

5.16 One of the main problems has been the lack of clear aims and objectives for school screening, which in turn leads to inconsistencies in the quality of the service and its follow up procedures. The Government intends to address these problems and improve school dental screening.

5.17 The Government will introduce a new national protocol, after discussion with the profession, setting out clear aims and objectives for school dental screening. The protocol will set clear criteria for exactly which conditions should be referred for further treatment and will set out follow-up procedures. Current best practice in encouraging treatment after screening must become routine for all CDS and school dental screening programmes.

5.18 The new protocol will be piloted from the beginning of the academic year 2001/02 and should be operating nationally by the following academic year.

Oral Health for Black and Minority Ethnic Groups

5.19 To help get better oral health messages to black and minority ethnic communities the Government has funded the translation of oral health advice into Urdu, Bengali, Gujarati, Punjabi, Cantonese and Mandarin. But literature on its own is not enough – direct intervention and involvement in communities are the only sure ways of bringing about real, lasting improvements.

5.20 The NHS has begun to tackle these issues. In Bradford, Birmingham and Bloomsbury the Health Authorities are running schemes to encourage the registration of children from black and minority ethnic communities. The Birmingham project is linked to the ‘Integra’ initiative, which funds the training of women from local ethnic communities to support families and help them to cope with socio-economic deprivation. East London and the City Health Authority is also helping members of ethnic communities to get NHS dentistry. The Government will look for ways to spread these sorts of initiatives further and wider.

5.21 The Government works with the National Transcultural Oral Health Centre at the Eastman Dental Institute on the delivery of care in a multi-ethnic society. The Centre’s expertise is relevant to both patient care and the development of a dental workforce which is representative of black and minority ethnic groups. The Department of Health is funding the Centre to develop a training package for health promoters and the dental profession on ethnicity and oral health issues.
Smoking and Alcohol Misuse

5.22 In 1998 the Government launched a three-year media campaign to tackle the problems of smoking and tobacco and is funding smoking cessation services over the same period. The Government is also developing a comprehensive strategy to tackle the effects of alcohol misuse, focusing on the health risks as well as the social costs.

Wider Action

5.23 Oral health promotion can also be worked into other initiatives supporting children, the elderly (particularly those living in residential care and nursing homes), black and minority ethnic groups and deprived areas. Partnership groups like Health Action Zones, Healthy Living Centres and Health Improvement Programmes are all aimed at reducing inequalities in health care and should consider dental needs. The partnerships provide an opportunity for shaping health services to the particular needs of a community, and demand co-operation between all of a community’s major health providers and supporters.

Health Action Zones

5.24 Health Action Zones develop and implement local strategies for tackling inequalities and delivering real improvements to public health and the quality and outcome of care. They trigger action in areas with poor health and significant pressures on services. The twenty-six HAZs set up in 1998 and 1999 cover about thirteen million people in inner cities, rural areas and ex-coalfield communities.

5.25 Some HAZs have already adopted oral health as part of their core programme and will expand into more oral health promotion initiatives. Their more integrated working methods also make HAZs a platform for delivering general oral health promotion messages.

Plymouth Health Action Zone

The Health Action Zone in Plymouth has developed a strategy for improving oral health and access to dentistry, including projects promoting healthier food choices, improving the community oral health programme and improving development opportunities for NHS dentists. The HAZ oral health programme is also improving access to oral health services for people with special needs.
Healthy Living Centres

5.26 Healthy Living Centres target the most disadvantaged groups and areas. They aim to influence the wider determinants of health, such as access to services, social exclusion and economic factors, and to reduce health inequalities. The Government expects a number of HLCs to build an oral health component into their activity.

Sure Start

5.27 Sure Start is a cross-Government initiative supporting families, promoting positive relationships and giving children the best possible start in life. There will be 250 Sure Start programmes across England over the next three years, helping agencies to work together in new and constructive ways to provide better services to families and children in disadvantaged areas.

5.28 Local Sure Start programmes are led by partnerships that include Health Authorities and NHS Trusts. Oral health schemes developed by HAs will be integrated with local Sure Start programmes, helping to tailor oral health promotion to the specific needs of a particular area.

Conclusion

5.29 Good oral health is central to well being and healthy living. The progress made over the last fifty years is huge, but it has left behind pockets of inequality that the Government will tackle by targeting help at children. Promoting oral health is not just a job for dentists – existing initiatives on the wider public health agenda will embrace oral health promotion as an integral part of their role.
6

The Way Forward

Modernising NHS Dentistry

The public is impatient for change in the NHS. People are entitled to expect a faster, more convenient health service better attuned to the demands of modern life. Modernising NHS dentistry to meet these demands is a challenging but achievable task.

The Government will make NHS dentistry a genuinely national service again, with high quality services guaranteed. The oral health of the nation must continue to improve, and current inequalities in oral health must be reduced.

To fulfil this modernising agenda successfully the Government, the NHS and the dental profession must work together. Only by combining our efforts can we realise the full potential of change in NHS dental services.

The Government’s Role

6.1 The Government will meet its responsibilities for making NHS dentistry a modern and dependable service by:

- making NHS Direct a gateway to dental services, providing information on the range of NHS treatments available and where to find them;

- establishing around fifty Dental Access Centres by March 2001 to relieve the areas with the worst access problems;
• rewarding dentists’ commitment and loyalty to the NHS with payments of around £18 million a year;

• funding modernisation of dental practices with up to £35 million in 2001/02;

• setting up the £4 million Dental Care Development Fund in 2000/01 to build on the success of the Investing in Dentistry scheme;

• examining the evidence for changing working patterns, including more flexible recall intervals for routine examinations, to ensure the most appropriate treatment and care for patients;

• introducing new arrangements for performance management of Health Authorities’ responsibilities for dentistry;

• reforming the system of prior approval for complex treatments and current orthodontics practice, working with the profession;

• consulting on how to make best use of the whole dental team, including more family friendly policies and maximising the contribution of dental therapists and hygienists;

• making better information more easily available to patients, describing the range of services provided by NHS dentistry and any charges involved;

• improving the quality of services by implementing clinical governance in NHS dentistry, and modernising professional self-regulation; and

• tackling fraud through the Directorate of Counter Fraud Services.

**Health Authorities’ Role**

**6.2** Health Authorities have an equally important role in the modernisation of dental services. Access to NHS dentistry is now specifically included in *Modernising Health and Social Services – National Priorities Guidance 2000/01–2002/03*, giving dentistry a new and long-term prominence in Health Authority planning and activity.

**6.3** The Guidance states that HAs will improve access to NHS dentistry through the range of measures published in these plans. They will be held accountable for the delivery of the strategy and their performance will be monitored and managed. Specifically, HAs will be expected to:
• ensure fair access to NHS dentistry, including work with local dentists to support commitment to the NHS, making sure that out of hours and emergency coverage is effective, and negotiating arrangements for referral of unregistered patients from NHS Direct;

• finance necessary developments in local dental services from the growth in their general funding which underpins the NHS Plan as a whole;

• work through Health Improvement Programmes, Health Action Zones, Healthy Living Centres and Sure Start to improve oral health, especially of children. HAs will be encouraged to instigate schemes aimed at increasing visits to dentists by children from black and minority ethnic communities;

• ensure effective and efficient delivery of appropriate salaried dental services, either through the Community Dental Service or Personal Dental Services pilots (including Dental Access Centres);

• plan and implement the modernisation of the committed dental practices which benefit from funding in 2001/02; and

• provide accurate and up to date information to NHS Direct on which dentists are accepting NHS patients and to work with NHS Direct to maintain the accuracy of this information.

The Profession’s Role

6.4 Success in modernising NHS dentistry also depends on the professional dental team. The commitment and support of the workforce are essential if the Government’s objectives are to be met. The Government asks the profession to:

• use clinical governance to ensure the continuing high quality of services and care within NHS dentistry;

• embrace continuing professional education;

• ensure new levels of professional self-regulation;

• work with the Government and Health Authorities to review arrangements for prior approval and orthodontics; and

• make optimum use of the skill mix within the profession by using the talents of the whole dental team.

6.5 Through these actions NHS dentistry can modernise and once again provide a high quality, easily accessible dental service across the country. NHS dentistry will then meet public expectations of a service better suited to the requirements of modern society.
Annex – Estimate & Receipt Form

NHS DENTAL CARE

Acceptance

Patient’s surname

Patient’s forename

Date of acceptance

For practice use

You are now under the NHS care of the dentist named on this form.
This gives you several entitlements and these are set out overleaf.
This arrangement will continue for the next 15 months or until an earlier date as I may indicate to you.
You may end this arrangement at any time and go to another dentist.

NHS TREATMENT PLAN

(Completed after the dentist has examined you)

This chart gives details of treatment carried out and, where applicable, cost of treatment. To find out if you are eligible for free dental treatment, see information on dental charges overleaf.

<table>
<thead>
<tr>
<th>Estimated Costs</th>
<th>Actual Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and treatment needed</td>
<td>Care and treatment needed</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Examination (already carried out)</td>
<td>Examination (already carried out)</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Scale and polish</td>
<td>Scale and polish</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Initial X-ray(s) already carried out</td>
<td>Initial X-ray(s) already carried out</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Further X-ray(s)</td>
<td>Further X-ray(s)</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Silver amalgam filling(s)</td>
<td>Silver amalgam filling(s)</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Tooth coloured filling(s)</td>
<td>Tooth coloured filling(s)</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Root filling(s)</td>
<td>Root filling(s)</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Crown(s)</td>
<td>Crown(s)</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Extraction(s)</td>
<td>Extraction(s)</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Denture(s) — plastic/metal</td>
<td>Denture(s) — plastic/metal</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Other treatment</td>
<td>Other treatment</td>
</tr>
<tr>
<td>£</td>
<td>£</td>
</tr>
</tbody>
</table>

Total estimated NHS charge £

Total Actual NHS charge £

☐ No treatment needed. I recommend a check-up in about ☐ months

PRIVATE TREATMENT OPTIONS

The NHS provides all the treatment necessary to secure and maintain your oral health. There are some treatments (mainly cosmetic) which are not available under the NHS, and you may choose to have these privately. You may also choose to have some treatment privately as an alternative to NHS treatment.

<table>
<thead>
<tr>
<th>Treatment additional to NHS treatment</th>
<th>Cost</th>
<th>Treatment additional to NHS treatment</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£</td>
<td></td>
<td>£</td>
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<td></td>
<td>£</td>
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<td>£</td>
</tr>
<tr>
<td></td>
<td>£</td>
<td></td>
<td>£</td>
</tr>
</tbody>
</table>

I agree to have the above treatment under private arrangements. (Please delete any treatment proposals not agreed)

Date: ___________________________

Patient’s signature

<table>
<thead>
<tr>
<th>NHS charge</th>
<th>£</th>
<th>Private charge</th>
<th>£</th>
<th>Total</th>
<th>£</th>
</tr>
</thead>
</table>

It may be necessary to alter this plan and (if charges apply) the estimated cost may change. If this happens I shall tell you and ask how you wish to proceed.

Date: ___________________________

Dentist’s signature
NHS DENTAL TREATMENT

NHS or private care?
Make sure that you are clear whether your dentist is treating you under the NHS, privately, or a mixture of both. If you are not sure at any time do not hesitate to ask your dentist or receptionist.

NHS patients are entitled to:

- Written information about their dentist and the practice
- All treatment necessary to secure and maintain their oral health
- Free repair and replacement of certain treatment that fail within a year
- Advice and, where necessary, treatment in an emergency
- A national set of charges
- A maximum charge per course of treatment
- Free or reduced cost treatment for some groups of patients
- Access to a formal complaints procedure

Registration with your dentist
When you are accepted as an NHS dental patient you become one of your dentist's registered patients (unless you are being treated at a dental access centre). Registration usually lasts 15 months from the end of the initial month of registration and can be extended for a further period of 15 months each time a course of NHS treatment is begun. Registration does not prevent you seeking NHS dental care from another dentist or your dentist deciding to withdraw from the arrangement (usually with three months of written notice). If your dentist is not able to accept you back onto his or her list then you may still be offered treatment as a private patient. NHS Direct can provide you with details of other dentists accepting NHS patients.

Do you have to pay?
Treatment is free if:
- You are under 18, or are a full-time student under 19
- You or your partner are getting the following benefits or tax credits
  - Income Support
  - Income Based Job Seeker's Allowance
  - Full Working Families Tax Credit or Credit reduced by £70 or less
  - Full Disabled Persons Tax Credit or credit reduced by £70 or less
  - You are expecting a baby when treatment starts, or you have had a baby in the last 12 months
- You or your partner have a certificate for full help with NHS services

Tell the dentist or receptionist that you are entitled to free treatment. You will be asked to provide evidence of your entitlement.

On low income but not on the list?
If you are on a low income but not eligible for free NHS treatment you may only need to pay a reduced amount under the NHS Low Income Scheme. If you feel that you may be entitled to help, pick up a HC1 form 'Claim for Help with Health Costs' from a Social Security office, NHS hospital or dentist.

What does it cost?
If you cannot get free NHS dental treatment or help with the cost, you pay 80 per cent of the cost of the treatment up to a pre-set maximum. The government sets the cost of NHS dental treatment and you will pay the same whichever dental practice you choose to go to. Your dentist can give a breakdown of your treatment. The table below gives examples of costs of NHS charges for some common treatments.

Estimates of NHS dental charges

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Patient Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Examination &amp; Report</td>
<td>£49.90</td>
</tr>
<tr>
<td>X-rays</td>
<td>£3.30 - £13.60</td>
</tr>
<tr>
<td>Scaling, polishing and simple periodontal treatment</td>
<td>£7.76</td>
</tr>
<tr>
<td>Amalgam Fillings</td>
<td>£5.24 - £13.56</td>
</tr>
<tr>
<td>Tooth coloured fillings</td>
<td>£9.88 - £15.48</td>
</tr>
<tr>
<td>Root filling</td>
<td>£3.16 - £5.28</td>
</tr>
<tr>
<td>Crowns (porcelain bonded crown)</td>
<td>From £3.20</td>
</tr>
<tr>
<td>Provision of Dentures (Full upper and lower dentures)</td>
<td>£107.00</td>
</tr>
<tr>
<td>Extraction of teeth</td>
<td>£4.84 - £29.28</td>
</tr>
</tbody>
</table>

Cost of private dental care
Information on the cost of private care is available from your dentist.

NHS registered patients and private care
Registered NHS patients have the right to receive under the NHS all the treatment that is necessary to secure and maintain their oral health. In some circumstances the dentist may suggest that treatment be undertaken privately, for example to achieve the best cosmetic result. If you do not wish to have private treatment, appropriate NHS treatment will be provided.

You may wish to have treatment that is additional or alternative to that required to achieve oral health, for example certain cosmetic procedures or particular types of crown. In these circumstances the NHS allows a dentist to provide the treatment privately except where both NHS and private treatment would have to be provided on the same tooth, during the same course of treatment.

NHS Complaints Procedure
If you need to make a complaint about the care or service provided by your NHS dentist or dental practice, contact the person responsible for the practice Complaints Procedure. You can make the complaint orally or in writing and you should receive a response within ten working days. Your dentist will try to resolve the complaint at this stage. If the complaint is not resolved to your satisfaction then contact your local Community Health Council for advice.

The next step in the procedure is to ask the local Health Authority to conciliate or convene an independent Panel to consider the complaint. If this process does not resolve the situation then you can take your complaint to the Health Service Commissioner (Ombudsman) who will review the case. None of these procedures provides financial compensation.

The Way Forward 51