



THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

Review of Dentistry in Kensington and Chelsea

October 2009

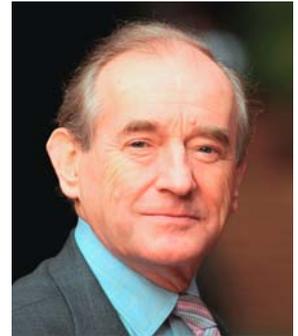
Chairman's Foreword

This Health Scrutiny Committee has reviewed the dentistry and oral health services in Kensington and Chelsea. I very much welcome this report which outlines the current position and problems in our Borough.

NHS Kensington and Chelsea ('the PCT') has improved its dentistry service in the past year. However, it still needs to raise its targets as far too many residents do not access any dental service and child oral health is very poor.

There is much to be done to improve local dental provision. This report makes twenty specific recommendations, but also can aid the understanding of dentistry and oral health services in Kensington and Chelsea.

I would like to give my thanks to all the members of the 'Review of Dentistry in Kensington and Chelsea' Sub-Group and the PCT for being fully involved in aiding the Health Scrutiny Committee's work on this review. In particular, I would like to thank Councillor Coleridge for his efforts chairing the Sub-Group, until 20 May 2009 when he was elected Mayor for Kensington and Chelsea for 2009-10, Councillor Freeman who chaired the final meeting and was responsible for coordinating the final recommendations and Henry Bewley (Health Policy Officer) for his hard work pulling it all together.



*Cllr Christopher
Buckmaster,
Committee Chairman*

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1. EXECUTIVE SUMMARY AND RECOMMENDATIONS

- 1.1 At the Health Scrutiny Committee (then known as the OSC on Health) meeting on 26 September 2007 it was agreed to carry out a review of Dentistry in Kensington and Chelsea during 2008-09.
- 1.2 There was a clear need for the Health Scrutiny Committee to review dentistry. Kensington and Chelsea was in the bottom place for comparative expenditure on dentistry in London in 2006-07. In 2008, it had the lowest number of adult and child NHS dental patients per population anywhere in the country¹.
- 1.3 At the end of March 2006, 43,642 people had used an NHS dentist in Kensington and Chelsea in the previous 24 months (NHS London target). 37,737 people had seen an NHS Dentist in Kensington and Chelsea in the previous 24 months as at March 2009. This constituted a shortfall of 5,905 patients against the NHS London target of 43,642 patients. The Primary Care Trust (PCT) is hopeful that it will be able to achieve this target by the end of the year.
- 1.4 The Joint Strategic Needs Assessment tells us that in Kensington and Chelsea: 33% of residents "use the NHS" for dentistry; 23% "do not use NHS and would not like to" and 44% "do not use the NHS and would like to".² This 44% figure is lower than average compared to London (47%), but higher than the average for England (41%).
- 1.5 A significant part of the Kensington and Chelsea population do not use a dentist, NHS or private, at all. The Health Scrutiny Committee recognises that NHS Kensington and Chelsea inherited this longstanding phenomenon. The Health Scrutiny Committee also recognises that tackling long-seated problems and increasing capacity will take time.
- 1.6 The Committee accepts significant progress has been made. The Committee is particularly pleased that the PCT is making the efforts to improve their position, as described in the Dental Plan 2009-11³. The initiatives planned are very encouraging. Particular initiatives the Committee was pleased to hear about included:
 - The PCT has invested £4,042,363 in dental contractors in 2008-09 compared to £3,438,149 in 2007-08. This is an increase of

¹ Page 21 "Planning for the Future - Summary JNSA" report available at: http://www.rbkc.gov.uk/partnerships/healthwellbeing/jsna_planning_for_future.pdf

² Page 24 "Planning for the Future - Summary JNSA" report available at: http://www.rbkc.gov.uk/partnerships/healthwellbeing/jsna_planning_for_future.pdf

³ A summary of the Dental Plan 2009-11 is set out in Section 3

18% in the number of Units of Dental Activity (UDAs) commissioned.

- The PCT is further investing over £1.5m over two years to increase capacity by over 7,000 patients. The PCT believes this to be a realistic goal.
- The PCT's commissioning and social marketing work has combined to produce a raft of improvements in provision and quality, evidenced by the introduction and launch of the Quality Outcome Framework (QOF) and the preventative "toolkit" for dentists.
- The PCT is improving the community dental facilities at St Charles site to double the existing capacity.
- The PCT is to provide dental service to all adults and children with special needs by opening Violet Melchett as a Community Dental Service in the south of the borough.
- The PCT is increasing capacity at the new Earls Court Health Centre practice to provide for an additional 4,000 new patients.
- The PCT regularly carries out clinical governance visits to all NHS dentists and has been dealing with the poorer performing practices.
- The PCT is offering local private dental providers NHS contracts during 2009 where such providers meet NHS requirements.
- The Council's Resident Panel survey results show there has been some improvement in patient access.

1.7 The Health Scrutiny Committee acknowledges that the PCT has been working to improve the position of dentistry in Kensington and Chelsea. The Committee notes that the PCT aims to provide quality NHS provision. The PCT states its aspiration to be a World Class Commissioner of dental and oral health services.

1.8 However, the PCT has set itself targets of only reaching the England average – for example on the number of people using an NHS Dentist; on the oral health of children in the borough, and on reducing the under 3 month re-attendance rate. On some targets the PCT's aim is to reach just the London average, which is less than the national average. The Health Scrutiny Committee believes that "aspiring to be average" is not an acceptable goal for Kensington and Chelsea residents. The Committee suggests that the PCT re-examines and strengthens these priorities. The PCT must aspire to be amongst the best Primary Care Trusts in England.

Recommendation 1: The Health Scrutiny Committee calls on the PCT to aim higher so that its provision of dental service is amongst the best in England, and for this to be supported by appropriate finance. The England average should be seen as a minimum standard rather than as a target to be achieved.

1.9 The Committee notes that the PCT Board has never been presented with a strategy paper on the totality of dentistry in Kensington and Chelsea. The Health Scrutiny Committee acknowledges that the Clinical Executive Committee signed off the Dental Plan 2009-11 and received dental performance managing reports, as a delegated committee of the board. The Health Scrutiny Committee also fully accepts the Board has received, over successive years, summaries and reports on parts of the total dental service.⁴

Recommendation 2: The Health Scrutiny Committee believes that the PCT Board needs to be presented with a single clear overarching strategy on dentistry in Kensington and Chelsea to enable the Board to provide the leadership to ensure improved standards of dentistry and oral health on a comprehensive basis.

1.10 The PCT analyses the performance of providers so it can ensure there is a high quality of service delivered.

Recommendation 3: The Health Scrutiny Committee supports the PCT in its implementation of the Dental Quality Outcomes Framework (QOF). The Dental QOF should have a significant positive effect on quality over the next year and we would expect all NHS practices will have moved to the British Dental Association (BDA) good practice standard by 2010-11.

1.11 The PCT has carried out 'dental practice insight' and 'mystery shopper' work in the past.

Recommendation 4: The Health Scrutiny Committee recommends that the PCT repeats its 'dental practice insight' and 'mystery shopper' work on a regular basis, bi-annually and annually respectively, so that comparisons can be made against previous findings.

1.12 There are very large numbers of Kensington and Chelsea residents not accessing any dental services. Currently it is estimated at 44%⁵. This is far too high. The Health Scrutiny Committee welcomes the PCT's commitment to extend access to NHS dental services. NHS Kensington and Chelsea is one of the first PCTs to commission social marketing to support uptake in NHS dentistry.⁶

⁴ For example: At the PCT Board (March 2009) the Dental Plan 2009-11 was presented in three different summarised formats (inc. the dental business case for 2009-11) and the Board approved the investment programme 2009-10. The PCT Board (July 2008) was presented with the 10 year primary care strategy, which had a sub-section on the dental strategy.

⁵ This 44 percentage relates to the residents who don't use the NHS and would like to.

⁶ The press release "Innovative new campaign to boost Kensington and Chelsea Dentistry" (12 August 2009) is available on the Internet at: <http://www.kc-pct.nhs.uk/new/news/story/default.aspx?id=381>

Recommendation 5: The Health Scrutiny Committee considers that the social marketing exercise will need to be fully evaluated before a decision is made about future funding. The successful parts of the programme should be adopted as core ongoing business and financed as such.

Recommendation 6: The Health Scrutiny Committee believes the large numbers of Kensington and Chelsea children not accessing any dental services is unacceptable. The Health Scrutiny Committee recommends that the PCT undertakes steps to improve the provision of dental check-ups for children, examines the very low take-up of services for the under 17 year olds and addresses the inequality in service provision across the Royal Borough.

1.13 The British Association for the Study of Community Dentistry (BASCD) survey gives the best available data on the state of children's oral health in the borough. The rate of decayed, missing or filled teeth amongst children under 5 in Kensington and Chelsea is 2.01 as compared to 1.2 for England, 1.67 for London, and 1.91 for NW London. It is recognised that this is only a partial picture as the sample is taken only from the children attending state schools. It does not include approximately 70% of resident children not attending state schools in the Royal Borough.

Recommendation 7: The Health Scrutiny Committee recommends that the PCT and Council set out the timescale for improving the rate of decayed, missing or filled teeth amongst children under 5 in Kensington and Chelsea's state schools to at least the England average. The Health Scrutiny Committee recommends the PCT and Council gain a better understanding of the extent of child oral health in the total child population in Kensington and Chelsea.

1.14 The Review heard much about the quality of the health promotion service and preventative work currently provided. The Health Scrutiny Committee welcomes the proposed child smile and child friendly dental programmes.

Recommendation 8: The Health Scrutiny Committee recommends more joint work to be carried out by the PCT with the Borough's Family and Children's Services (FCS), nurseries, children's centres and schools to further improve preventative work. Following on from Recommendation 6, the Health Scrutiny Committee recommends that the PCT, FCS and schools also work together to better encourage pupils to visit a dentist.

1.15 The Review found much evidence that schools are willing and engaged to accept dental health promotion on their premises. Schools take part in training (for teachers and support staff) and conduct familiarisation trips to local dental practices. Both

competition for teacher training subjects and taking pupils out of classes are notoriously difficult to achieve and these activities show schools' commitment to this matter. However, the Review heard anecdotally of resistance to oral health promotion in some schools and believes the scale of the problems of poor dental health of local children calls for renewed action.

Recommendation 9: The Health Scrutiny Committee recommends the active promotion of good dental health in Borough schools. FCS to encourage school headteachers to promote oral health and dentistry promotion within their school premises. Schools could further encourage work to increase the number of pupils registered with a dentist (e.g. more schools could be linked with particular dental practices). The Health Scrutiny Committee recommends that marketing materials promoting unhealthy food or drink should be self-assessed out of schools (including making this a part of the Healthy Schools Programme criteria).

Recommendation 10: The Health Scrutiny Committee recommends that the PCT and the FCS should work together to promote oral health as part of the other health promotion work directed towards children (for example, tackling obesity and preventing the take up of smoking).

1.16 The PCT should communicate clearly how people might find a dentist through the most appropriate media and what to expect from a dentist when they get there.

Recommendation 11: The Health Scrutiny Committee recommends to the PCT that it increase its promotion of its telephone helpline. The dental helpline must be kept fully up to date with changes in the opening and closing lists by existing practices; on new commissioned services; and providing callers with an estimate of the length of possible waiting lists, and to give callers a choice of dentist where possible.

1.17 People are generally most interested in accessing services in their local vicinity. There could be much better signposting between different local NHS services such as between dentists, pharmacists and GPs.

Recommendation 12: The Health Scrutiny Committee recommends that the PCT carries out small geographical area marketing of dentists, pharmacists, GPs and other local health and social care facilities. For example, there could be posters advertising local NHS services in dentists', pharmacists' and GPs' facilities.

1.18 The Health Scrutiny Committee welcomes the work to be carried out by the PCT to support practices to improve their facilities and

communication techniques. For the "Toolkit" to be well used it must be full of useful "tools". The more useful information the toolkit contains the more likely it is to be a valued (and used) resource.

Recommendation 13: The Health Scrutiny Committee recommends the PCT adds to the prevention toolkit for dentists as much patient focused information as possible to make it an invaluable resource. Following on from Recommendation 10, it should contain details of local health and social care facilities – GPs, pharmacists, other dentists etc.

1.19 Launched by the Department of Health on 21 November 2007, "Valuing People's Oral Health"⁷ is best practice guidance to improve oral health of disabled children and adults. It is an evidence-based guide for those who provide or commission dental services for people with disabilities.

Recommendation 14: The Health Scrutiny Committee recommends the PCT should adopt in full the recommendations contained within "Valuing People's Oral Health".

1.20 Whilst the overall Emergency and Hospital (EDC) services provided are considered to be satisfactory, the PCT needs to ensure that it is fully aware of the real demand for dental services, patient experience, and the care pathways for adults and children with special needs and disabilities.

Recommendation 15: The Health Scrutiny Committee recommends that research should be undertaken to establish demand for Emergency and Hospital (EDC) services, patient experience and the care pathways for adults and children with special needs and disabilities.

1.21 Practices have complained that they find the process of referring a patient is excessively cumbersome (more fully described in section 12.8). Some hold the practice accountable for the delays, and discontinue self-referral.

Recommendation 16: The Health Scrutiny Committee recommends that research is undertaken to establish if the 'referral to specialist services' system is fit for purpose. If there are problems these need to be addressed. Even if there is a perception of problems this should be explored and addressed.

⁷ "Valuing People's Oral Health" is available on the Internet on: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080918

1.22 The PCT commissioned the KCW BME Health Forum study (July 2009) into the barriers BME groups experienced in accessing NHS dentistry.

Recommendation 17: The Health Scrutiny Committee recommends that the PCT should explore ways to improve access to interpreting and translation services and continues its work with the KCW BME Health Forum to addresses any gaps in service highlighted by their report, commissioned by the PCT.

Recommendation 18: The Health Scrutiny Committee recommends that the PCT undertakes research to establish future dental and oral health needs to ensure they have the right dental health provision in the longer term. The PCT should explore the needs of the elderly to ensure they have the proper domiciliary provision at home and in care homes including dentures, through the commissioning of the domiciliary service from the Community Dental Service.

Recommendation 19: The Health Scrutiny Committee recommends that the PCT is clear about the progress that is still needed before dentistry and oral health in Kensington and Chelsea is up to world class standards.

Recommendation 20: The Health Scrutiny Committee requests the PCT to provide an annual report over the next five years to enable the Committee to monitor standards and improvements in dental and oral health services in Kensington and Chelsea, in particular: (i) child oral health, (ii) dental patients per population, and (iii) access and satisfaction.

2. DENTISTRY AND ORAL HEALTH “NEEDS”

2.1 The PCT commissioned a needs assessment of the oral health of the population of Kensington and Chelsea at the end of 2008.

- NHS Kensington and Chelsea has the lowest number of adult and child NHS dental patients per population of anywhere in the country.
- Children's tooth decay in state primary schools is worse than the England average⁸. This is amongst the worst in London. Kensington and Chelsea's decayed, missing or filled teeth rate (DMFT) for children under five is 2.01. This is significantly worse than the 1.2 DMFT rate for England (for comparison the rate is 1.67 for London, and 1.91 for NW London).
- Furthermore, when children and adults in Kensington and Chelsea do see a dentist, they are more likely to receive Band 2 and Band 3 treatments (e.g. fillings, extractions, or bridges) than have Band 1 treatments (e.g. check-ups) compared to the averages for London or England.⁹ [Note: This statistic shows the dental health of a sample that does not include children who go to private schools].
- NHS Kensington and Chelsea has said, “There are low levels of dental registration, high levels of poor oral health, and unknown visiting patterns with private dentistry.”¹⁰ In 2004 only 22% of the PCT's population were registered with a dentist. This compares with other PCTs in North West London having registration rates of just over 50% and a London average of 51%.¹¹
- Oral health is poorer in areas of highest deprivation. Despite an overall decline in the number of practices in the borough, there is a cluster of practices in the north accounting for over half the UDAs commissioned. Therefore, capacity can be met if access is increased. There is a higher than average proportion of 0-19 year olds in the wards, with three of the four wards having a 0-19 year old population more than 25% higher than the borough average.
- Statistics from the National Patient Survey suggest that Kensington and Chelsea has the 4th highest uptake rate of private dentistry in London and the 12th highest in the country, with 40% going privately in the previous two years.

⁸ “Kensington and Chelsea Health Profile 2008” available on the Internet at: <http://www.apho.org.uk/resource/item.aspx?RID=52446>

⁹ From PCT Operating Plan 2008-09

¹⁰ Page 14 of the NHS Kensington and Chelsea commissioning strategy 2008-13 available on the Internet at:

<http://www.kc-pct.nhs.uk/corporate/meetings/2008/11/documents/2.1aDraftCommissioningstratagy13Nov08.pdf>

¹¹ From PCT Operating Plan 2008-09

- 2.2 There were 43,642 patients in the previous 24 months accessing NHS Dentistry in Kensington and Chelsea in 2005-06 (This March 2006 position is the baseline currently used by NHS London for performance monitoring). The Sub-group received performance figures for the end of March 2009. In the preceding quarter 37,737 people had seen an NHS Dentist in the last 24 months: a short-fall of 5,905 patients against the NHS London target. Quarter 1 data shows three successive quarterly increases and hopefully the PCT will be able to reach the NHS London target by the end of this year.
- 2.3 In Kensington and Chelsea, the PCT had a 5-6% underspend on dental provision in the first two years of the new contract as patients did not use the service. However, for the first time, in its third year it delivered 100% of UDAs. The issue of the public not using provided dental services was highlighted by the London Assembly report "Teething Problems – A review of NHS dental care in London (December 2007)"¹² in which it noted that people were not using NHS dentists, rather than that there was a lack of available dentists. However, research conducted by the Citizens' Advice Bureau (National)¹³ found that one in six people have not seen a dentist for over two years, often because of a lack of available NHS dentists in their local area.

Re-attendance in under 3 months

- 2.4 There is a high level of re-attendance for a new course of treatment in under 3 months in Kensington and Chelsea. This might reflect poor oral health of our residents or that contractors are not properly implementing National Institute for Clinical Excellence (NICE) guidance on recalling patients for treatment or both. The PCT plans¹⁴ to reduce under 3 month re-attendance to the London and then national averages by ensuring practices use NICE guidance on recall treatment:
- By the end of 2009-10, re-attendance will be reduced to the London average or less.
 - By the end of 10-11 for re-attendance to be reduced to the English average or less.

¹² The London Assembly report "Teething Problems" is available on the Internet at: <http://www.london.gov.uk/assembly/reports/health/dentistry.pdf>

¹³ Private Healthcare UK: NHS structure pushing people into private dentistry <http://www.privatehealth.co.uk/news/march-2009/nhs-structure-private-dentistry-30331/>

¹⁴ Taken from page 75-78 from the PCT's "Operating Plan 2009-10" available at: <http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.1.2CoproateObjectivesapx2OperatingPlan.pdf>

2.5 This is intended to be achieved through better contract management, investment in education and training, IM & IT and introducing a Dental Quality and Outcomes Framework (QOF).

2.6 The Sub-group supports these endeavours by the PCT at reducing the levels of re-attendance. After a question from Cllr Coleridge, the Sub-group was re-assured that people would not get turned away if they returned earlier than the three months target.

3. STRATEGIC PLANNING

3.1 The PCT has agreed a commissioning strategy "Dental Plan 2009-11".

THE DENTAL PLAN FOR 2009-11^{15 16}

Introduction

The Dental Plan sets out how NHS Kensington & Chelsea will extend NHS Dental services in Kensington and Chelsea over the next two years and by doing so improve the oral health of our population. The plan sets out how we will invest an additional £3.2mill in NHS dental services over the 2 years. Our return on this investment will be:

- An increase in access to NHS Dental services through our meeting and then exceeding the 09 -10 operating plan target of 43,650 patients seeing an NHS Dentists in 24 months
- A significant improvement in the oral health of our residents and especially that of the borough's children
- An improvement in the quality in the services we commission from our contractors
- NHS dental services established as a valued and trusted brand by the residents of Kensington & Chelsea

Our vision is that by 2014 we will have:

- Increased access to NHS dentistry to that of the London Average, i.e. for 50% of the population of Kensington & Chelsea to be able to use NHS Dental Services
- Shown a reduction in the level of DMFT (decayed, missing, filled teeth) within

¹⁵ Part of this description of the dental plan 2009/11 is taken from the report "Progress report on the Implementation of the 10 year Primary Care Strategy", presented to the PCT Board on 31 March 2009, and available on the Internet at:

<http://www.kc-pct.nhs.uk/corporate/meetings/documents/2.2ImplementationPrimaryCareStrategyprogressreport.pdf>

¹⁶ The key elements of the dental action plan 2009-10 (including finance) are set out on pages 19-24 of the document "Budget Setting and Investment Plan 2009-10" available on the Internet at:

http://www.kc-pct.nhs.uk/corporate/meetings/documents/3.2200910BudgetSetting10309_v2.pdf

children in Kensington & Chelsea PCT. Our goal is to move from our current score of 2 to the English average of 1 DMFT

- Reduced the level of band 2 treatments (e.g. Fillings) received by children as well as the use of the paediatric secondary care services at Chelsea and Westminster. These outcomes will be the result of an improvement in the oral health of children in Kensington & Chelsea over the previous 5 years.
- Raised the level of attendance at NHS dentists by children in Kensington & Chelsea's most deprived wards so that 80% of children under 7 will have seen a dentist at least annually.
- Fully implemented NICE guidance on recall for treatment in all NHS Dental practices.
- All NHS dental practices meeting the requirements of Health Technical Memorandum 01-05 on infection control
- Full access to NHS dental services our residents with special needs and an improvement in their oral health as a result of this.
- All providers meeting the requirements of "Delivering Better Oral Health" including the % of children attending a dentist regularly receiving fluoride varnishes - to be at least 80%
- Established NHS dental services as a valued and trusted brand which our residents want to use
- Introduced a standard unit cost (£ per UDA rate) for NHS Dental services in Kensington & Chelsea

Cost

This is an ambitious plan and will require the Dental Commissioning budget to increase from its current level of £4.2 million to over £6 million by the end of the plan. The investment required is shown in the following table.

Summary Costs	2009 - 10 £	2010 - 11 £
Capacity	700,000	1,500,000
Social Marketing	354,978	189,956
Quality	184,000	184,000
Total	£ 1,238,978	£ 1,873,956

Capital investment of £192k will be required in the first year of the strategy.

Delivery

To achieve these goals the PCT will not only invest in increased capacity, i.e. procuring more dental practices, but will also change the way we commission, promote and market NHS dental services. We will also invest and improve the quality of the services we commission.

We have therefore divided this business plan into a 3 part programme. The 3 parts of the programme are:

1) Increasing Capacity

The PCT will commission additional capacity in 2009-10 so that it can achieve and then surpass its operating plan target of having 43, 560 patients see a dentist in 24 months. The PCT intends to commission an additional 15,000 patients over the next 2 years. This will consist:

- Increase capacity commissioning additional services from our current practices - by the end of May 2009
- Commissioning a new Children and Family dental service at the Colville Health Centre – to open July/August 2009
- Commissioning a new practice in Earl's Court – in 2010
- Via a procurement open up the market to private dental practices in Kensington and Chelsea –by September 2009
- Procure a new 3 chair practice in the PCT area by November 2009.

2) Implementing the Dental Social Marketing Scoping Report

The PCT recognises that to be able to meet its operating plan target and to significantly improve the oral health of our residents it will need to both increase the level of NHS Dentistry it commissions but also understand more fully what makes our residents choose to use or not use NHS Dental Services. The PCT has therefore decided to use Social Marketing as a way of achieving a suitable increase in the number of people using NHS Dental services. The first part of the project, the scoping stage, has now been completed and its recommendations are being developed into proposals to increase the number of people seeing an NHS dentist. Subject to the business case being approved the PCT will implement the recommendations of the Dental Social Marketing Report, this includes:

- Employing a project manager to implement the recommendations of the Dental Social Marketing Report – from April 2009
- Commissioning Child Oral health campaign to improve Children's Oral Health and use of NHS Dental Services by September 2009
- Running a marketing campaign to attract new patients to NHS dental services from Quarter 1 2009
- Supporting dental practices to market their services, from Quarter 2 2009
- Establishing the NHS Kensington and Chelsea dentistry as a trusted brand from Quarter 1 2009

3) Quality in NHS Dental Services

As part of its procurement of new dental services in 2009-10 the PCT will seek to improve the quality of NHS dental services in Kensington & Chelsea. The CEC agreed the following quality indicators:

- Fully implementing "Improving Oral Health" the prevention toolkit in all practices from Quarter 1 2009 and to be completed by the start of Quarter 4 2010.
- Ensuring practices offer children Fluoride varnishes - from Quarter 1 2009
- Ensuring all practices meet NICE requirements on recall for treatment from Quarter 1 2009
- Ensuring that New Decontamination requirements met by practices from Quarter 1 2009 to Quarter 4 2009-10
- Introducing a Dental QOF and a balanced score card from Quarter 1 2009
- Investing in Dental Practices' premises to improve their appearance and increase their capacity. from Quarter 1 2009 to Quarter 4 2009-10
- Introducing Clinical Audit in NHS Dental Practices In Quarter 2 2009-10

4. FINANCE

4.1 The PCT is responsible for ensuring the availability of dental services. It is required to commission local dental services on a cash-limited basis. The strategy is to direct resources to areas of most need, which will receive additional funding.

4.2 This indicative budget was presented to the Sub-group on 15 April 2009.

Services commissioned	2008-09 £	2009-10 £	2010-11 £
GDS Services	4,089,852	4,098,441	4,098,441
Invest in current GDS practices		300,000	300,000
Kensington Access Centre		300,000	600,000
Earls Court Access Centre			400,000
Colville, Children and Family centre		193,000	325,000
New entrants		100,000	200,000
Dental QOF		169,000	169,000
Clinic Audit		15,000	15,000
CDC K&C (St Charles and Violet Melchet)	508,694	650,825	650,825
Violet Melchet Access for older people and families	150,000	152,250	152,250
SDS H & F	180,000	182,700	182,700
Out of Hours services (Triage and CCH)	32,000	32,480	32,480
Chelsea and Westminster Children's Paediatric dentistry	?	?	?
Marketing: (a) Childsmile		124,978	129,956
Marketing: (b) New patient recruitment / Data Capture		120,000	40,000
Marketing: (c) Brand Building		100,000	
Total Revenue Spend	4,960,546	6,538,674	7,295,652

Capital	2008-09 £	2009-10 £	2010-11 £
Infection Control		112,000	
New chairs		30,000	
Signage / Better Premises		50,000	
Total Capital Spend		192,000	

Total Spend (capital and revenue)	2008-09 £	2009-10 £	2010-11 £
Total Spend	4,960,546	6,730,674	7,295,652

5. THE DENTAL CONTRACT AND PROFESSOR JIMMY STEELE'S REVIEW

5.1 Like General Practitioners, dentists are "independent contractors" who are able to practise where they like. Everyone is entitled, in theory, to see an NHS dentist for emergency or urgent treatment whether registered or not. NHS dentists can not reasonably refuse to see a patient who asks for NHS dental treatment. If they do not

have immediate capacity to see a patient, then they should advise them of the next available NHS appointment and if this is not acceptable, direct them to the Patients Advice and Liaison Service (PALs). Also, they can not recommend private treatment as being superior.

- 5.2 The new dental contract came into effect as of 1 April 2006 (Appendix 4). It was intended to give everyone better access to high quality services and bring in a new charging system. However, the start of the new contract has presented difficulties in improving access to better quality NHS dental services, in providing greater clarity about charging for patients and in job satisfaction for dentists. Nonetheless, the Government insists that the new arrangements will achieve these objectives with time.
- 5.3 The British Dental Association¹⁷ has highlighted what it sees as "significant problems" with the dentists' contract and patient charges introduced in April 2006. The NHS Information Centre¹⁸ showed that 1 million fewer patients accessed NHS dentistry in the two years following the reform than the two years before it. This is backed up by surveys by the British Dental Association (BDA), the Citizens Advice Bureaux (CAB) and Which? A BDA survey of 394 dentists found that the majority did not think the reforms had improved access. The CAB found that 2 million patients did not have access to an NHS dentist. A Which? survey found that two-thirds of dentists were turning away patients.
- 5.4 The Patient Association's report "The Dental Contract: Full of Holes and Causing Pain?"¹⁹ (March 2008) reveals:
- Widespread confusion for patients about access to dental services in their locality
 - An unacceptably variable service depending on the PCT commissioning the services
 - Patients are at risk of inadequate care because UDAs – units of dental activity – rather than patient need are being funded
 - Detection and prevention of oral health disease is at risk
 - A rise in dental complaints
- 5.5 The Government appointed an independent group led by Professor Jimmy Steele to review NHS Dentistry. This "Review of NHS Dental

¹⁷ British Dental Association website: <http://www.bda.org/>

¹⁸ NHS Dental Statistics, 2007-08 annual report:
<http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/nhs-dental-statistics-2007-08-annual-report>

¹⁹ The Patient Association's report, 'The Dental Contract: Full of Holes and Causing Pain?' (2008) is available on the Internet at:
<http://www.patients-association.org.uk/dbimings/DENTAL%20REPORT.pdf>

Services" was published on 22 June 2009. The key recommendations are set out below.

EXTRACTED FROM 'REVIEW OF NHS DENTAL SERVICES IN ENGLAND'²⁰

- We recommend the continuation of this process but that the access programme uses the opportunity for new procurement to pilot some of the key components of our recommendations.
- PCTs and the NHS should communicate clearly how people might find a dentist through the most appropriate media and what to expect from a dentist when they get there.
- We recommend that NHS primary care dentistry provision should be commissioned and delivered around a staged pathway through care which supports these priorities.
- We recommend that patients registered in a continuing care relationship with a practice have an absolute right to return to that practice for both routine and urgent care.
- We recommend that urgent care services should be accessible and commissioned to a high and consistent level of quality.
- We recommend that strong clinical guidelines are developed to support dentists and patients through specific pathways of treatment.
- We recommend that the free replacement period for restorations should be extended to three years and that the provider should bear the full cost of replacement rather than the PCT or the patient.
- We recommend that dental contracts are developed with much clearer incentives for improving health, improving access and improving quality.
- We recommend that the current contract is developed specifically to allow payments for continuing care responsibility, blended with rewards for both activity and quality. We further recommend that these are piloted and then nationally applied.
- We recommend introducing an annual per person registration payment to dentists within the contract
- We recommend that the quality of a service and the outcomes it achieves are explicitly recognised in the reward system of the revised contract.
- We recommend that a high priority is given to developing a consistent set of quality measures.
- We recommend that PCTs should be required to demonstrate good organisation and structures, including in senior leadership in the PCT and strong clinical engagement, and that strategic health authorities and Department of Health oversee this process.
- We recommend that DH develops a clear set of national data requirements for all providers.
- We recommend that PCs are used in all dental surgeries within three years and are, ultimately, centrally connected to allow clinical data to support shared information on quality and outcomes.
- We recommend that this process continues and we have proposed a basis for a funding formula that can allow that to happen.

6. CHARGING

- 6.1 The Sub-group discussed dental charges at its second meeting. Even under the NHS, most adults are liable for charges and pay approximately 80% of the dentist's fee. As patients can receive NHS treatment and private treatment in one sitting, the system of charging has proved to be lacking in transparency.

²⁰ The "Review of NHS dental services in England" is available on the Internet at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_101137

- 6.2 There are three standard charges for NHS dental treatment (from 1 April 2009):
- Band 1 (£16.50) covering examination, diagnosis (e.g. x-rays), advice on prevention, scale and polish and urgent treatment
 - Band 2 (£45.60) covering everything in Band 1 plus fillings, root canal and extraction
 - Band 3 (£198.00) covering everything in Bands 1 and 2 plus crowns, dentures and bridges.
- 6.3 These are the only dental charges a patient should be asked to pay when having a course of NHS treatment.
- 6.4 Patients in certain categories are eligible for free NHS dental treatment. Those exempt include people under 18 or in full-time education, pregnant or nursing mothers and those receiving certain means-tested benefits.²¹
- 6.5 All patients should complete the HC1 form for their eligibility to NHS services. Some patients (under 18, in full-time education and pregnant or recently had a baby) can obtain services free of charge and people on income support or pension credits are eligible for part payment. More information about entitlements is available on the PCT's website <http://www.kc-pct.nhs.uk>
- 6.6 Locally, patient charge income amounts on average to 16% of a practice's income
- 6.7 The Commission for Patient and Public Involvement in Health (CPPIH) published the results of Dentistry Watch²², the largest dental survey ever carried out in England. Between July and September 2007, 5,212 patients along with 750 dentists were asked for their views on the dental service. The survey found that 20 per cent of patients had refused treatment because the cost was too high and 6 per cent had treated themselves at some point.
- 6.8 The Sub-group is concerned that some low-income patients delay visiting their dentist, at a cost to their long-term dental health.
- 6.9 The Sub-group heard that a new centrally produced leaflet on charges is being sent out to all dental practices.

7. COMMISSIONING TREATMENTS

²¹ NHS Choice: Am I entitled to free dental treatment:
<http://www.nhs.uk/chq/Pages/1786.aspx?CategoryID=74&SubCategoryID=74>

²² More details on the results from "Dental Watch" are available on the Internet at:
<http://www.networks.nhs.uk/news.php?nid=1819>

- 7.1 Kensington and Chelsea PCT has the lowest number of adult and child NHS dental patients per population of anywhere in the country. Having the lowest uptake levels in the country could point to a serious public health issue. Left untreated, poor oral health can lead to serious health consequences such as tooth loss and infection.
- 7.2 When patients do visit the dentist, it is more likely to be for treatment requiring a filling or a crown or bridge. "Patients in Kensington and Chelsea have the 3rd *highest* proportion of Band 3 activity (remedial work such as crowns and bridges) and the third *lowest* proportion of Band 1 (check ups) in the country. Children are more likely to have fillings as a first treatment and the number of child NHS patients seen in the four most northerly wards is approximately 25% lower than the London average"²³ This reflects some association between exempt patients and Band 3 work, reinforcing the link between deprivation and poor oral health.
- 7.3 A third of residents use an NHS dentist. The proportion of people in the borough who are not using an NHS dentist but would like to is slightly higher than average compared to England but the 9th lowest rate in London. A quarter of people say they do not go to the dentist every two years, the same as nationally and less than London average.²⁴
- 7.4 Dental practices in Kensington and Chelsea appear to serve a more deprived patient base than London or England: approximately two thirds of all units of dental activity carried out for adults in Kensington and Chelsea is for exempt adults, compared to a half for London and a third for England.²⁵
- 7.5 Children, exempt adults and non-exempt adults are all more likely to be receiving complex dentistry compared to London and England, suggesting that those who are not on benefits may still be putting off going to the dentist, more so than comparable patients in London and England.²⁶
- 7.6 In the last two years, the number of dental practices providing NHS care in the borough has reduced from 30 to 16.
- 7.7 Kensington and Chelsea's dental contracts are worth about £4 million in total, with practices currently commissioned to provide a

²³ Page 11, Initial Scoping Report: Increasing Access to Dental Services in Kensington & Chelsea

²⁴ Taken from Kensington and Chelsea's JSNA

²⁵ Taken from Kensington and Chelsea's JSNA

²⁶ Taken from Kensington and Chelsea's JSNA

total of 136,413 UDAs as at 31 March 2009.²⁷ Whilst there are contracts with 16 practices, 6 of these provide over 80% of commissioned work.

- 7.8 The Sub-group is pleased that the PCT is to procure additional capacity from current providers where the provider shows that they are fully contract-compliant; are “green” on the PCT’s dental balanced scorecard, and follow NICE recall guidelines and preventive toolkit.

World class commissioner of dental services²⁸

- 7.9 The PCT states that it wishes to be a “World Class Commissioner” of dental services. It shares and discusses good practice and exchanges ideas in commissioning services with other London PCTs.
- 7.10 The Sub-group heard that no patient has been turned away by a dentist in Kensington and Chelsea due to end of year budgetary considerations in 2006-07 or 2007-08. All practices are advised that the PCT will fund work where a practice may have exceeded its number of UDAs.

8. DENTAL PRACTICES

- 8.1 There has been a reduction in the number of dental practices from 34 to 16 since the advent of the new dental contract. The number of practices may have been reduced, but the number of UDAs and spend has increased. The size of surgeries varies. It is estimated that approx 80% of NHS dentistry is provided by approx 8 practices, predominantly in the north and centre of the borough. The details of the 16 dental surgeries providing NHS treatment (name, addresses and telephone number) are listed in Appendix 7.
- 8.2 It is possible that the number of practices may reduce further as those with small contracts or in unsuitable premises struggle to meet the full requirements of the dental contract. The increasing cost of premises in Kensington and Chelsea may put financial pressure on some practices particularly in the south of the Borough. The PCT will not commission new dental services from practices who cannot meet Disability Discrimination Act requirements or the new Decontamination requirements.

²⁷ Taken from the DH “Dental Contracts and Commissioning” web page:
<http://www.info4local.gov.uk/filter/?item=1229161>

²⁸ The DH guide “Primary care and community services: improving dental access, quality and oral health” is to help PCT’s become world class commissioners of dental access, quality and oral health. Available on the Internet at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093831

- 8.3 The introduction of the new dental contract in 2006 has been blamed for a number of practices deciding to close down or cease undertaking NHS work. However, some practices have simply closed down due to retirement of the dentist, or relocation and have not been replaced; however their work has been taken on by other dentists. There are parts of the borough where rental prices for premises can be extremely high but this does not necessarily relate to the wealth of the patients. Practices in Earls Court, Kings Rd and Westbourne Park serve a high proportion of NHS patients, in an area that attracts high rents.
- 8.4 An estates study demonstrated that Earl's Court had high demand, a transient community and limited access to primary care, especially NHS dentistry. The PCT has since secured the use of a building in the Earl's Court area that will be developed into a primary care centre that will offer improved access to GPs, dentistry and other clinical services. The Earl's Court development is a two chair new practice and is planned to be open by the summer of 2010.
- 8.5 The PCT has also started procurement for a 3 chair practice in the south of the borough that should be operational from the spring of 2010.

9. QUALITY OF SERVICE

- 9.1 The PCT captures patient data via NHS Business Service Authority data to maximise its performance on access to dentistry. The Sub-group supports the PCT in its efforts to better performance-managing existing providers and to continue to actively deal with UDA underperformance by transferring unused capacity to providers willing to deliver a high quality NHS dental service.
- 9.2 The PCT is implementing a Dental Quality Outcomes Framework (QOF) in Kensington and Chelsea which it hopes will have a significant positive effect on quality (see box below for more details).

Kensington and Chelsea Dental Quality and Outcomes Framework 2009-10

The introduction of a Dental Quality and Outcome Framework (QOF) in Kensington & Chelsea can incentivise NHS dental practices to improve the quality of the services they offer. Like the GP QOF, the Dental QOF has been designed to incentivise practices to achieve a number of quality targets over the course of the year.

Practices who sign up to the Dental QOF scheme have the opportunity to have their £ per UDA rate increased by £1.00 over the course of the year if they can show that they meet and continue to meet a number of quality targets and standards.

NHS Kensington and Chelsea will use data from NHS Dental Services monthly and quarterly reports and annual contact reviews to judge how the practices are meeting the

QOF quality targets. The following data will be used:

- The Quarterly vital signs report
- The number of New Patients seen in 24 months
- Patient Satisfaction
- Number of Children seen and the number of fluoride varnishes provided
- NICE recall implementation – number of patients recalled for treatment in less than 3 months
- Staff training for non clinical staff – e.g. NVQ training
- Use of the NHS logo in the practice
- Assessment of compliance and implementation of ‘child-friendly’ criteria
- Successful enrolment and completion of the BDA Best Practice Scheme
- ‘Mystery shopper’ evidence

The Dental QOF will be reviewed at the end of 2009-10. Whilst there is funding in place to continue the scheme in 2010-11 this will depend on how many practices opt into the scheme and how effective it is in raising quality standards.

9.3 Patient safety must be of paramount importance. There is a network of quality standards and contractual requirements around clinical governance that practices must meet and NHS Kensington and Chelsea can enforce. NHS services benefit from a higher level of quality assurance, clinical governance and screening than private practice, with greater patient recourse for enforcement and complaint procedures.

9.4 The Sub-group was told that practices are inspected at least annually and there are standards for training and continuing professional development for NHS dentists. The Sub-group suggested that there should be adequate training for practices in dealing with the public and for dental teams on costs, procedures and entitlements.

Working conditions

9.5 The House of Commons Health Select Committee²⁹ has said that dental working conditions have deteriorated in the last two years.

9.6 In Kensington and Chelsea the quality of premises varies widely from practice to practice. Some are of an extremely high quality, with modern, newly fitted interiors, light and spacious waiting areas with well-designed receptions. Individual dental rooms are spotlessly clean and of high specification. Staffs are welcoming and waiting areas have pictures and dental and oral health information and products displayed, free drinking water and plenty to occupy the mind whilst waiting.

9.7 “Other practices are in a poor state of repair, with cramped and unwelcoming waiting areas and indifferent reception staff. Premises

²⁹ The Commons Health Select Committee report “Dental Services - Fifth Report of Session 2007–08” is available on the Internet at:
<http://www.publications.parliament.uk/pa/cm/cmhealth.htm>

are not as clean as would be expected for a clinical setting; waiting areas are uncomfortable and tatty, with no facilities to ensure a comfortable wait. Dental and oral health information is displayed but is often a pin-up version of NHS information, dated and peeling at the edges, as opposed to more bespoke promotional material designed to raise awareness of good oral health. Lighting is usually harsh and florescent.”³⁰

- 9.8 Overall, few practices have any facilities for children such as books, toys or entertainment.
- 9.9 The Sub-group heard that NHS Kensington and Chelsea was leading in some areas of infection control (e.g. dedicated infection control nurses, investing heavily in practices, lots of training offered and taken up).

Satisfaction

- 9.10 There is a “Satisfaction Survey” as part of the Vital Signs’ reporting on dentistry. At March 2009, 83% of patients were satisfied with the dentistry they received (This compares slightly unfavourably against the London-wide SHA figure of 86.4%).
- 9.11 The Royal Borough’s Resident Panel survey³¹ found a high rate of satisfaction with the overall quality of dentistry services in the borough (86%) – no change since last year. However, satisfaction rates were lower for disabled people and for those over 50 and for those living in the south of the borough.

Complaints

- 9.12 Complaints are monitored so any issues arising can be taken up with the particular practice. There is a PALS service which reports on complaints. The trend in complaints to PALS is away from patients being unable to see an NHS dentist to being more about patient charges and the offering of private treatment instead of NHS treatment.
- 9.13 The Sub-group noted that the PALS service reported three of the top 10 issues that it was contacted about were dental-related (how to find a dentist, dental fees, and dental treatment concerns)

³⁰ Page 54: “Initial scoping report: Increasing access to dental services in Kensington and Chelsea”

³¹ Full Residents’ Panel report is available at the completed consultations of the Council’s website, which would involve users to type in ‘Annual Health Care Check’ to access the PDF report:

https://www.consultation.rbkc.gov.uk/kms/dmart.aspx?strTab=PublicDMart&noip=1&filter_Status=2

between 1 April 2008 - 31 March 2009.³² This indicates an ongoing³³ gap in general public knowledge about dentistry in Kensington and Chelsea.

- 9.14 Patients have reported confusion around fees and costs. Dentists are obliged to outline both NHS *and* private treatment charges to each patient they see, leaving it to patients to decide which option they take. Common complaints are patients believing they have two options, the NHS option being the sub-standard one. Cosmetic versions of NHS treatments can be a common cause of resentment e.g. white fillings are not available on the NHS, even if they are in highly visible places in the mouth.

Mystery shopping

- 9.15 A 'mystery shopping' programme was carried out in 2008, which aimed to identify which practices were taking on new NHS patients and which were declining/postponing them. The programme highlighted that much of the low activity rate relates to lack of demand as well as people being turned away by practices; five of the 15 practices taking part stated that they were not taking on new NHS patients, when this was not the case. The PCT contractually reminded the practices to give a reason for stating why they were not taking on new NHS patients, to provide an alternative, or refer to PALS.

Dental Practice Insight

- 9.16 A number of practices participated in a Dental Practice Insight project; all had capacity to increase the number of patients seen, but struggled to find extra patients. The key issues for the practices were found to include:

- Insufficient NHS patients to fulfil their potential capacity
- High rates of Did Not Attends
- Delays, excessive paperwork, poor communication in the specialist referral process
- Lack of time, expertise and resources to commit to commercial marketing
- High staff turnover and variable quality
- Insufficient capital investment

³² The report "Complaints, Claims and Patient Advice and Liaison Service Annual report 1 April 2008 – 31 March 2009 is available on the Internet at: http://www.kc-pct.nhs.uk/corporate/meetings/documents/3_2ComplaintsClaimsIncidentsPALSReport01April2008-31March2009.pdf

³³ Page 10 "Integrated Governance Committee Report" (Agenda item 6.1. PCT Board 27 Jan 09). This quarter earlier report previously highlighted the same problems of how to find a dentist, dental fees, dental treatment concerns in the top 10 PALS concerns.

Involvement in planning own care

- 9.17 All patients should be given a Personal Dental Treatment Plan, outlining their course of treatment and costs before receiving either Band 2 or Band 3 treatment.
- 9.18 Following NICE guidelines, regular six-monthly recalls are no longer recommended for all patients. Instead, patients should be asked to come back according to individual need.
- 9.19 69% of respondents to the Royal Borough's Residents Panel survey³⁴ this year said they had a say in planning their care at their Dentist - no change from a similar survey carried out last year. A much higher proportion of disabled people and those over 50 said they had an involvement compared to those from the BME communities and those living in the south of the borough. This suggests there is scope for improvement.

Treating patients with dignity and respect

- 9.20 91% of respondents to the Royal Borough's Residents Panel survey³⁵ this year said they were treated with dignity and respect at their Dentist – no change from a similar survey carried out last year. A higher proportion of respondents living in the north of the borough and those who were disabled said they were treated with dignity and respect compared to people living in the south and those from BME communities.

10. ACCESS

- 10.1 All residents should have the right to see a NHS dentist. The Sub-group heard that patients do not have to be registered for a certain time period nor access a dentist within their local area.
- 10.2 A high proportion of respondents to the Royal Borough's Resident Panel survey³⁶ this year said it was easy to register with a Dentist (87%), make appointments (85%) and physically access the dentist premises (91%). There has been a significant increase (9%) since

³⁴ Full Residents' Panel report is available at the completed consultations of the Council's website. Users need to type in 'Annual Health Care Check' to access the PDF'd report: https://www.consultation.rbkc.gov.uk/kms/dmart.aspx?strTab=PublicDMart&noip=1&filter_Status=2

³⁵ Full Residents' Panel report is available at the completed consultations of the Council's website. Users need to type in 'Annual Health Care Check' to access the PDF'd report: https://www.consultation.rbkc.gov.uk/kms/dmart.aspx?strTab=PublicDMart&noip=1&filter_Status=2

³⁶ Full Residents' Panel report is available at the completed consultations of the Council's website. Users need to type in 'Annual Health Care Check' to access the PDF'd report: https://www.consultation.rbkc.gov.uk/kms/dmart.aspx?strTab=PublicDMart&noip=1&filter_Status=2

last year in the proportion of people saying it was easy to access dental surgeries. A higher proportion of disabled respondents and those over 50 found it easy to make appointments compared to non-disabled residents and those under 50; and a higher proportion of BME respondents and those from the south of the borough found it easy to register compared to White residents and those in the centre of the borough.

- 10.3 However, there has been a decline in dental patients accessing dental surgeries from March 2006 to March 2009. The March 2006 position (43,642 patients accessing NHS Dentistry) is the baseline NHS London use in their performance monitoring, as the period used to evaluate is a 24 month period. It is estimated that 24 months is how long patients wait before accessing a dentist for a new appointment. The Sub-group heard about performance figures for the end of March 2009. In the preceding quarter 37,737 people had seen an NHS Dentist in the last 24 months. The numbers of people seeing an NHS dentist in Kensington and Chelsea has been persistently low for a number of years. About 23% of our population see a dentist each year compared with a national average of around 50%.
- 10.4 Some of the practices have full disabled, wheelchair and pushchair access, while others do not. Of the 16 NHS practices in the borough, 10 are listed as being fully accessible. Of those that are, some have impractically small waiting rooms, so whilst accessing them is possible, waiting in them is not. This is especially true for parents with children in pushchairs. It is possible to spread appointments for wheelchair users, in order to ensure waiting rooms do not become overcrowded, but not possible for pushchairs, as there is a much higher incidence of patients with children in pushchairs.
- 10.5 One practice does not have good access but has a policy of referring disabled patients to another NHS practice further down the road. However, one practice has free parking, excellent disability access and a modern, welcoming surgery, yet few disabled patients.
- 10.6 If patients need treatment but cannot find an NHS dentist in their area, they should be able to ring their local PCT to join a waiting list. In some areas it has taken only a few days for a place to be found for a new patient, but long waits have been reported elsewhere.
- 10.7 If practices say they are not taking NHS patients, they should either give a timescale for when they will do so or refer patients to PALS.

10.8 In an emergency, PCTs can direct patients to emergency dental clinics which should be able to see people straight away.

11. COMMUNICATION

Internet

11.1 NHS dentists can be contacted using the internet through the NHS Choices link: <http://www.nhs.uk/Pages/HomePage.aspx>

General contact numbers

11.2 Individual practices can be called. An alternative contact is Kensington and Chelsea PALS on: 020 8962 4547 or NHS Direct on 0845 4647.

11.3 For emergency dental care, the contact is North West London Dental Emergency Call Centre on 0208 867 1411

11.4 Clear information should be available on entitlements, system (for referrals) and charges.

Dental access helpline

11.5 Every primary care trust in England runs a dental access helpline to help match up patients looking for NHS care with a dentist in their area. In August and September 2008, the Citizens Advice Bureau (CAB) undertook a mystery shopping exercise of 55 dental helplines across England, to see how effective these helplines are in providing patients with the information and advice they need to find a dentist. The survey³⁷ found that:

- The majority of mystery shoppers (72 percent) reported that their calls were either useful and/or provided them with the information they needed.
- However, callers were less satisfied in areas of shortage - not just because it was not possible to get an appointment with a dentist, but also because of the service they received from the helpline, where they were less likely to be able to speak to an adviser.
- Dental helplines need to keep informed of new commissioning to give callers an idea of the length of possible waiting lists, and keep information up to date, as existing practices open and close their lists.

³⁷ The full findings of the survey, and CAB's conclusions can be viewed in the following report: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_094994

- It is also important in the CAB's view to give the caller, wherever possible, the choice of dentist rather than just offering a single contact number.
- The CAB said in a report: "The helpline may provide an excellent service, but if the people who most need that service don't know of its existence, then it is failing at the first hurdle ... It will not be adequate to rely on people firstly having access to the internet and secondly being able to find the appropriate website in order to locate the telephone number - a process which may well exclude many of the people most in need of dentistry."

The practices themselves

11.6 There is some activity from dental practices themselves in adopting marketing and promotional techniques for NHS patients. The main source of new NHS patients is cited as word of mouth when practices were interviewed. Estimates are that as many as 80% of new patients are attracted in this way. Some practices simply do not feel they have the time or resources to market themselves. All practices are listed on the NHS Choices website, and have a listing for NHS Direct calls. Additional marketing includes;

- Yellow pages (one practice pays £3,500 pa and gets approx 5 calls per month)
- Website (most practices have their own website)
- Leaflets distributed locally
- Advertising (local press, supermarkets, GP surgeries etc)

11.7 One practice has been particularly pro-active. Their direct mail campaign targeted 50,000 local households over 4 – 6 weeks at the end of 2008. This practice also ran a TV advert in Chelsea and Westminster Hospital waiting area, with details of the practice in 'take me' dispensers. Key rings, pens and flyers were given to existing patients and handed out on the street. Another practice has subscribed to a dental marketing agency; a growing number of agencies now provide marketing, training and business development services for dental practices. Beyond this, there is an expectation that it is the PCT's responsibility to promote NHS dentistry in the borough and increase the number of new patients attending practices.

General promotion

11.8 From the Residents' Panel, 93% of respondents said the information they were given by their Dentist was easy to understand – no change from a similar survey carried out last year.

11.9 In terms of general promotion, a NHS Kensington and Chelsea leaflet listing NHS Dental practices in the borough is produced.

Around 3,000 are printed and have been distributed to GPs surgeries, pharmacies and went to all voluntary organisations and housing associations in the borough. The Sub-group was circulated with copies of the PCT's newsletter "Broadcast" (Issue 15, March 2009). The front page photograph and an article "Toothy grins at local schools" were dedicated to promoting local dentistry. The Sub-group was pleased to receive a copy of the PCT's leaflet promoting NHS dentistry sent out to all Kensington and Chelsea residents, voluntary sector, libraries etc.

11.10 NHS Kensington and Chelsea has a clearly visible banner on its home page for people wishing to locate an NHS dentist in the borough. The banner clicks through to the NHS Choices website which displays a list of all NHS dental practices in Kensington and Chelsea.

11.11 Beyond these generic routes, promotion usually takes the form of an event, activity or themed promotion run in conjunction with the oral health promoter, as with communities requesting dialogue and/or information. For example; Smile Month, No Smoking Day, Mouth Cancer Awareness Week.

11.12 Those referred to smoking cessation and obesity programmes are particularly likely to be at risk of poor oral health associated with smoking (mouth and throat cancer, oral hygiene) and diet. There is no automatic referral to NHS dentistry for these groups.

11.13 The Sub-group supports the PCT in its endeavours to ensure patients are fully aware of dental service and charges such as:

- Providing better "branding" of dentistry in Kensington and Chelsea (i.e. on stationery, signage, appointment cards, patient information leaflets and posters).
- More publicity of dentists needed through health centres and NHS Direct.
- Improving visibility of service with signage and better information on NHS charges/pricing for treatment displayed and up-to-date (e.g. poster and on the website) and where to go if unhappy.
- Providing information on the performance of practices to help patients make a more informed choice.
- Exploring the idea of giving out information on registering with a dentist when a person registers with a doctor.

11.14 The PCT involved Sixty Plus to consult on its proposals for developing the Community Dental Service at Violet Melchett.

11.15 The Health Scrutiny Committee (then known as the OSC on Health) recommended in its "Review of Health Inequalities in Kensington

and Chelsea" in 2008 included that the PCT should: Ensure that information on dentistry services is more widespread and provided from a variety of venues; Ensure that more health professionals are involved in promoting dental health messages across the borough; and, Ensure that these messages are consistent across all agencies.

12. EMERGENCY AND HOSPITAL (EDS) SERVICES - SPECIALIST TREATMENTS

12.1 There are a number of specialist services that include the Community Dental Services, Emergency Service, Out of hours service and specialist inpatient services.

12.2 Nationally, dentists are carrying out less complex work since the introduction of the new contract. Figures from the Information Centre for health and social care³⁸ show dentists are doing fewer fillings, radiographs and crowns. The House of Commons Health Select Committee³⁹ has said the number of complex treatments, such as the fitting of crowns, bridges and dentures, fell by 50% over the first year of the contract. Dentists were now less likely to carry out root canal treatment and more likely to extract teeth.

12.3 NHS figures⁴⁰ show that dentists working under a new contract are more likely to pull teeth out or fit false ones than before. The House of Commons Health Select Committee also report increased incidence in teeth pulling (rather than treatment) nationally. There is no known evidence of this being an increased problem in Kensington and Chelsea.

12.4 In Kensington and Chelsea, the high proportion of complex dentistry carried out among both adults and children suggests that the residents who use the service may be putting off going to the dentist for a check-up more so than people using NHS dentistry in other boroughs.

12.5 Orthodontic work is not carried out within the borough but commissioned from a neighbouring borough. This is accessed via referral. Louise Pinckney (Social Marketing Consultant) referred to the trend among young people in the more affluent parts of the Royal Borough (particularly girls in the 14-17 age group) to wear a brace. This was primarily for cosmetic, rather than clinical, reasons

³⁸ Dentists doing less complex work, figures show:

<http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/dental-treatment-band-analysis-england-2007:-preliminary-results>

³⁹ The Commons Health Select Committee report "Dental Services - Fifth Report of Session 2007-08" is available on the Internet at:

<http://www.publications.parliament.uk/pa/cm/cmhealth.htm>

⁴⁰ NHS figures on the increased pulling teeth was reported by the BBC (21 August 2008): <http://news.bbc.co.uk/1/hi/health/7574049.stm>

and the dental work was likely to be carried out by a private practice. If a young person approached an NHS dentist, they could be offered advice and referred to a practice outside Kensington and Chelsea which practised orthodontics. Edward Ward (PCT's Head of Primary Care Commissioning) recognised the possibility that additional orthodontic care might need to be commissioned in the future to meet demand.

Referral to specialist services

- 12.6 Referral to specialist services is a significant and highly charged issue for the practices. Some practices report approx 100 people per month have referred to specialist treatment on the NHS.
- 12.7 Practices are not authorised to carry out treatments that require anaesthesia and tranquillisation (e.g. 'u-bend' root canal treatment, multiple crowns). Patients referred must travel to a practice at Parsons Green for dental work. Given that the work will usually be complex and require tranquillisation or anaesthesia, the distance to, and nature of, the treatment may be a barrier to attendance.
- 12.8 There is a strong feeling among practices that the process of referring a patient is flawed. They find it excessively cumbersome; completing the necessary paperwork is time-consuming and complex. Initial referral rejections from Specialist services are often on the grounds that the paperwork is erroneous. This is disputed by the practice. They also feel that the default position of Specialist services is rejection in favour of extraction; a procedure that all practices carry out. However, due to the rejection and resubmission process, a customer journey from referral to treatment can take 6 – 9 months in some cases. The result is patients 'give up' and 'DNA' (do not attend) when they eventually get an appointment, or opt for extraction, or opt to go private. Some hold the practice accountable for the delays, and discontinue self-referral.

13. SOCIAL MARKETING - DELIVERING BETTER ORAL HEALTH

- 13.1 The PCT is to commission a social marketing campaign to increase year-on-year increases in the number of people in Kensington and Chelsea being seen by an NHS Dentist. Social marketing is the combined application of commercial marketing plus other concepts and techniques to define behavioural challenges and design behaviour change programmes based on insight. Interventions are tailored to the individual and designed to offer effective competition or solutions to the barriers people face in changing their behaviour.
- 13.2 The Sub-group was given a presentation from Louise Pinkney (Social Marketing Consultant). Four of her slides are reproduced in the box below:

THE SOCIAL MARKETING PROGRAMME⁴¹

1. Toolkit for NHS KC Dentists

- Complements Preventative toolkit
- Provides marketing and promotional material
 - Recall cards, letter templates, posters etc
 - Staff training, on-line forums, website templates
 - Improved communication on charges, options, signposting from and to brief interventions (smoking, weight management etc).
- Improve data capture and management
 - Better info sharing from KC (Vital Signs etc)
 - On-line booking, new patient recruitment
- Criteria and guidance for improved services
 - Child friendly, female only, language specific, extended hours, phobia specialists

2. New patient recruitment

- Campaign to 'Register with a dentist'
 - Advertising and PR campaign encouraging residents to 'register' their detail via a website or freepost cards
 - Freepost cards widely distributed; GP surgeries, libraries, leisure services, schools, pharmacies, retailers etc
 - Respondents offered dental appointment
- Data processes, segmented and passed to dentists
- Dentists use Toolkit to follow up

3. Reputation and brand building

- 'Kite-mark' criteria for KC NHS Dentistry brand
 - Implementation of Toolkit and Prevention Toolkit, QOF framework
- Does practice meet the need?
 - Extended hours, female only, child friendly, phobic treatment, interpretation and translation services
- 'Practice of the year' award
- Rotating column with GP in press
 - Softer angles, responsive to national issues
- Mystery shopping / Health Shoppers guide

4. Child Oral health programme – based on 'Childsmile' model

- Targeted interventions
 - Pre natal visit, post natal appointments
 - Oral health/health promotion teams
 - Supervised daily brushing
 - Fluoride varnishes
 - Implementation of Preventative toolkit
- KC 'child friendly' dental service developed and branded
- In school promotion linking an 'experience' with good oral health – free brushes, paste, 'The Brushing Song'. Materials
- Integration and linking to Healthy schools, diet, PSHE

13.3 The Sub-Group's attention was drawn to the various barriers to achieving good dental health (particularly relevant to those

⁴¹ This table reproduces Louise Pinkney's slides (marked 1-4) from her presentation to the Sub-group on 10/3/09.

residents living in the most deprived wards). These factors included: a low perception of dental need; poor understanding of the need to address oral health in a child's early years; fear and phobia; and being unable to find a local dentist. Louise also talked about the 'behaviour transfer' whereby poor dental habits (e.g. not regularly brushing teeth, poor/no attendance at dentist) were passed from one generation to the next.

- 13.4 The Sub-Group noted that a toolkit providing a range of specific tools was proposed for NHS dentists in the Royal Borough, which should allow them to adopt a more targeted approach. The design group for the toolkit had involved dentists, and dental practices were generally enthusiastic about its introduction. The Sub-group was very pleased that the PCT is committed to implementing a preventative toolkit in Kensington and Chelsea.
- 13.5 There will need to be a review of the social marketing campaign thereafter so that successful work can be carried out on an ongoing basis. Louise Pinkney suggested a two–three year programme was needed to reverse a trend of poor dental health which has developed over decades. The Sub-group supports the taking forward of the Social Marketing Initiative to increase the uptake of NHS dental services.
- 13.6 The Sub-group was told that £220,000 spent on the 'registration' and Toolkit work in 2009, with £40,000 - £60,000 allocated in 2010 to refresh the Toolkit and Registration process. The child smile campaign spends for 2009 is £124,978; with £129,956 spend for 2010-11. The combined sum of £514,934 represents the total social marketing spends for 2009 – 2011. This excludes the 2008 commission of the consultants "Lamerton Swales" from the National Social Marketing Centre.

14. CHILDREN

- 14.1 The Sub-Group recognises the great importance of getting the right messages to parents and into schools, Children's Centres etc. It joined members of the Health Scrutiny Committee's Sub-Group on Childhood Obesity at a meeting on 30 April to look at issues for the 5-16 year-old age group. This was the first time that two Health Scrutiny Committee Sub-groups have "joined forces" on any issue and was a useful experiment in the development of scrutiny arrangements.
- 14.2 Tooth decay is the third most common reason children end up in hospital: more than 36,000 children are admitted to hospital with

tooth decay each year and the figure is rising.⁴² Five-year olds at primary schools in Kensington and Chelsea have more decayed or missing teeth than average for England. The Sub-group was also told that children are more likely to have fillings as a first treatment, and the number of child NHS patients seen in the four most northerly wards is approx 25% lower than the London average. This will be tackled through the PCT's work plan "Delivering Better Oral Health".

14.3 The Sub-group heard how Under 18's are more likely to visit a dentist if they live in a deprived area.

Under 18's are more likely to visit a dentist if they lived in a deprived area⁴³

Findings from the British Association for the Study of Community Dentistry (BASCD) survey consistently highlight that Kensington and Chelsea state school children's teeth are much poorer than the London and England averages with, on average, 2.2 decayed, missing or filled teeth (compared to 1.7 in London and 1.5 in England). Looking at local statistics on dental uptake for children and the map produced from multiple index of deprivation, it shows that children resident in the wards that are deemed to be deprived were more likely to visit an NHS dentist. The North boroughs (Golborne, St Charles, Notting Barns, Colville, Norland, Pembridge) had 26% of resident children visit a dentist, Central boroughs (Holland, Campden, Abingdon, Queens Gate) had 6% and South boroughs (Earls Court, Courtfield, Brompton, Redcliffe, Stanley, Hans Town, Cremorne, Royal Hospital) had 15%. When the two most deprived wards from the south are removed (Earls Court and Cremorne) the percentage of children visiting a dentist dropped to 11%. This may be explained by the fact that the wards in the middle and south of the borough are more affluent and therefore residents are more likely to access private dentistry. There are 33 state schools and 43 private schools in the borough. A recent Health Care Commission survey estimated 40% of Kensington and Chelsea residents used private dentistry and these are more likely to live in the central and southern wards of the borough. However, it is estimated that the number of child patients seen in the four most northerly wards still remains lower than in London: roughly 25% lower than the London average. NHS Kensington and Chelsea has a list of schools that are at risk of poor oral health and this is often used in targeted approaches.

Attendance rates in under 18's generally in the borough show the least uptake in 0-2 year olds, and greatest uptake in 6-11 year olds. However, uptake in the 0-5 year old groups drops significantly in the northern wards, with just 17% visiting in St Charles and Colville, both deprived areas.

14.4 The Sub-group was shown a breakdown of Kensington and Chelsea residents under 17 attending an NHS dentist by geographical area. The most deprived 6 most wards had 29% of children attending an NHS dentist (however the spread was between 35% in Notting Barns to 19% in Earls Court). The spread in the least deprived wards was from 17% in Stanley to 3% in Campden. The use of private sector dentists cannot account for this wide variation.

⁴² Evening Standard article: "Tories attack rising tooth decay" is available at: <http://www.thisislondon.co.uk/standard/article-23647918-details/Tories+attack+rising+tooth+decay/article.do>

⁴³ Taken from page 33 of the PCT's "Initial scoping report: Increasing access to dental services in Kensington and Chelsea"

14.5 Following on from a question on the need to target children in areas of deprivation, Louise Pinckney commented that children in these areas tended to be the least migratory in the borough and therefore it should be possible to target them effectively, particularly through local schools and Children's Centres.

14.6 The Health Scrutiny Committee (then known as the OSC on Health) recommended in its "Review of Health Inequalities in Kensington and Chelsea" in 2008 included that the PCT should: Encourage all health professionals to promote annual dental health checks for 2-3 year olds so that dental problems are picked up at the earliest opportunity; and, Work with the Council to make dental advice available at the children's centres.

Early Years Service

14.7 The Early Years Service works in a number of ways to improving oral health in younger children. The oral health messages are given at any possible chance opportunistically with contact with parent. Oral health messages are formally passed to parents via:

- **Brushing for Life (BFL)** – Brushing for Life packs are given out at all baby 6 – 9 months during developmental checks by Health Visitors, with advice to encourage parents to start brushing baby's teeth as soon as the first one appears. The aim is to encourage the formation of an early tooth brushing habit. A list of local NHS dentist lists is also provided to parents.
- **Weaning Parties** - These are Health Visitor-led get togethers, with Oral Health Promoter delivering the dental section. BFL packs, lists of dentists and appropriate leaflets are distributed.
- **Oral Health Promotion Sessions** - These fun informal sessions are jointly led by the Bilingual Link Worker and Oral Health Promoter targeting parents with their children. BFL packs, lists of dentists, leaflets, handouts and colouring sheets given.
- **Parent Sessions** - These are jointly run by Bilingual Link Worker and Oral Health Promoter at an information table with a display. This can be part of a coffee morning or at the centre entrance at the end of the day as parents collect their children. One to one interventions take place with parents. BFL packs are given with list of dentists and leaflets. All Children's Centres are visited, bimonthly.

Bottle to Cup Campaign

14.8 The Sub-group noted the deleterious effect on young children's teeth from prolonged suckling on bottles filled with sugary liquids.

14.9 The Public Health Nutrition Team is currently working with Oral Health Promotion to re-launch the Bottle to Cup Campaign through the children's centres and health centres. The aim is to work towards reducing inappropriate and extended use of bottles across the borough which includes, increasing the awareness of the related health problems including reducing the rates of dental decay.

Screening

14.10 Screening can be shown to be effective in reducing levels of untreated dental disease in areas where oral health is poor. And if the follow-up process for positive children was more rigorous, there would be benefits in terms of oral health. The PCT is not currently commissioning the Community Dental Service to carry out annual school dental screening. However, the PCT takes part in the BASCD surveys in state primaries and letters will be going out to parents / guardians of children who are attending local children centres and schools to highlight the need to take their child for a dental check-up.

Schools

14.11 The School Nurse teams and Healthy School co-ordinators work on general health promotion of which oral health is a part. They are supplied with lists of NHS dental practices by the oral health promoter for distribution. They advise on brushing, oral health and identify children who may have oral health problems. Where this occurs, the common practice is for a letter to be sent to parents with guidance on accessing NHS dentistry. Currently, it is believed there is no tracking procedure in place. Follow-up for non-compliance is to reissue parents' letters.

14.12 All new intake children receive a questionnaire, of which one of the questions asks when they last saw a dentist. At the time of writing this report, the figures for this were unavailable.

14.13 The Sub-group was told about oral health promotion in schools at its third meeting. Activities in schools have included:

- Support for teachers and school nurses delivering classroom sessions.
- Training for teachers/support staff.
- Familiarisation trips for Key Stage 1&2, involves trips with parent /carer to their nearest dental practice.
- Linking local NHS dental practices to local schools, and children and family centres to increase the local populations' awareness of dental services and to work towards encouraging more families to attend dentists. The practices are offering

familiarisation sessions for children with their carers and parents.

- Work on nutrition, diet and food to minimise tooth decay.
- Water in Schools Project to promote drinking just water during school time.
- School visits (e.g. Brushing for Life).
- Oral health information stalls, as part of healthy schools events.
- Distribution of the local available NHS Dental practices leaflet.
- Monthly or themed promotions [e.g. Smile Month (17 May – 16 June 2009)].

14.14 The PCT is currently addressing the issue of improving access, and increasing the level of children and families who attend the local NHS dental practices. The Oral Health Promoter has been linking local primary schools with their nearest dental practice with the aim of working towards increasing the number of children and families attending the dentist. This work is being planned to be extended to children centres.

14.15 When practices have attempted to engage with schools they have reported difficulties in obtaining the interest and/or commitment of some teachers. One practice ran a Children's Afternoon, but had very poor response rates. Cllr Coleridge said that it would be very helpful if schools could be better encouraged to make sure that school children were registered with a dentist. Edward Ward suggested that there could be merit in linking more schools with particular dental practices. Agreement was reached on the need to ensure the additional oral health visitors were targeted and welcomed into the schools.

The Healthy Schools programme

14.16 The Healthy Schools programme, as part of the Family and Children's Services business group, supports any recommendations to improve the health of young people in schools and is the main vehicle for health promotion within schools. The Healthy Schools programme is actively working in partnership with the PCT and schools to address child oral health.

14.17 It is important to note that oral health is not explicitly mentioned within the 41 criteria set out in the National Healthy Schools standard. Schools do not necessarily have to address oral health to meet the standard. However, our local programme has recognised the high levels of tooth decay within the school population in Kensington and Chelsea and has set this as a priority for our local programme, in spite of its absence in the national programme and subsequent guidance.

- 14.18 The Healthy Eating section of the National Programme outlines the importance of reducing the consumption of foods high in sugar for example, fizzy drinks, crisps and snacks within school. The requirement for schools to meet these standards can be directly linked to promoting and working towards maintaining good oral health for school aged children in line with the Governments Education Nutritional Standards and Requirements for School Food England Regulations (2007).
- 14.19 All of the borough's schools are currently engaged in the Healthy Schools programme and as a result are committed to all of the 41 criteria for reducing health inequality within the school population. 76% of schools have achieved Healthy Schools Status. A number of schools having implemented a Whole School Food Policy which outlines a total ban on confectionary snacks and fizzy drinks onsite.
- 14.20 The local Healthy Schools Programme Coordinator (FCS) works closely with the PCT Oral Health Promoter, PCT Childhood Obesity Dietician and PCT Schools Nurse service to support schools to deliver the Personal, social and health education (PSHE) curriculum. To support this delivery, in 2008-09 Healthy Schools provided funding to the Oral Health Promoter for resources to assist with the delivery of oral health promotion within PSHE Education in primary schools.
- 14.21 The Healthy Schools programme runs a number of training days for PSHE, Healthy Schools teachers and other professionals i.e. play workers and youth workers throughout the year. Targeted In-Service Education and Training (INSET) focusing on oral health, healthy eating and food hygiene is run as part of the PSHE programme on an annual basis.
- 14.22 In 2008-09 the Healthy Schools programme funded the well received oral health play 'Little Trolls' touring theatre company for schools. This was a production for Key Stage 1 and 2 on dental hygiene and was promoted to schools via the School Improvement Team and directly to Healthy School and PSHE Leads, with a follow up resource pack provided. Whilst successful, this initiative was decommissioned earlier this year as funding for this project (via the Local Area Agreement reward grant) ceased.

Progress

- 14.23 The Sub-group was pleased to hear that oral health was considered as a priority, both in the Children and Young People's plan and the local Healthy Schools Service Improvement Plan. Notably, the latter carries an aim to increase the percentage of children from the local population being registered in local NHS dentists.

14.24 The Sub-group was pleased to hear about the progress the PCT had made in a number of areas:

- Procuring a new children and family dental service at the Colville Health Centre. This would provide an additional 4,000 treatment places at an estimated cost of £450,000 for children and families in the north of the PCT and should make a significant contribution to improving children's oral health.
- The implementation of the Oral Health Prevention toolkit to improve oral health and attendance by Children at NHS Dental practices by creating "Child Friendly" practices - This will increase uptake of dental services for children.
- Targeting health visitors as a means of promoting oral health.

15. PEOPLE WITH SPECIAL NEEDS

15.1 The Health Scrutiny Committee (then known as the OSC on Health) recommended in the "Review of Health Inequalities in Kensington and Chelsea" in 2008 included that the PCT should: Ensure that there is a clear mainstream care pathway to access dental services; Improve information of the provision of dental services for mental health service users, where they are located and what charging policies apply; and, Ensure systems are in place for flagging up patients with learning disabilities and their associated needs.

15.2 The Sub-group was pleased to learn that the PCT has focused effort to commission services for adults with complex needs. For example, section 3 and 4 of the oral and dental health strategy has the priorities for 2008-11 as follows:

- To ensure that all children with special needs have access to NHS dental services and that their dental treatment is actively case managed by the PCT's Community Dental Service (CDS) by April 2009.
- Maintain and improve the capacity of the CDS at Violet Melchett and St Charles to provide dental services for adults with disabilities, learning difficulties, and special needs during 2008-09.
- To ensure that all adults with disabilities, learning difficulties, and special needs have access to NHS dental services and that their dental treatment is actively case managed by the PCT's CDS by April 2009.
- Maintain and improve the capacity of the CDS services at Violet Melchett and St Charles Hospital to provide dental services for adults with disabilities, learning difficulties, and special needs during 2008-09.

15.3 There is work to be done. For example, addressing issues for accessing dental treatments such as general anaesthetics.

16. CATERING FOR SPECIFIC GROUPS

- 16.1 Practices state that their patient base is broadly reflective of the local population; people generally choose the practice nearest to where they live. So some practices have a high percentage of one or two ethnic groups, depending on location. However, there are also huge levels of diversity, the Ladbroke Grove practice reports a diverse range of patients from Moroccan, Somali, Polish and Turkish groups.
- 16.2 What is not apparent is any catering for specific groups or needs. Not one practice has been offering bespoke services such as child-friendly or women-only dentistry. In a borough with such a diverse population, this must be restricting access.

BME dental health

- 16.3 The Health Scrutiny Committee (then known as the OSC on Health) recommended in its "Review of Health Inequalities in Kensington and Chelsea" in 2008 included that the PCT should: Consider cost effective ways of collecting information on the dental health needs of black and ethnic minority (BME) communities so that targeted dental health interventions can be made.
- 16.4 Members of the Kensington and Chelsea & Westminster (KCW) BME Health Forum⁴⁴ discussed NHS dentistry, access and the main issues for BME communities in March 2008 (Reported in Embrace Volume 8, Issue 2 – June 08).
- 16.5 The PCT commissioned the BME Health Forum to research into the barriers BME groups experienced in accessing NHS dentistry. This work funded local community representatives to work with a number of dentists (& GPs) on how to improve the experience of BME patients in primary care. The community leaders are also actively promoting and outreaching to key groups the services that are available.
- 16.6 KCW BME Health Forum launched their report 'Commissioning World Class Dentistry in Kensington & Chelsea and Westminster - A race equality impact assessment of how the current approach to the provision of dental services is affecting BME communities'⁴⁵ on 8 July 2009.

⁴⁴ Kensington and Chelsea & Westminster Black and Minority Ethnic Health Forum website: <http://www.westminster-pct.nhs.uk/diversity/bmehealthforum.htm>

⁴⁵ KCW BME Health Forum dentistry report is available on the Internet at: <http://www.westminster-pct.nhs.uk/pdfs/2009/July%202009/Commissioning%20World%20Class%20Dentistry%20in%20KCW.pdf>

KCW BME FORUM DENTISTRY REPORT (JULY 2009) RECOMMENDATIONS

Interpreting - Dentists and practice managers should be shown how to book interpreters. Such information should be communicated in person since the local NHS have already sent this information to the practices but the practices are still unable to use it. Practices should be told to ask patients whether they need an interpreter and the local NHS should make it clear that interpreters should be provided in order to meet the legal requirement to provide equitable access. This may help reduce oral health inequalities and support the local NHS in achieving the requirements of World Class Commissioning.

Ethnic monitoring – (1) The local NHS should provide training to dental practices to record ethnic monitoring statistics properly and ensure that this is done. Information about which communities are more likely to have their teeth extracted and which communities are least likely to have time consuming treatments including crowns, bridges, dentures and root canals needs to be collected and analysed. (2) The local NHS should also review this information by taking into account that Band 2 treatments should not be automatically regarded as better than band 3 treatments, since a crown may be a more positive outcome than an extraction from the patient's perspective. (3) Ethnic monitoring statistics will aid the local NHS in commissioning evidence-based services and reduce health inequalities as directed by the World Class Commissioning Programme.

Private treatment - There should be tighter regulations about practices suggesting to patients that private treatment is better (from a non-cosmetic perspective) or that it is their only suitable alternative. Dentists should be asked to show that before performing a private treatment, they offered an NHS alternative.

Capacity - This report welcomes the plans to increase the capacity of dental practices in both boroughs. The local NHS should continue in its efforts to commission sufficient capacity to meet the needs of its populations and ensure year-on-year improvements in the number of patients accessing NHS dental services. This is necessary to meet the NHS operating framework objectives.

Information - An information campaign to KCW residents in different languages and formats which should include: A list of local NHS dentists; Information that registering with a dentist is not required and that NHS dentists are accepting new patients; Preventive Advice; Information on entitlements (free treatment if on benefits, reduction in costs with certificate if on a low income, band system); and, The similarities between NHS and private treatment.

What the local dentists can do - Offer and book interpreters when needed; Complete ethnic monitoring; and, Ensure provision of information in the appropriate languages and formats.

16.7 The Sub-group was pleased to hear that the PCT had produced guidance for patients and dentists during Ramadan.⁴⁶

Elderly people

⁴⁶ NHS Kensington and Chelsea's "Guidance for dental treatment during Ramadan", in English, Arabic and Farsi, is available to download from the Internet at: <http://www.kc-pct.nhs.uk/new/news/story/default.aspx?id=379>

- 16.8 The Sub-Group noted that, unless exemptions or reduced fees applied, elderly people were required to pay the full cost of dental treatment.
- 16.9 The Sub-group is pleased that the Community Dental Service for the elderly from St Charles Hospital and Violet Melchett are being improved.
- 16.10 Domiciliary visits are arranged from St Charles Hospital and Violet Melchett. Nevertheless, the types of treatment that can be carried out during a domiciliary visit are limited, and do not compare with the treatment available in a dental practice.

17. PRIVATE DENTISTRY

- 17.1 An alternative to using an NHS dentist is to pay for private dental treatment, which, given the increasing costs of dental treatment on the NHS and depending on the type of treatment needed, may not be significantly more than the cost of NHS treatment.
- 17.2 Since the new contract, whenever a dentist leaves the NHS to do private work, the money that would have gone to that dentist comes back to the PCT, to commission alternative NHS services.
- 17.3 The PCT will be using procurement to bring in new providers from the private sector in Kensington and Chelsea during 2009.
- 17.4 Statistics from the National Patient Survey suggest that Kensington and Chelsea has the 4th highest uptake rate of private dentistry in London and the 12th highest in the country, with 40% going privately in the previous two years. Over 144 out of the 440 respondents to our Resident Panel survey⁴⁷ said that they used a private dentist – the main reason given is that a NHS dentist is not available locally.

⁴⁷ Full Residents' Panel report is available at the completed consultations of the Council's website. Users need to type in 'Annual Health Care Check' to access the PDF'd report: https://www.consultation.rbkc.gov.uk/kms/dmart.aspx?strTab=PublicDMart&noip=1&filter_Status=2

APPENDIX 1: TERMS OF REFERENCE⁴⁸

- 1.1 To consider the provision of dentistry services for the inhabitants of the Royal Borough; to identify any shortcomings; and to suggest areas where improvements might be made.
- 1.2 The review will aim to focus on identifying and addressing a range of specific questions about provision. Particular areas for consideration include:
 - 'Needs' in Kensington and Chelsea;
 - Commissioning dental and oral health services
 - Provision of dentists
 - Access and communication
 - Prevention
 - Children
 - Specialist treatments

⁴⁸ Agreed at the Health Scrutiny Committee (formally known as the OSC on Health) on 7/1/09

APPENDIX 2: SUB-GROUP MEMBERSHIP AND MEETINGS

1. MEMBERS

Councillor T Buxton
Councillor Coleridge (Chairman of the Sub-group up to 20/5)
Councillor Freeman (Chairman of the Sub-group from 20/5)
Councillor Mason

Officer support

Henry Bewley (Health Policy Officer) – Lead officer for this review.
Ahmed Farooqui (Scrutiny Development Manager)
Gavin Wilson (Governance Administrator)

NHS Kensington and Chelsea

Frankie Lynch (Director of Primary Care)
Edward Ward (Head of Primary Care Commissioning)

Occasional attendance – as date shown

Sharon Hart (Clinical Lead, School Nursing) – 30/4
Beth Menger (Childhood Obesity Prevention Dietician) – 30/4
Louise Pinkney (Social Marketing Consultant) - 10/3 and 15/4
Justine Prentice (Head of Communications) - 15/4
Melanie Smith (Director of Public Health) – 10/3
Rosemary Thompson (Associate Director of Operations – Children’s Lead)
– 30/4
Virginia Wilcox (Healthy Schools Co-ordinator) – 30/4

2. SUB-GROUP MEETINGS

It was proposed⁴⁹ that each meeting of the Sub-group focuses on a particular objective (the date that the meeting took place is shown in bracket):

- 1 Understanding of the level of ‘need’ for dentistry and oral health promotion in the borough; and understanding the PCT’s oral and dental health strategy. (10 March 2009)
- 2 Understand the current and projected finances for dentistry; dental action plan 2009-10; and, marketing. (15 April 2009)
- 3 Gaining an in-depth understanding of schools and children’s issues (30 April 2009)
- 4 Summarising the findings of the review, discussing and agreeing final recommendations (20 July 2009)

⁴⁹ Agreed at the Health Scrutiny Committee (formally known as the OSC on Health) on 29/1/09

APPENDIX 3: COMPARATIVE EXPENDITURE 2006-07

Gross and net expenditure per capita on primary dental care services within the London Strategic Health Authority area, 2006-07⁵⁰

PCT name	Gross expenditure per capita (£)	Net expenditure per capita (£)
BARKING AND DAGENHAM PCT	53.12	44.13
BARNET PCT	40.06	34.58
BEXLEY CARE PCT	33.43	27.29
BRENT TEACHING PCT	52.13	44.32
BROMLEY PCT	30.11	24.89
CAMDEN PCT	38.84	33.46
CITY & HACKNEY TEACHING PCT	43.36	39.98
CROYDON PCT	45.20	37.17
EALING PCT	61.73	46.40
ENFIELD PCT	36.96	36.96
GREENWICH TEACHING PCT	61.73	53.78
HAMMERSMITH & FULHAM PCT	58.69	51.09
HARINGEY TEACHING PCT	62.70	56.11
HARROW PCT	39.73	31.34
HAVERING PCT	50.53	39.44
HILLINGDON PCT	38.57	29.99
HOUNSLOW PCT	59.84	49.81
ISLINGTON PCT	54.47	48.16
KENSINGTON AND CHELSEA PCT	17.99	15.37
KINGSTON PCT	31.31	25.03
LAMBETH PCT	46.21	40.02
LEWISHAM PCT	53.91	45.51
NEWHAM PCT	55.13	50.66
REDBRIDGE PCT	52.93	44.52
RICHMOND & TWICKENHAM PCT	26.29	22.35
SOUTHWARK PCT	47.25	42.12
SUTTON AND MERTON PCT	37.21	30.40
TOWER HAMLETS PCT	57.41	53.79
WALTHAM FOREST PCT	44.29	37.49
WANDSWORTH PCT	38.42	32.65
WESTMINSTER PCT	50.12	44.09

Notes:

1. Gross expenditure represents total cost of dental services. Net expenditure represents costs to the NHS after taking account of dental charge income paid by patients.
2. Patients may attend dentists at a locality of their choice, e.g. near their workplace or at a convenient town centre, so the level of service provision in a PCT may not be directly related to the size of its resident population.

⁵⁰ Source: Calculated from details of gross primary dental care expenditure and income from dental charges recorded in the accompanying notes to PCT accounts. Per capita expenditure is based on mid 2006 all ages population estimates compiled by Office of National Statistics.

APPENDIX 4: THE DENTAL CONTRACT

The Dental Contract came into effect as of 1 April 2006. It came about to give all better access to high quality services and a new charging system.

The following are some of the highlights from the new contract for the full document of "What you need to know about changes to NHS dentistry in England" go to www.doh.gov.uk and search for the title of the document.

1. Registration with a dentist

Patients no longer need to register with a dental practice. Before making the appointment you should ask if the dental practice is offering NHS treatment. Some dental practices will offer a mixture of both private and NHS treatment and others may treat children only. However, a dentist may not accept children as NHS patients on condition their parents agree to sign up for private treatment.

2. Charges

For patients who receive free dental treatment as they are exempt from paying, this will remain the same.

For those patients who pay for treatment there are 3 standard charges for NHS treatment. The amount you pay depends on the treatment you need.

You will only pay one charge even if you need to visit more than once to complete a course of treatment. If you are referred to another dentist you will still only pay the one charge (to the dentist who refers you). If you need more treatment at the same charge level (e.g. an additional filling) within 2 months of seeing your dentist, this will be free of charge.

3. Prescriptions

There will be no charge for writing a prescription (usual charges apply when taking the prescription to the chemist) or for removing stitches.

4. Dentures

Repairs to dentures will remain free of charge.

5. Treatments available on the NHS

All clinically necessary treatments and dentures will still be available on the NHS, i.e. treatment that is necessary to secure and maintain your oral health. If you want, or your dentist suggests treatment that is purely cosmetic (e.g. white fillings, tooth whitening or white crowns on back teeth), you can decide to have this done privately.

You should ask your dentist how much this would cost in addition to NHS charges. You are able to have a mixture of NHS and private work completed on your teeth.

6. How do I find a dentist?

You can contact your local Primary Care Trust, Patient Advice and Liaison Service (PALS) or NHS Direct to find a dentist. Contact information is listed at the end of this appendix.

7. Will I be charged if I miss an appointment?

No, there will no longer be a charge for missed appointments, but if you continue to miss appointments they may decide not to offer you treatment. Please try to give as much notice as possible if you need to cancel or change your appointment.

8. Where can I get out-of-hours and urgent treatment?

Contact your PCT or NHS direct who will be able to tell you where you can go.

9. What do I do if I wish to make a complaint?

You should send a written letter to the person responsible for complaints at your dentist's practice. You can get support from PALS or the complaints manager at your PCT, Citizens Advice or visit www.dh.gov.uk.

10. Where can I get information and advice?

You can get further information from:

- Patient Advice & Liaison Service (PALS) or visit www.pals.nhs.uk.
- British Dental Health Foundation – dental helpline 0845 063 1188 or visit www.dentalhealth.org.uk.
- Citizens Advice Bureau or visit www.citizensadvice.org.uk.
- NHS Direct www.nhsdirect.nhs.uk - 0845 46 47

APPENDIX 5: LOW PERCEPTION OF DENTAL NEED AND BEHAVIOURAL BARRIERS⁵¹

One of the strongest behavioural challenges to emerge from this research for NHS Kensington and Chelsea in increasing access to NHS dentistry is a low perception of need among residents, resulting in the fact that pain or trauma are the cues to action in making a dental appointment. Residents equate good oral health with no pain or trauma. This appears to be reflected in the high rate of Band 3 treatment, whereby residents only attend when something is wrong. Fear and phobia that has either been a learned response from parents or peers, or the result of an unpleasant treatment or bad experience, reinforce the barrier to behaviour change. If no preventative measures are taken, oral health deteriorates until pain or trauma is the cue to action, thus perpetuating the entire cycle.

Poor oral health can be directly related to low self-referral rates, and addressing this should be part of an intervention to increase numbers accessing NHS dentistry. The value of preventative treatment appears to be low or very low among lower socio economic groups. This corresponds to the fact that those living in more deprived areas have poorer oral health. These are residents predominantly living in the northern wards of the borough, as well as the wards of World's End and Cremorne in the centre. Use of NHS dentistry in these areas is higher than other areas of the borough, which suggests that those living in the more affluent areas of the south represent the bulk of approx 40% who are using private dentistry.

Behavioural barriers to action to maintain good oral health (regular checks ups) can be passed on from adults to children, showing as a correlation between adults who use no dentistry and the number of their children who are also not using dentistry. This suggests these behaviours are passed on from parent to child and generation to generation, once again reinforcing the long term cycle of poor oral health. However, these parents do value the importance of good oral health for their own children, yet do not exhibit the behavioural goal of taking them for regular check ups. This suggests the behavioural barriers lie in parents' fear, phobia and experiences, and not wanting to expose their children to that. Parents frequently enquired about child friendly dentistry, or mentioned it during the research phase. There was a lack of understanding about the importance of preventative treatment for children aged 0-2 years, as the majority of parents thought oral health only became an issue when children began to get their first set of teeth. The value of good oral health is learned from an early age. If a child is not exposed to regular preventative actions, such as tooth brushing and check ups, this reinforces the low value placed on oral health. This low value leads to lack of the desired behaviour at a stage in life when habits

⁵¹ Taken from the Executive Summary of the PCT's "Initial scoping report: Increasing access to dental services in Kensington and Chelsea"

are formed. If preventative treatment is not part of habitual behaviour from early child hood, it is more likely that child will have a low perception of need of good oral health into adulthood, and cues to action will therefore be pain or trauma. This may be passed on to their children, perpetuating the cycle, so behavioural barriers become inherited. Therefore, creating preventative habits and priority around oral from birth could break this cycle.

Having sufficient capacity to treat self-referring patients does not appear to be a significant factor in behavioural barriers, although is perceived by a proportion of residents to be an issue. The underspend of UDA, and evidence from borough dentists, show that capacity exists, but residents are simply not presenting for treatment. Westminster PCT has a comparable borough profile, but has 50 NHS practices, as opposed to just 16 in NHS Kensington and Chelsea, yet has similar low levels of oral health and high levels of Band 3 treatment. Preventative care does not attract a UDA in the borough.

The research targeted cross sections of the borough and in doing so, obtained a broad and varied representation from all sections of the community included in the remit of this exercise. All focus groups, surveys and questionnaires were racially and culturally mixed. A targeted case study was done with a Somalian group, and the literature review directly addressed BME issues. Specific behavioural barriers within the BME community were identified, such as the need for translators and information in different languages, advice on what was acceptable during Ramadan and women only dentistry. However, it appeared that the behavioural barriers facing the majority of the BME community were those faced by the majority of residents of the borough in terms of a low perception of need, reinforced by phobia or fear, memories of unpleasant experiences and a lack of appropriate services such as child friendly dentistry.

There is much that can be done to address the behavioural barriers that have been identified and a wealth of good practice and expertise that can be drawn on to inform and inspire. Improving the overall perception of the importance of preventative oral health is a vital component of increasing access to NHS dentistry in the borough.

APPENDIX 6: RESIDENTS PANEL SURVEYS 2008 AND 2009⁵²

A representative sample of the borough's population made up of 440 residents has been asked the same questions related to the dental services they have received over two years. The results of these questions can be compared between the two years. Questions 8-10 are the ones specifically on dentistry.

Out of the 440 people who responded to the Survey, 129 had visited their Dentist in the previous year, and this report is based on their experience.

Treating patients with dignity and respect

91% of respondents to our Residents Panel survey this year said they were treated with dignity and respect at their Dentist – no change from a similar survey carried out last year. A higher proportion of respondents living in the North of the borough and those who were disabled said they were treated with dignity and respect compared to people living in the South and those from BME communities.

Accessible information

93% of respondents to our Residents Panel survey this year said the information they were given by their Dentist was easy to understand – no change from a similar survey carried out last year

Involvement in planning own care

69% of respondents to our Residents Panel survey this year said they had a say in planning their care at their Dentist - no change from a similar survey carried out last year. A much higher proportion of disabled people and those over 50 said they had an involvement compared to those from the BME communities and those living in the South of the borough. This suggests that there is scope for improvement.

Accessible and responsive care

A high proportion of respondents to our survey this year said it was easy to register with a Dentist (87%), make appointments (85%) and physically access the dentist premises (91%). There has been a significant increase (9%) since last year in the proportion of people saying it was easy to access dentist premises. A higher proportion of disabled respondents and those over 50 found it easy to make appointments compared to non disabled residents and those under 50;

⁵² Full Residents' Panel report is available at the completed consultations of the Council's website, which would involve users to type in 'Annual Health Care Check' to access the PDF'd report:

https://www.consultation.rbkc.gov.uk/kms/dmart.aspx?strTab=PublicDMart&noip=1&filter_Status=2

and a higher proportion of BME respondents and those from the South of the borough found it easy to register compared to White residents and those in the centre of the borough.

Our survey found a high rate of satisfaction with the overall quality of dentistry services in the borough (86%) – no change since last year. However, satisfaction rates were lower for disabled people and for those over 50 and for those living in the South of the borough.

Over 144 out of the 440 respondents to our survey said that they used a private dentist – the main reason given is that a NHS dentist is not available locally.

APPENDIX 7: DENTAL SURGERIES PROVIDING NHS TREATMENT

All Saints Dental Clinic (DA)
9 All Saints Road
London W11 1HA
Tel 020 7727 8328

A S Ghauri & Associates
247 Westbourne Grove
London W11 2SE
Tel 020 7229 4813

The Dental Surgery
80 High Street Kensington
London W8 4SG
Tel 020 7938 2833

The Dental Surgery
2 Russell Gardens
London W14 8EZ
Tel 020 7603 5063

D Morgan Dental Surgery (DA)
59 Golborne Road
London W10 5NR
Tel 020 8964 0186

Earls Court Dental Practice
121 Earls Court Road
London SW6 9RL
Tel 020 7373 4846

The Grove Dental Practice (DA)
351 Ladbroke Grove, London W10
6HA
Tel 020 8969 0656

The Hub Dental Rooms
Suite 123, Network Hub
300 Kensal Road
London W10 5BE
Tel 020 8962 0000

JD Hull & Assoc – Fulham Rd Dental
Care (DA)
242-244 Fulham Road
London SW10 9NA
Tel 020 7376 3330

Kensington Dental Practice
129 Kensington High Street
London W8 6SU
Tel 020 7937 9097

Ladbroke Grove Dental Clinic (DA)
118 Ladbroke Grove
London W10 5NE
Tel 020 7727 9836

Moselhi Dental Surgery
22 Notting Hill Gate
London W11 3JE
Tel 020 7727 8370

Notting Hill Dental Surgery
22 Pembridge Road
London W11 3HL
Tel 020 7727 4795

Shah Dental Surgery (DA)
407 Kings Road
London SW10 0LR
Tel 020 7352 7049

Violet Melchett Dental Clinic (DA)
30 Flood Walk
London SW3 5RR
Tel 020 7349 2821

Mr Yeoh's Dental Surgery (DA)
4 Worlds End Place, Kings Road
London SW10 0HE
Tel 020 7352 0926

BIBLIOGRAPHY

1. Legislation, Regulations and Directions

All the current dental legislation, regulations and directions can be accessed via the primary care contracting web-link shown below:

<http://www.primarycarecontracting.nhs.uk/134>

*** Directions to Primary Care Trusts Concerning the Exercise of Dental Public Health Functions 2008**

These directions describe how PCTs should carry out The Functions of Primary Care Trusts (Dental Public Health) (England) Regulations 2006. PCTs will already refer to Delivering Better Oral Health in providing oral health programmes and DH Guidance on Dental Screening (inspection) in schools and consent.

http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/DH_090515

2. Building on Choosing Better Oral Health: An Oral Health Plan for England (November 2005)

This plan sets out to inform and provide support for dental practices as they focus more on preventive care under the new contractual arrangements which will be in place from 1st April 2006.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4123770

3. NHS Dental Reforms: One year on (August 2007)

This report outlines the progress made and the challenges ahead after the first year of reforms of the NHS dental system. According to the report, the reforms are allowing local NHS bodies to develop services in areas with the greatest need. The document says PCTs have now commissioned more services than were delivered in the last year of the old system.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077238

4. Commissioning NHS primary care dental services: meeting the NHS operating framework objectives (January 2008)

This DH guidance sets out: the Government's commitment to NHS dental services and the expectations on the NHS to deliver year on year increases in access, as set out in the NHS Operating Framework 2008/09;

and, more detail on what this means for commissioners and providers in developing dental services, including managing the 2009 transition.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082104

5. Delivering Better Oral Health: An evidence-based toolkit for prevention (September 2007)

This is guidance on evidence based prevention.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078742

6. Guidance on screening in schools and consent – Jan 2007

This guidance from the DH: notifies PCTs of the advice of the UK National Screening Committee on dental screening of 6-9 year old children; invites PCTs to consider whether or not to continue local screening programmes and, if not, how best to address inequalities in oral health in other ways; provides advice on working with schools and local authorities to introduce revised arrangements for parents/carers to give consent to children receiving dental inspections in connection with epidemiological surveys.

http://www.primarycarecontracting.nhs.uk/uploads/Dentistry/january_2007/guidance_on_screening_consent.pdf

8. Government's Response to the Health Select Committee Report on Dental Services

This document sets out the interim Government response to the conclusions and recommendations in a report on dental services.

<http://www.info4local.gov.uk/filter/?item=987903>

9. DH Dental Contracts Statistics

This page links to the latest statistics on dental contracts.

<http://www.info4local.gov.uk/filter/?item=1043784>

10. Review of NHS dental services in England

This independent review of dentistry, carried out by Professor Jimmy Steele, identified ways of improving access to NHS dental services and improving the quality of care.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_101137

GLOSSARY

A&E	Accident and Emergency (Casualty)
BASCD	British Association for the Study of Community Dentistry
BME	Black and Minority Ethnic
Citizens Advice Bureaux (CAB)	The Citizens Advice service helps people resolve their legal, money and other problems by providing free information and advice, and by influencing policy makers.
Clinical Executive Committee (CEC)	NHS Kensington and Chelsea have called their Professional Executive Committee the "Clinical Executive Committee". It works to deliver the aims and objectives of the PCT by supporting and developing clinically driven primary and community services and ensuring that the local health needs are fed into the planning.
Community Dental Service (CDS)	Dental care is provided in community settings for patients who have difficulty getting treatment in their "high street" dental practice.
Department of Health (DH)	The health and social care department of the English Government.
FCS	The Royal Borough of Kensington and Chelsea's Family and Children's Services
Health Scrutiny Committee	This is a Council body that has a statutory obligation to scrutinise the response of the Council and health services to local issues. It was previously called the Overview and Scrutiny Committee (OSC).
IM & IT	Information Management and Information Technology
National Institute for Clinical Excellence (NICE)	Independent organisation that provides national guidance on the promotion of good health and the prevention and treatment of ill health.
NHS Kensington and Chelsea	The Primary Care Trust in Kensington and Chelsea is the statutory body responsible for commissioning health care for local people and reducing health inequalities.
Patient Advice and Liaison Service (PALS)	PALS is a free and confidential service which helps patients, parents and carers with any information, concerns, or problems that they have about their NHS
Personal, social and health education (PSHE)	PSHE deals with many real life issues young people face as they grow up.
Primary Care Trust (PCT)	This is a statutory body responsible for commissioning health care for local people and reducing health inequalities. The PCT in Kensington and Chelsea is called "NHS Kensington and Chelsea".
Quality and Outcomes Framework (QOF)	A nationally negotiated contract that rewards best practice and improved quality of services.
SDS H&F	The Hammersmith and Fulham Specialist Dental Service covers the specialties of oral surgery, restorative dentistry, endodontics, periodontics and prosthodontics.
Social marketing	Social marketing is the combined application of commercial marketing plus other concepts and techniques to define behavioural challenges and design behaviour change programmes based on insight.
UDAs	Units of dental activity