

Birmingham East and North Primary Care Trust

**ORAL HEALTH IMPROVEMENT &
DENTAL COMMISSIONING STRATEGY**

Purpose

This strategic document is designed to set out how BEN PCT can improve oral health and NHS dentistry over the next five years. It also explains the PCT's contribution to achieving the dental service goals of the Strategic Health Authority's strategic framework 'Investing in Health' which are:

- Patients throughout the West Midlands are able to access high quality NHS dentistry locally and conveniently
- Achieving a greater focus on health improvement and disease prevention in dentistry, so as to reduce inequalities in dental health and build further on our position of having the best children's teeth in Europe, and extending that benefit through the adult population.

Section 1 ~ Context

Section 1a ~ National

This strategy is written against the background of a number of national policy documents, strategies and national initiatives, non-dental and dental. It is important that the themes laid out in these documents are picked up in this strategy both to ensure that dental services develop in line with all the other services in the NHS but also that oral health can derive benefit from innovations that are designed to move forward health improvement generally and in particular that health inequalities are tackled.

i. Our NHS, Our Future- Lord Darzi's Review of the NHS

Lord Darzi's interim report - 'The NHS Next Stage Review' recommended that the vision for the NHS should be that it is Fair, Personalised, Effective, and Safe. The interim report laid out steps which should be taken which are echoed in the operating framework. It particularly highlighted that:

In terms of fairness;

- inequalities must be tackled,
- there is a need for new models of care
- newly procured health centres should offer a range of convenient services
- there is a need to review out of hours services

In terms of personalised care;

- patients must be treated with dignity and respect
- care should be integrated
- patients should have opportunities for choice and personal control

In terms of effective care:

- delivering outcomes that are equal to the best in the world
- establishing a clear framework for measuring results

In terms of safety

- the need for clear and simple incident reporting
- the need for information to support excellence

In terms of local accountability

- Improving the evidence base for decision making
- the need for clinical involvement and leadership
- Proper workforce planning, education and training

The Final Report – 'High Quality Care for All' focuses on:

- High Quality care for patients and the public including creating an NHS that helps people to stay healthy.
- Working in partnership with staff
- The proposed 'NHS Constitution'

ii. 'World Class Commissioning'

This document, published in December 2007, is aimed at delivering outstanding performance in the way health and care services in the NHS are commissioned.

It highlights the need for PCTs to develop the knowledge, skills, behaviours and characteristics that underpin effective commissioning. The competencies required are grouped under the following headlines:

- Locally lead the NHS
- Working with community partners
- Engage with public and patients
- Collaborate with clinicians
- Manage knowledge
- Prioritise investment
- Stimulate market
- Promote improvement and innovation
- Secure procurement skills
- Manage the local health system
- Make sound financial investments

iii. The 18 week patient pathway framework

The NHS Improvement Plan (June 2004) set out the aim: 'By 2008 no one will wait longer than 18 weeks from GP referral to hospital treatment.' The implementation framework explains the nature of the 18 week pathway challenge based on extensive analysis completed during 2005/06. The target applies to dental specialties and referrals from General Dental Practitioners.

iv. The Operating Framework for the NHS 2008/09

This document has defined five key areas improving access to NHS services as one of the key areas where PCTs are expected to pay particular attention. Each of these is relevant to dental services and oral health to a greater or lesser degree.

These areas are:

- Improving cleanliness and reducing Health Care Acquired Infection.
- Improving access through the 18 week referral to treatment pledge and improving access to primary care services
- Keeping adults and children well, and improving their health and reducing health inequalities

- Improving patient experience, staff satisfaction, and engagement; and
- Preparing to respond to a state of emergency, such as the outbreak of pandemic flu.

The framework makes specific mention of primary care dental services ; laying out the requirement for PCTs to ensure robust commissioning strategies for primary dental services based on the assessment of local needs and with the objective of ensuring year-on-year improvements in the number of patients accessing NHS dental services

National Policy with a Dental content

i. 2006 General Dental Services Contract

The 'new' General Dental Services contract introduced in April 2006 devolved the responsibility for commissioning primary dental care to Primary Care Trusts. The contract fundamentally changed:

- the relationship between the PCT and dental practitioners
- the way that practitioners are paid
- The way the charges which patients pay are calculated.

The contract has been controversial with dental practitioners many of whom remain unconvinced of its benefits. However, the PCT can now commission services on the basis of need and the new contract has significantly more levers with regard to quality of care.

ii. Choosing Better Oral Health - An Oral Health Plan for England

This plan followed both the publication of the new General Dental services contract and 'Choosing Health: Making Healthier Choices'. It is part of 'Delivering Choosing Health' the delivery plan for 'Choosing Health'.

The document outlines the key responsibilities of PCTs in improving oral health as being:

- Ensuring that oral health is an integral part of their Local Delivery Plans
- Liaising with Local Authorities, to ensure that improving oral health is included in joint planning
- Ensuring that the dental services they commission have an evidence based preventive focus
- Ensuring that they are able to obtain appropriate health needs information and advice in developing local programmes for implementation.

It gives the key areas for action as;

- increasing the use of fluoride (Birmingham's water supply is fluoridated so this is less relevant here)
- improving the diet and reducing sugar intake
- encouraging preventive dental care
- reducing smoking
- increasing the detection of mouth cancer
- reducing dental injuries

The plan highlights the need for a skilled workforce, emphasises the need for a common risk approach to improving oral health and the need to involve communities to achieve sustainable oral health improvements.

- #### iii. 'Delivering Better Oral Health: An evidence based toolkit for prevention' published in September 2007 gives dental teams clear guidance about the advice that they should give and the actions they need to take to ensure that they are doing their best for their patients in terms of preventing disease.

- iv. 'Smokefree and Smiling'; helping dental patients to quit tobacco. Published in May 2007, this document gives six clear recommendations for dentists, their teams, PCTs and dental schools to ensure that smoking cessation is actively promoted by General Dental Practitioners and their staff.
- All dental patients should have their smoking status established and checked at regular intervals. This information should be recorded in the patient's clinical notes.
 - All smokers and chewers of tobacco should be advised both of the value of stopping, and of the health risks of continuing. The advice should be clear, firm and personalised. It is essential that the message all smokers take away with them is that only complete cessation will do.
 - All smokers should be advised of the value of attending their local NHS Stop Smoking Services for specialised help in going smoke-free. Smokers who are interested and motivated to stop should be referred to these services.
 - In a small minority of cases, dental patients who are smokers and who want to quit, but who do not wish to use the NHS Stop Smoking Services, should be offered appropriate help in stopping by their dental team. Only dental team members who have received accredited training in tobacco cessation should offer this assistance.
 - Primary care trusts are advised to take full account of the potential that members of dental teams have to contribute to their NHS Stop Smoking Services. Dental teams should be offered appropriate cessation training, and local systems of referral should be established.
 - Dental schools are encouraged to develop smoking cessation training for all members of dental teams.
- v. 'Valuing Peoples Oral Health – A good practice guide for improving the oral health of disabled children and adults'

This document was published in November 2007 is latest in the series of supplementary guidance to 'Choosing Better Oral Health' and again gives 7 clear recommendations for improving oral health for people with disabilities .

These are to:

- Assess need through local surveys
- Design and implement effective preventive actions and programmes
- Provide consistent messages across all health and social care boundaries
- Build competence through training and sharing of knowledge
- Include oral health in every care plan
- Develop and maintain responsive, needs led treatment services
- Provide information for people whose first language is not English.

vi. Commissioning NHS Primary Care dental services: Meeting the NHS Operating Framework Objectives

This document published In January 2008 gives guidance on the Government's commitment to maintaining and expanding NHS dental services and increasing access year on year.

Section 1 b ~ Strategic Health Authority Policy

I. 'Investing for Health'

Section 5.9 of this document is devoted to improving the availability of NHS dentistry. It points out that there is a high level of public dissatisfaction with the availability of NHS dentistry and evidences this with the results of a MORI survey undertaken in the summer of 2006 (see section 2.3 'Patient and Public views').

'Investing for Health' also draws attention to the new quality controls which are in place for NHS dentistry. In particular, it reflects on the effect of the extension of mandatory registration with the General Dental Council to the all members of the dental team and the potential adverse effects of a less than smooth transitional registration process. The isolation of the dental team and the difficulties this presents for potential whistle blowers and the less systematic development of clinical governance with general dental practice is also highlighted.

The document highlights the importance of the following factors increasing capability and capacity of NHS dental services:

- the number of dentists in the area
- the extent that dentists provide NHS service
- the types of work those dentists are undertaking
- levels of dental health

The impact of the move towards evidence based practice is also emphasised and in particular the impact of the NICE review on dental recall intervals which concluded that adult patients should be recalled in line with their assessed risk up to a maximum of 24 months. This strongly contrasts with the traditional practice of 6 monthly recalls which is deeply ingrained in both professional and public consciousness.

The plan concludes that:

- better information is needed for public and patients and the dental team,
- that PCTs do not currently always either understand dentistry or how to effectively commission it;
- that each should develop an oral health improvement dental commissioning strategy (this document fulfils that requirement)
- Incorporate performance management measures that will ensure equity of access to NHS dentistry
- Improving public confidence in NHS dentistry is dependant on ensuring that the quality of care on offer from the service is good, based on the best quality evidence and that disease prevention is a focus for action as well as treatment.
- Securing a properly trained work force is key to the delivery of a quality service and that anew dental hospital and school is essential to developing the workforce of the future.

Section 2 ~ Baseline/ Current Position

Oral Health Status, including inequalities and special groups within the PCT area

Section 2 a ~ General

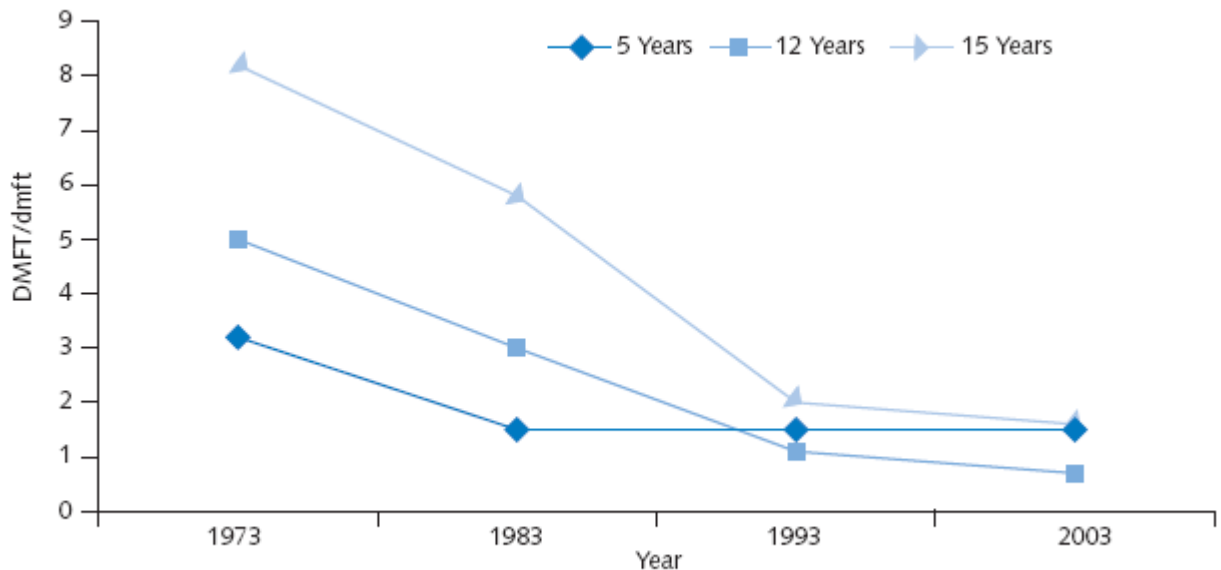
Birmingham's water supply has been fluoridated since the early 1960s and the position with regard to oral health is consequently substantially better in Birmingham East and North than similar areas elsewhere in the country.

Section 2b ~ Children's Dental Health

National position

Nationally, oral health amongst children has improved steadily over the last thirty years. This is illustrated in the graph below which shows the average number of decayed, missing or filled teeth per child in England plotted over 30 years.

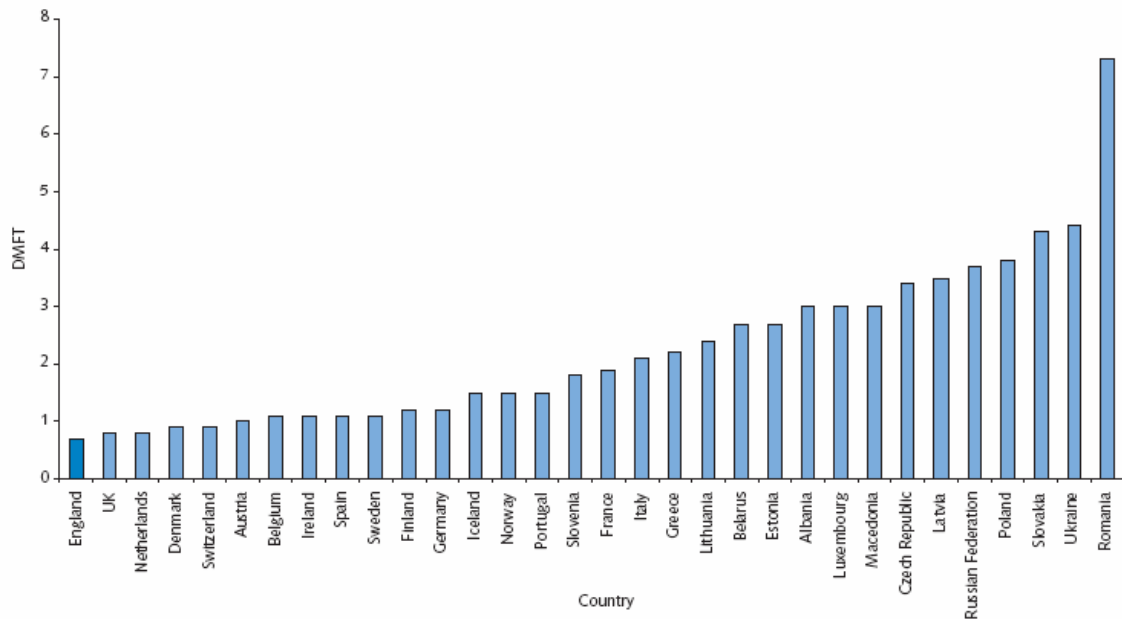
Figure 3 Average DMFT/dmft per child in England, 1973 to 2003



Source: National Children's Dental Health Surveys 1973 to 2003. Harker R and Morris J (2005). Office for National Statistics, London.

Amongst 12 year olds oral health is now amongst the best in Europe (see bar chart below)

Figure 4 Average levels of tooth decay in 12 year old children in Europe



Source: WHO Oral Health Country/Area Profile programme, 2005

However, significant differences remain related both to geography and socio-economic status.

Local position

Oral health amongst the population of five year old children in the Birmingham East and NorthPCT area is very good and even possibly improving. This is measured by regular dental epidemiological surveys which until 2005 were co-ordinated by the British Association for the Study Community Dentistry (BASCD)

Table of results showing the prevalence of active dental decay in five year old children since 2001

Year	2003	2005
%of children surveyed at the age of five with active dental decay		
Eastern Birmingham	37.8	35.58
North Birmingham	28.1	21.09

As can be seen above, in North Birmingham, the latest published data from an epidemiological survey conducted in 2005/6 shows that 21.1% of five year old children had untreated dental decay which contrasts with 35.6% in Eastern Birmingham, 33% in Heart of Birmingham PCT and 46.8 % for the Northwest Strategic Health Authorityⁱ which does not have a fluoridated water supply.

These figures demonstrate that although Birmingham East and North have undoubted benefits from the fluoridated water supply in Birmingham as demonstrated by the difference in the oral health of five year olds here and in the North West, there are large internal inequalities in oral health within the PCT. These inequalities need to be tackled by an active programme of oral health promotion within the PCT.

In addition, some of these inequalities are related to the general social inequality evident in the population and therefore it is important that dental services contribute what they can to reducing these general inequalities in addition to the traditional oral health promotion which has been available for many years. Promoting community awareness and engagement amongst dentists and their staff, ensuring that patients are treated with dignity and respect, encouraging proper employment policies and encouraging dental staff to enhance their

educational and training status can all make a small contribution to improving the social capital of a locality and tackling the underlying determinants of ill health in the area.

Dental issues for children who may be vulnerable

'Looked after' Children

The term "looked after" refers to any child in the care of the Local Authority. This can mean being placed in a residential unit, foster placement, offenders' institution, receiving respite care or on a full care order but living at home. There are currently just over 2,000 children who are looked after in Birmingham. There are 20 mainstream residential units; one of which is a secure unit and another is a remand centre. There are also 6 units for children with disabilities within the city.

'Looked After' children are potentially the most vulnerable in society. In later life, this vulnerability may lead to homelessness, unemployment, mental health problems and sometimes entry in to the criminal justice system. Whilst dental services cannot deal with this type of systemic problem, services can be designed to ensure that 'looked after' children's oral health can be maintained and in the future, poor oral health does not contribute to them failing to obtain employment ⁱⁱ

All children in this group have access to a health assessment under Department of Health Guidelines. The Pan-Birmingham Health Team managed by South Birmingham PCT is dedicated to providing care for this group of children, and undertakes this assessment which includes signposting children to dental health services. However, data is not currently collected separately for dental health of this group and therefore an oral health needs assessment exercise should be undertaken for this group to ensure that their needs are being met adequately.

Oral health in children with disabilities and long term medical conditions

Oral health for children with disabilities and or long term medical conditions has not been specifically examined in Birmingham for sometime. However, nationally, studies have found that many children who have disabilities have been found to have poor oral health. The prevalence of dental decay per se has not been found to be higher in children with learning disabilities but fewer teeth are treated. It has also been shown that oral hygiene and control of dental plaque is worse in this group.ⁱⁱⁱ

Many children with disabilities are currently treated within the pan-Birmingham salaried dental service managed by Heart of Birmingham PCT.

The pan-Birmingham Children's Health Team managed by South Birmingham PCT has an aim to improve the uptake of dental surveillance and an audit of dental services should be conducted in conjunction with this team. It is important that that the concern about access to dental services for the whole population should not distract from small groups of needy individuals such as these.

Outstanding issues for children

- *There are significant inequalities in the oral health of five year old children within the PCT which need attention.*
- *The oral health needs amongst looked after children and those with disabilities and long-term medical conditions have not been assessed.*

Orthodontic need and treatment

There are a number of issues relating to orthodontic need demand and service provision. A strategy for Orthodontic Services in Birmingham and Solihull has been drafted and will be reviewed and refreshed in

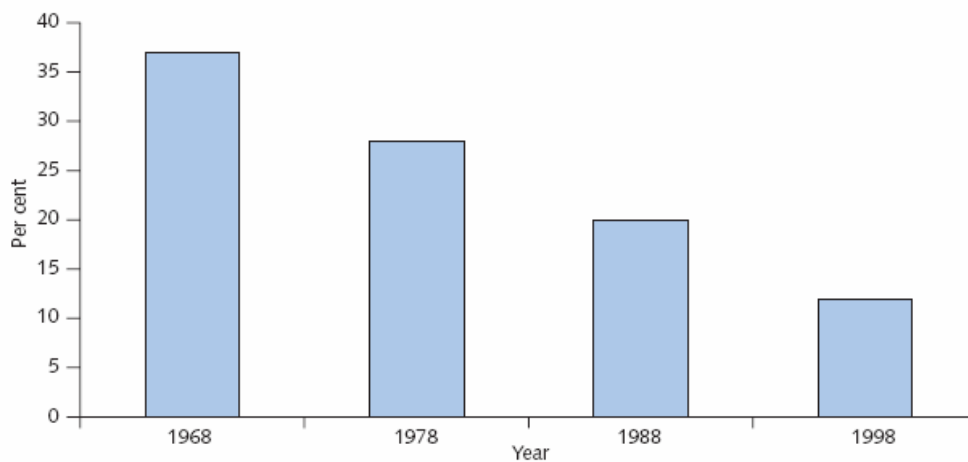
collaboration with clinicians and taking public and patient views into consideration. Preliminary findings suggest that investment in additional services in orthodontic services will be required to address waiting list issues. This is particularly important if the PCT is address the inequity of access to service for those who cannot afford to pay for treatment privately. NHS orthodontic treatment is now targeted at conditions which have a health impact and is not available for purely cosmetic treatment.

Section 2c ~ Adult Dental Health

Tooth loss

Nationally, adult dental health has also been subject to enormous improvement over the past 40 years. In 1968 37% of the adult population had no natural teeth. By 1998 this had decreased to 13% and it projected to be as low as 3% by 2018. This is shown below in the chart taken from the national Adult Dental Health Survey report 1998.

Figure 1 Proportion of adults with no teeth in England, 1968 to 1998



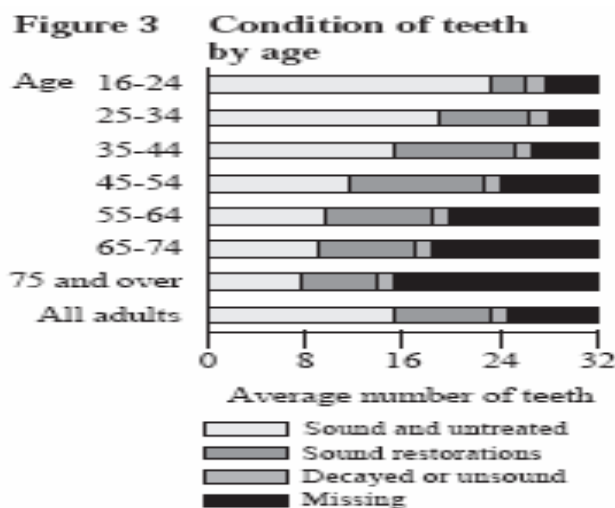
Source: National Adult Dental Health Survey, 1968 to 1998 (Kelly M, Steele J, Nuttall N, Bradnock G, Morris J, Nunn J, Pine C, Pitts N, Treasure E and White D (2000). *Adult Dental Health Survey 1998*

Teeth affected by dental disease

The post-war dental caries epidemic has left its mark on the oral condition of people over the age of 40. Many people over the age of 40 have had extensive restorations to previously decayed teeth and over the years these have been replaced, become larger and now present significant challenges to dentists trying to restore.

The extent of the problem is illustrated in the chart overleaf, also taken from the Adult Dental Health Survey 1998 which shows the number of teeth affected by dental disease.

Chart illustrating the condition of teeth by age group (ADH 1998)



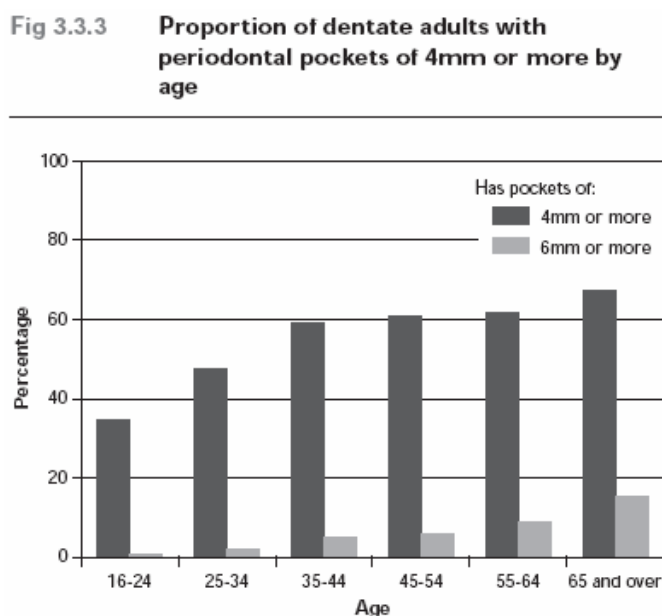
Within the last 20 years technology has advanced significantly and it is now possible to save teeth which previously would have been extracted. In addition it is now possible to replace others with implants and bridges when dentures would have been routinely used in the past

Excellent treatment planning, a higher level of skills, more time and equipment are all required if a good quality of care is to be provided for the population. The benefits of providing such a high quality service are clear for both the individual and the community. These are: Oral and dental function is retained; diet is not restricted to soft processed food; social confidence is retained.

Periodontal (Gum) disease

As fewer teeth have been lost due to decay, the prevalence of periodontal disease has become more important. Loss of gum attachment to the teeth causes pocketing of the gums and can lead to tooth loss. The Adult Dental Health Survey in 1998^{iv} estimated that significant loss of gum attachment affects 10 % of the population as a whole. Overall the prevalence of gum disease is much higher as shown below.

Chart illustrating the percentage of adults with teeth in the UK with periodontal (gum) pocketing(ADH 1998)



For some time there has been a suspicion that periodontal disease is a risk factor in coronary heart disease. A meta-analysis, published in 2007^v and reviewed again in 2008,^{vi} adds some strength to this hypothesis and concludes that given the relatively minor morbidity of periodontal therapy and the high mortality rate of cardiovascular disease maintenance of periodontal health should be amongst the recommendations for the prevention of heart disease.

In the main, gum disease can both be prevented and treated by adopting good oral hygiene practices and removal of dental calculus. There are however, issues with treatment which are highlighted in the section on service provision.

Summary of issues adult dental health

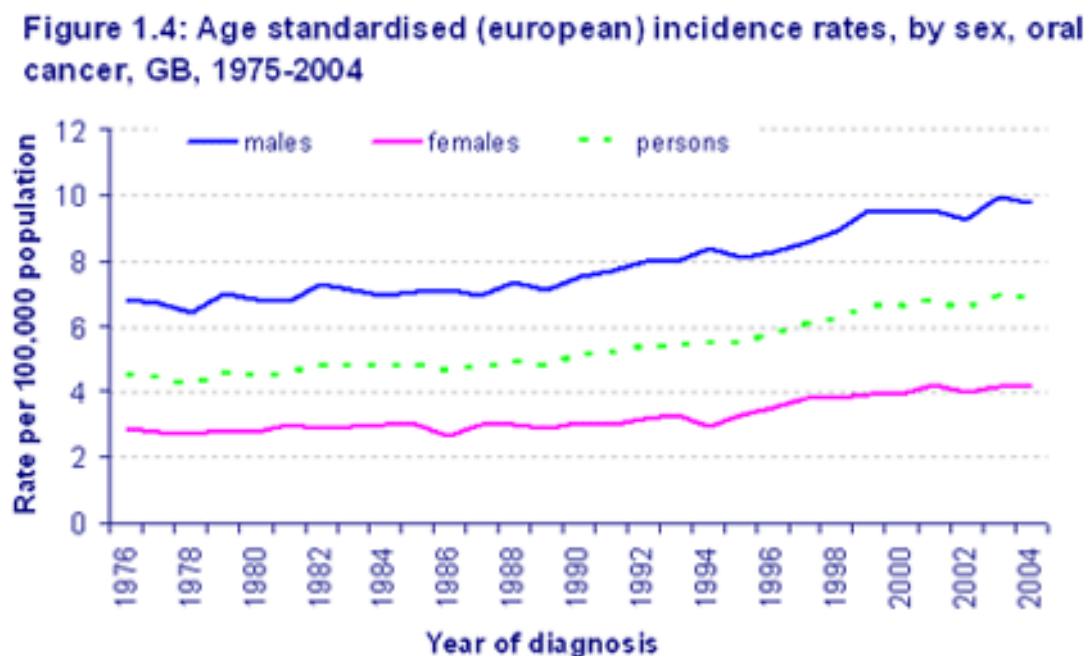
- *There is a dichotomy of need between older and younger age groups of adults with older people having higher and more complex needs*
- *There is widespread prevalence of periodontal disease which is both preventable and treatable and may have impact on wider health*

Section 2d ~ Oral Cancer

Oral cancers affect about 3700 people in England annually. Although if treated in its early to locally advanced stages, between 70% and 90% of people survive, unfortunately it is usual for cases to present late and the survival rate then decreases to between 46% to 52%.

The number of cases nationally has increased nationally by more than 30% nationally in the last 10 years.

Chart showing the rise in the incidence rates of oral cancer 1976-2004



As an indication of the level of the problem locally, designated oral cancer centres in the West Midlands treated 249 cases in 2005.

Oral cancer is strongly related to alcohol intake and smoking. It is of concern that more cases are being diagnosed in patients in their middle years than in the past when mainly older people were affected. In addition, there has been a gender shift in prevalence. 50 years ago, 5 times as many men as women died of mouth cancer. Today the ratio has reduced to 2:1. These changes are thought to be related to the increase in alcohol intake in the younger population and increases in smoking and drinking amongst women. Paan and betel nut chewing is also a risk factor in oral cancer.

There are marked differences in survival rates for oral cancer between socio-economic groups. The Office for National Statistics records a 16% difference in five year survival from cancer of the tongue between the highest socio-economic groups and the lowest with the lower groups surviving less long. (Cancer of the tongue represents 25% of the cancers of the mouth). The disease is also more common amongst socio-economically deprived social groups and is therefore more common amongst those least likely to attend the dentist regularly.

Nationally, around one in five of all referrals - 21 per cent - for cancer of the mouth are made by dentists demonstrating the potential importance of General Dental Services in screening for oral cavity cancer. A recent Health Technology Assessment^{vii} suggested that opportunistic screening in General Dental Practice of high risk groups may be cost effective although more knowledge is needed about malignant transformation rates and disease progression. There is no evidence that population screening is effective^{viii} Therefore, people should be encouraged to seek regular dental care and, dentists should be encouraged to take full alcohol and smoking histories from patients and should carefully examine the soft tissues during their routine examination of patients.

Birmingham is well served with good quality oral cancer services. Birmingham Dental Hospital, University Hospital Trust and Heart of England Foundation Trust all operate services for suspected cancer. The Rapid Access Clinic at Birmingham Dental Hospital has recently been cited as an example of good practice in a peer reviewed audit of the services. However, as with many oral cancer centres in the country the provision of restorative dental services could be improved significantly.

Issues with regard to oral cancer

- Groups at risk of high intake of alcohol and smoking should be encouraged to seek dental care and be encouraged to reduce their alcohol consumption and quit smoking. Homeless people, those with mental illness, drug abusers and alcohol misusers and people in prison should all be a focus for individual programmes of care aimed at giving them access to good quality oral health services which include signposting to help with smoking cessation and alcohol advice.
- Dentists should be encouraged to take full alcohol and smoking histories from patients and carefully examine the soft tissues during their routine examination of patients.
- Dentists should have easy access to guidelines on making rapid access referral for oral cancer and should undergo regular training updates on the detection of the disease. The population as a whole should be made aware of oral cancer and advised about the risk factors and how to avoid them
- The provision of restorative dental services for people suffering from oral cancer services should continue to be monitored and investment made as necessary.

Section 2e Groups of adults requiring special attention

Medically compromised patients

Advances in dental technology have mirrored those in medical science. The proportion of people now being treated in the community for a chronic disease of some sort is higher than 30 years ago.

The graph overleaf illustrates the trend in the prevalence of long term conditions amongst the general population.

Graph showing those who report long term illness and restricted activity in Great Britain 1972-2002 (General Household Report 2002)



The paragraphs below, taken from the General Household Report (2002) illustrates this clearly;

'Over the lifetime of the GHS, the prevalence of self-reported longstanding illness in adults and children has risen from 21 per cent in 1972 to 35 per cent in 2002. The prevalence increased steadily in the 1970s and early 1980s, continuing to increase gradually until 1996. Since then the proportion has fluctuated between 32 and 35 per cent, with no clear pattern over time.

The prevalence of limiting longstanding illness in adults and children has risen from 15 per cent in 1975 to 21 per cent in 2002. It has shown a similar trend to the prevalence of longstanding illness, although the overall increase in prevalence has been less over time.

The proportion of all persons reporting restricted activity due to illness or injury in the two weeks prior to interview doubled from 8 per cent in 1972 to 16 per cent in 1996. The proportion has since remained relatively stable (15 per cent in 2002).'

This has implications for dental treatment. The need for eliciting medical histories from dental patients is now more important than ever. Understanding of medical conditions and how they might affect treatment planning and what effect they have on the oral tissues is of great importance. Caution about treating chronically ill patients leads some dentists to refer patients who should properly be seen in a community setting. Such patients may not meet referral criteria for specialist services and as a result patients may be referred several times before receiving the dental care they need or in the worst case scenario not receive care at all. This is a particularly serious problem if oral health problems could damage the patients general health; for example in the case of those taking bisphosphonate therapy to treat bony disease such as osteoporosis and bony secondary cancer. In addition, patients with complex multi-system disease whose dentists may be reluctant to treat them for fear of causing a medical problem face difficulty in accessing routine dental care. This has been reported by some consultant physicians.^{ix}

Patients with a disability or severe mental health problem

Gallagher and Fiske^x have drawn attention to reports of lower levels of oral health in a range of patient groups, including people with learning disabilities^{xi}, cerebral palsy^{xii}, epilepsy^{xiii}, multiple sclerosis^{xiv} and psychiatric illnesses^{xv}.

Many patients with disabilities undoubtedly already receive very satisfactory care from General Dental Practitioners but patients with behavioural issues and those with more severe physical disabilities may find access to dental service challenging. The main problems for many disabled people and their dentists are lack of availability of sufficient clinical time and lack of skill in behaviour management. Physical access may be less of a problem since the inception of the Disability Discrimination Act but many dental practices are still situated upstairs and small enough to be exempt from being required to make major modifications to their premises. In accordance with the national initiative to improve NHS dental services, BENPCT supported the investment of capital funding in dental practices to improve access to premises and the patient experience. The PCT approved capital funding to nine practices with the intention of undertaking building works practice premises.

Elderly people

Being elderly itself does not necessarily bring with it dental problems. However, long term illnesses, disability or dementia can all affect both access to dental services and the ability for self care. Dementia alone is thought to affect one person in twenty over the age of 65 and one in five over the age of 80^{xvi}.

As illustrated previously elderly people are more likely to keep their own teeth now than 30 years ago and this brings with it.

Within Birmingham East and North there are 26 nursing homes with residents receiving funded nursing care. It is not known whether all of these residents have access to dental care, and if so from whom and whether it is provided on site or at a dental surgery. Community nurses frequently report difficulty in obtaining regular dental care for their patients. This issue should be addressed.

People with anxiety related to dental treatment

The exact prevalence of anxiety about dental care is not clear. Estimates vary between 10% and 30% ^{xvii} of the population suffer from measurable dental anxiety. This anxiety can range from the relatively mild through to a true dental phobia. However, dental attendance and the range of acceptable treatments is affected across the range of anxiety.

Summary of issues relating to the above groups

The numbers of all those with some sort of special needs is potentially great. This demonstrated nationally by Gallagher and Fiske ^x who estimate that in the UK over 200000 adults have profound learning disabilities and or complex medical conditions. The Office for National Statistics estimate that as many as 9.4 million adults have some sort of disability in the UK and that 20% of the working age population in Birmingham as having some form of disability.

- It can be difficult for patients from these groups to access care from high street practitioners for a number of reasons
- Referrals are not always straightforward and the patient pathway can be complex, confusing and very frustrating
- Strong clinical leadership is required to lead the development of appropriate services and smooth the patient pathway for patients with all types of specific need.

Section 2f: Black and Minority Ethnic Groups

There is little up to date specific information relating to the particular oral health needs of people who belong to the wide variety diversity of minority ethnic groups within Birmingham. Data gathered in the 1990s showed that children from Muslim Asian background where the mother does not speak English had worse levels of decay than their peers. Oral cancer is also more common in groups from the Asian subcontinent. Little specific information is available on other communities.

However, the prevalence of some systemic disease is higher amongst some ethnic groups and this can have implications for both oral health and dental treatment. For example Sickle cell disease and Thalassaemia both have implications for treatment under general anaesthetic, Behcet's syndrome which is more common amongst Turkish and Iranian peoples can present with severe oral ulceration.

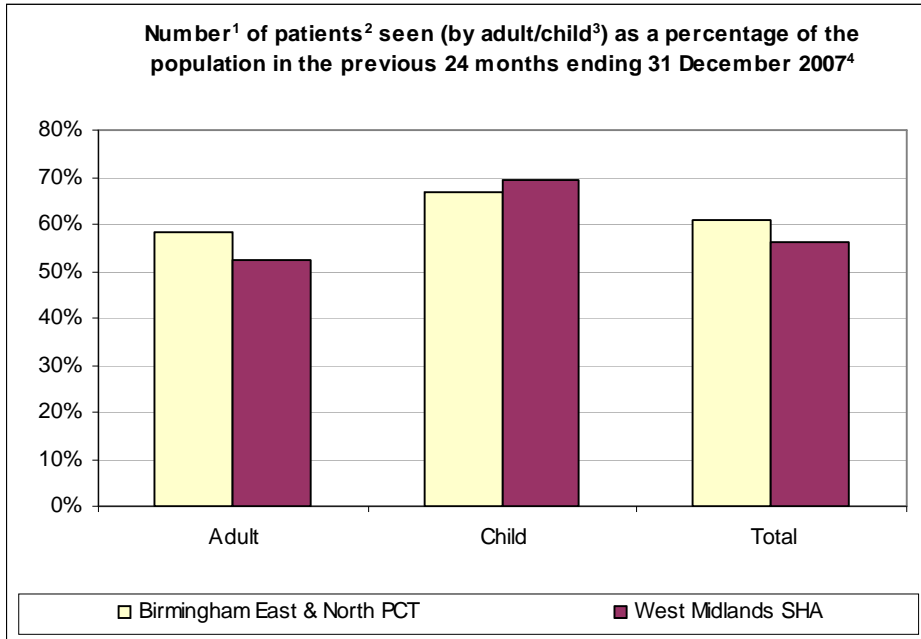
Independent contractors report frustration in trying to provide treatment for people where language is a significant barrier and patients report that communication is common problem when receiving dental care. Equality and diversity training has not been widespread amongst General Dental Practitioners and their staff and misunderstandings can arise as result.

Issues relating to oral health in people relating to Black and Minority ethnic groups

- There is a need to understand the current needs of the communities served by Birmingham East and North better if local commissioning is to be as effective as it could be.
- Equality and diversity training should be made available to General Dental Practitioners and their teams.

Section 2.1 Uptake of Care

This data regarding uptake of care have been published by the NHS Information Centre. These are shown below as a bar chart.



The Dental Practice Division of the Business Service Agency reported that in March 2006 when it was estimated 60.4 %of the population were registered with a dentist. This has remained stable with the latest available statistic showing that 60.7% in December 2007.

All the above figures should be interpreted with caution. They are derived from attendances and registrations of patients with dentists whose addresses lie within the PCT area. They are NOT derived from attendances of patients resident in the PCT area. Some effort needs to be made to clarify the data if we are to move forward positively in regard to access to services within the PCT.

2.3 Public and patient views

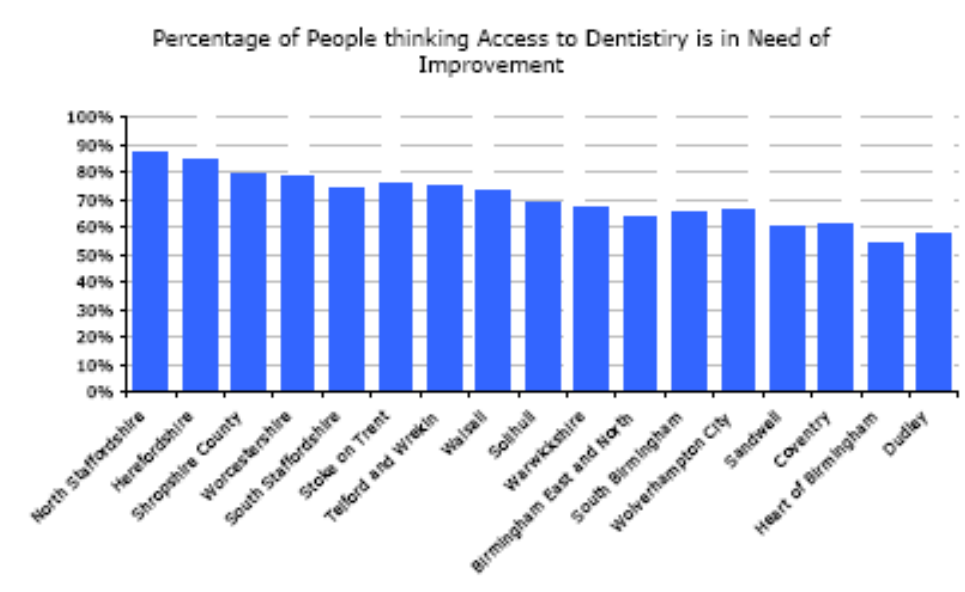
There are several sources of patient and public views which are relevant to the development of this strategy. These are described overleaf:

- The Mori Poll on patient view on NHS dental services commissioned by the West Midlands SHA
- The patient survey programme co-ordinated by the Healthcare commission
- Calls to the Patient Advice & Liaison service
- Results of focus group consultations
- Ad hoc comments from other source

Mori poll

The bar chart below illustrates the level of patient concern expressed about dental services in the SHA area. It is noticeable that people in Birmingham East and North PCT were recorded as being less dissatisfied than in some other PCT areas but over 60 % registered their concern about the state of NHS dentistry.

Bar chart showing results of MORI survey



This poll was inevitably influenced by the adverse press coverage that the new GDS contract received and the publicity campaign run by Birmingham Local Dental Committee which very effectively conveyed local dentists concerns about the contract and suggested that many would be withdrawing from the NHS.

The poster shown below was widely displayed at that time throughout dental practices in Birmingham and was the subject of adverts in the local written media.



In addition to this local campaign, national coverage of concerns about availability of NHS dentistry and dentists leaving the NHS fuelled local concerns and beliefs about the availability of services. In September 2008 The 'Google' search engine registered 32600 results when the search terms 'Shortage NHS dentists' was entered many of which are articles in the national and local press.

Access to dental services in Birmingham East and North was largely maintained during the introduction of the contract. Some contracts were lost and the UDA s attached to these were subsequently re-let within the PCT. However, in the light of continued adverse publicity surrounding funding the availability of NHS dental services it is likely that widespread concern still exists in the local community.

Health care commission surveys

The most recent of the patient surveys conducted by the Picker Institute on behalf of the Health Care Commission was undertaken in 2005. With regard to the experience of dental care five questions were asked. The results for Birmingham East and North are shown below.

Results of Dental Questions posed by healthcare commission survey 2005

Eastern Birmingham

Dental care

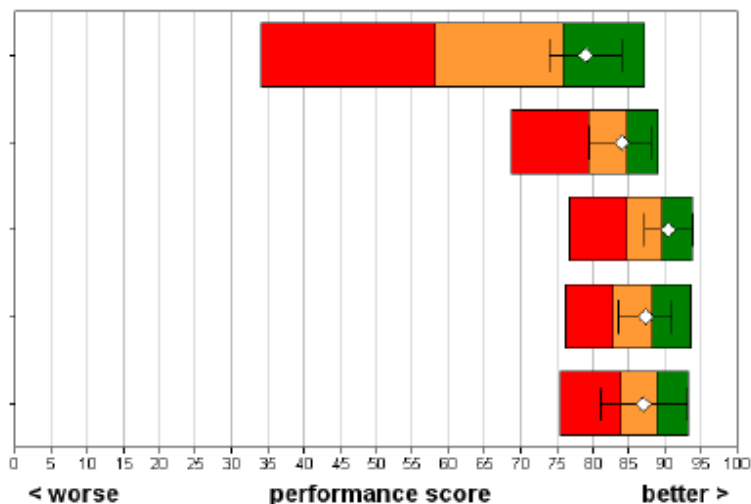
Are you currently on a dentist's list as an NHS patient?

Were you involved as much as you wanted to be in decisions about your dental care?

Did the dentist explain the reasons for any treatment in a way that you could understand?

Did you have confidence and trust in the dentist?

Did dental staff do everything they could to help control any pain you experienced?



North Birmingham

Dental care

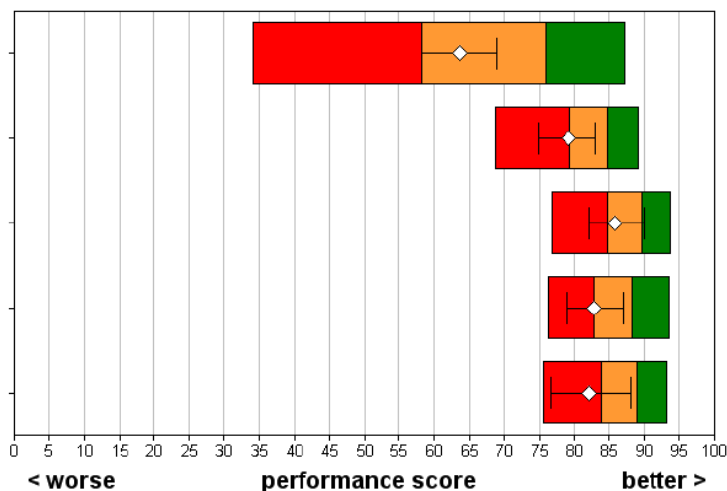
Are you currently on a dentist's list as an NHS patient?

Were you involved as much as you wanted to be in decisions about your dental care?

Did the dentist explain the reasons for any treatment in a way that you could understand?

Did you have confidence and trust in the dentist?

Did dental staff do everything they could to help control any pain you experienced?



It should be recognised that the understanding of what 'being on a dentist's list' meant was weak because of the confusion about the registration period which pertained at the time. Registration with a dentist was abandoned with the introduction of the new general dental services contract so this question could be viewed as a proxy for the level of satisfaction that patients felt in being able to access NHS general dental care. This varied significantly between North Birmingham and Eastern Birmingham. The answers to the other questions were similarly variable.

In 2008, there was only one questions asked in the Healthcare Commission survey on dental care. This was 'Are you able to visit your dentist as an NHS patient as often as you want to?' In Birmingham East and North

54 % of the respondents answered 'Yes'? This put BEN PCT in the amber category of the traffic light system used by the Health Care Commission which puts it in the 60% of trusts not in the lowest or highest categories.

PALs service

During a 'snapshot' period between 1st April 2006 until February 2008 174 enquiries and 6 complaints were made about General Dental Services in Birmingham East and North Birmingham regarding dental services.

These were broken down as follows;

BEN PALS Dental enquiries

Total – 174 (April 06 – Feb 08)

Type of Enquiries / Complaints	Number of enquiries
Access Problems	6
Charges enquiries	21
Poor Service	33
Seeking an NHS dentist	71
Domiciliary services	17
Orthodontic	14
Other	12

The number of complaints were broken down as follows;

BEN Dental Complaints

Total – 6

Type of Complaints	Number of complaints
Out of hours service	
Charges	2
Poor Service	1
Orthodontics	2
Other	1

Focus group consultations

In preparation for developing dental services in Birmingham, some groups were identified as potentially having more problems with access to good quality oral health care than others. The first groups identified were elderly Afro-Caribbean residents of Birmingham, new migrants and homeless men. This programme of focus groups will need to be extended progressively to gain a more comprehensive view of patients needs and views.

Most people in the groups were satisfied with the availability of dental service. However, a Somali group were the least satisfied with both the availability and quality of dental care. Each of the groups expressed confusion about the payment for dental care and in particular the difference between private and NHS care. Prevention of dental diseases were seen as important and the majority of participants felt that prevention should focus on helping parents to improve the oral health of children. More information was requested on the benefits of fluoridation of water.

As a follow up to this investigation in two further focus groups of Yemeni and Somali men and women were consulted on their attitudes to dental health care ^{xviii} Both groups were found have a basic understanding of available services and treatments but language and communication issues played a large role in preventing deeper understanding on treatment options available.

Barriers to seeking dental care included:

- language problems
- fear of the dentist
- mistrust of the dentist
- lack of flexibility in arranging appointments,
- lack of child friendly facilities.

Summary of issues relating to patient views

- There is a belief that oral health is important amongst most population groups
- There is a widespread view that NHS dental services are not easily available.
- There is a fear of dentistry and a mistrust of dentists amongst some groups in the population.

2.4 Current Status of Dental Services

2.4.1 Primary Care

- General Dental Services

Service capacity

Currently, there are 56 General Dental Practices in Birmingham East and North and over £14 million is ring-fenced for use in primary dental care. £1.3 million is available for developments in this year.

The individual size of provider contracts varies markedly from £11,000 to £830000. A number of providers work nearly or completely single handedly.

The providers are spread relatively evenly around the localities within the PCT. In dentistry as opposed to medicine it is more the norm for people to travel longer distances or to access treatment close to their place of work. The frequency of visits to a dentist is quite limited. The result is greater cross boundary flows.

Distribution of dental activity

Ward	000 UDAs	£Million
Acocks Green	84	2.4
Bordesley Green	21	0.5
Erdington	10	0.2
Hodge Hill	26	0.5
Kingstanding	44	1.0
Oscott	33	0.7
Perry Barr	19	0.4
Shard End	41	1.0
Sheldon	23	0.8
South Yardley	96	2.2
Stechford & North Yardley	22	0.5
Stockland Green	56	1.2
Sutton Four Oaks	25	0.6
Sutton New Hall	3	0.7
Sutton Trinity	71	1.7
Sutton Vesey	11	0.2
Tyburn	49	1.3
Washwood Heath	52	1.1
Total	686	17.0

Service Effectiveness

Access to dental services is not currently a major problem in BEN PCT. However, as demonstrated earlier there is a national and local perception that there is a shortage of NHS dentists. However, in terms of effectiveness, access is not the only issue to be considered. High quality of dental care is key to improving oral health. The consensus of professional opinion is that treatment plans should be well thought through and

restorations placed to a high standard because inappropriate treatment plans and placement and replacement of restorations have the potential to damage oral health.

If a dentist is under pressure to complete a treatment target or get more patients into the practice without adequate capacity to undertake the additional work, standards of care are likely to drop. However, if targets did not exist for improving the uptake of care, the evidence of the past 40 years suggests that uptake will not improve. The task of the PCT is to balance the need to increase the uptake of care and to ensure the care is undertaken to a high standard. The PCT needs to consider appropriate incentives to promote high quality holistic dental care based on good treatment planning. Another issue relating to service effectiveness is the level of cross boundary flow.

The table below illustrates the PCTs from which Birmingham East and North residents gained their dental treatment during the period April 2007 –December 2007

Table showing the PCTs from which BEN residents accessed dental care April 2007-December 2007

Contract health body (1)	Number of Patients Treated (2)
Birmingham East & North PCT	99,887
Heart of Birmingham PCT	15,133
Solihull Care Trust	8,055
South Birmingham PCT	4,480
Non Neighbouring Bodies	2,254
Warwickshire PCT	1,812
Walsall PCT	1,054
South Staffordshire PCT	867
Total	133,542

It can be seen from this table that approximately 34000 BEN residents accessed dental care outside of the PCT boundaries. This represents 24% of BEN residents who accessed care during this period. Birmingham East and North dentists treated residents of other PCTs as shown below. As expected the net inflow is larger than the outflow with more residents of other PCTs seeking dental care in Birmingham East and North. They represent approximately 38 % of patients seen by BEN dentists. This is illustrated overleaf:

Patients treated in BEN PCT by PCT of Residence

Patient's home health body (1)	Number of Patients Treated (2)
Birmingham East & North PCT	99,887
Solihull Care Trust	18,707
Heart of Birmingham PCT	14,557
Unknown Health Body	7,430
Walsall PCT	6,459
Non Neighbouring Health Body	4,952
South Birmingham PCT	3,603
South Staffordshire PCT	3,446
Warwickshire PCT	1,857
Totals	160,898

This picture of net inflow of patients is replicated over the three Birmingham PCTs. This reflects the status of the City of Birmingham a major hub of the West Midlands conurbation. Of more concern is the figure relating to uptake of care amongst BEN residents. If the numbers of patients resident in Birmingham East and North treated in 9 months is extrapolated to a full year, those recorded as receiving treatment would only represent 41% of the population.

With new investment, capacity to see new patients will increase in Birmingham East and North. However, it will be necessary to encourage PCT residents to take up this service. We also need to understand the barriers that exist to prevent them from doing so.

Effectiveness of the new contractual arrangements

There has been considerable negative comment about the new GDS system and the legacy of professional disenchantment with the contract will have implications for the relationship between the PCT and local practitioners for some time to come but all payment systems have the potential to distort the delivery of care. Both fee per item of service and capitation schemes have been tried in dentistry and the former had the potential to encourage over treatment^{xix}, and the latter under treatment^{xx}.

The current scheme operates on a scheme of units of dental activity. 1 unit is allocated for a treatment plan and simple preventive work, 3 units for straight-forward restorative work such as fillings and 12 units are allocated for treatment requiring laboratory work. The units are allocated per treatment plan so if a patient needs one filling or five the dentist will claim for 3 units, similarly for crowns and other laboratory work. The value of the UDA in any one practice reflects the value of claims submitted under the previous fee per item of service system and therefore varies from practice to practice. There is a strong tendency amongst GPs to view 1 UDA for treatment planning as signalling its relative importance and spend potentially spend a relatively short time in undertaking this element of care which is in reality key to the success of subsequent treatment.

The Department of Health point out that there are relative gains and losses in any one practice. Some treatment plans are very simple and some very complex. It is suggested that by looking across the whole, the dentists can gain enough time to do complex work because he or she is being relatively well paid for simple work. Dentists respond that this may be true in a practice with a stable patient base where patients are recalled every 6 months but if they follow the NICE guidelines on patient recall intervals, the number of simple treatment plans is reduced and the more complex ones increase.

It is important for the PCT to recognise the debate and work it through with practitioners. The role of the PCT is to maximise the potential benefits of the GDS contractual arrangements and minimise the dis-benefits. General Dental Practitioners have voiced the need to develop a positive relationship with the PCT to contribute to this sort of work. One issue for the PCT is how to limit the potential distortion inherent in the low value ascribed to treatment planning whilst not overpaying for simpler treatments. Most dentists would argue that the NHS does not overpay for any item but the 'correct' value is difficult to determine.

Cost effectiveness

Birmingham East and North PCT is allocated £14.8 million for primary care dentistry. This sum is ring-fenced until 2011.

The population of Birmingham East and North is 437,000. This means that on average approximately £35 per person is available to the PCT to maintain their oral health. If we aim for 50 percent take up of care the average cost of a treatment plan would £70. If we increase the goal to 75% it is £60 per patient.

Insurance companies pay dentists between £200-00p and £230-00p per patient to undertake their care. These patients tend to be already well motivated and have a history of regular dental care. However, NHS dental care has an advantage in that its large patient base will ensure that patients whose individual needs are great may be

balanced by those whose needs are less. Dentists point out that there is a higher financial risk to the dentist in taking on new patients in a deprived urban area as the needs may be high.

Given there is little lee-way in terms of availability of resource and that most patients would wish to be treated fully and correctly first time rather than have repeated treatments, the aim should be to fully engage the population in maintaining their oral health to avoid unnecessary intervention and ensure that treatments given are of a high standard to avoid unnecessary repeat treatments with their inherent risk of leading to more complex and even less affordable work later.

The philosophy underpinning the commissioning of dental services should be to encourage prevention and self-care, encourage proper treatment planning which also should engage the patient and to encourage good quality treatment avoiding unnecessary intervention, supervised neglect and repeat treatments.

Quality of care

There is a comprehensive clinical governance framework which is part of the NHS GDS contract and this is monitored as part of the contract management process both in year and at year end. However, like many frameworks it tends toward checking the mechanistic elements of care rather than the quality of treatment planning, treatments or the holistic quality of care provided by the practice. From the patients point of view it is possible that a practitioner fulfils the requirements of the framework but does not provide the quality of care that they expect or require. It is also possible that from a public health point of view oral health is not improved significantly by the application of the framework and from the dentists point of view it doesn't recognise or reward the more in-depth aspects of service quality and could lead to encouraging a 'lowest common denominator' approach.

The PCT has agreed a Patient Advice and Support mechanism with the LDC but this has been little used recently and needs review. Initiating a pilot of a dental practice accreditation scheme similar to that being tried elsewhere in Birmingham is being actively discussed. The decision to progress with this or explore other options is dependant on engaging local dentists in the process.

Infrastructure

Dental Practices in BEN are often housed in properties either owned or leased by general dental practitioners themselves. All practices have been surveyed recently for compliance with the Disability Discrimination Act and funding from monies made available by the Department of Health has been agreed for improvement where necessary.

This model of general dental provision is increasingly out of step with other health provision. It would seem sensible to move towards a mixed economy for the future whereby there are General Dental Services available to all the population both within and outside health centres.

Workforce

The dental workforce in the General Dental Service in Birmingham is heavily dependant on Birmingham University graduates. See table below supplied by Birmingham Dental School.

Table 9. General Dental Practitioner numbers

Former Strategic Health Authority Area	Number of Dentists	Dentists graduated from Birmingham	% Graduated from Birmingham
Birmingham and Black Country	872	410	52
West Midlands South	685	301	44
Shropshire and Staffordshire	561	168	30
Total	2,118	879	41

Note: The number shown is the actual number of practitioners working in the area, not the number of contract holders (which is higher as many GPs hold more than one contract)

These figures may have changed a little in the last two years but the overall picture is unlikely to have changed significantly.

This is important as Birmingham Dental School and Hospital will face an uncertain future if the building is not replaced^{xxi}.

General Dental Practitioners have voiced the need for better provision of continuing professional development for Birmingham dentists to help them meet their mandatory requirements.

With regard to Professionals Complementary to Dentistry (dental nurses, therapists, hygienists and technicians), there are a variety of outstanding issues.

All groups of staff can be difficult to recruit and retain. There are opportunities for development of staff which would include extending the provision of health promotion and providing semi- specialist oral hygiene services which could be both attractive to staff and enhance the service provided for the population.

- Salaried Dental Service

Heart of Birmingham hosts the pan-Birmingham salaried dental service which serves all three PCTs within the city.

The service is currently commissioned to see children and adults who otherwise would have difficulty in accessing dental services. In practice, this means that the service concentrates its efforts on young children with high treatment needs who do not access care elsewhere, children and adults with physical and learning disabilities, people with mental illness including those in the 'Reaside' secure unit, offenders in HM prison Birmingham, Winson Green, and elderly people who are housebound. There are 6 clinics in Birmingham East and North PCT and the service as a whole has 30000 patient contacts in one year.

Service effectiveness

The salaried dental service is nationally recognised as being well managed being one of the first to convert from a Community Dental Service to a salaried Personal Dental Service in 2000. It has a focus on children on adults with additional needs and flexibly responds to requests for care which cannot be met within the GDS. However, given the nature of the patients seen and the time taken to see them it is a resource that should not be needlessly directed towards routine care of patients who could be accommodated within the General Dental Service. Its role is, and should be, more specialised but there is room for further development in this direction.

Service Quality

The salaried dental service operates a clinical governance scheme within the PCTs framework. It has made use of the Dental Reference Officer Service in the past as part of this scheme but this may need to be revisited as that service changes to meet new needs. There are regular staff meetings, audits and learning opportunities and events and appraisals are conducted for all staff.

Work force issues

Recruitment to the salaried dental service presents an on-going problem at the higher grades although this is less of an issue with the dental officer grade.

- Primary dental Care provide by Birmingham Dental Hospital and School.

In addition to the primary care services provided by the General Dental Service and the salaried dental service. The walk in attendances is illustrated overleaf.

Table 7. Source of Patient Activity

Full Year 2006/07	Walk-in Attendances	Outpatient Attendances	Day Cases
Total 2006/07	35,486	71,508	1,586
Proportion from:	%	%	%
Pan Birmingham	84.2	65.3	68.6
Black Country	5.4	9.3	10.2
Shropshire & Staffordshire	2.7	8.5	9.0
Coventry & Warwickshire	2.1	6.7	5.2
Hereford & Worcestershire	3.2	6.4	4.4
Other	2.4	3.8	2.6

It can be seen that nearly 30,000 walk-in attendances are provided each year for the Birmingham and Solihull PCTs. Many of these patients are redirected for student care but there is not currently a clear mechanism for redirecting those who are not suitable for student regular care to an NHS practitioner elsewhere.

Service effectiveness

The Dental School and Hospital provides a valuable urgent care service which supplements that provided by the Personal and General Dental Services and has the advantage for the patient that it is entirely free of patient charge. However, the relationship between high street primary dental care and primary care in Hospital is not seamless. In addition, as student numbers have temporarily grown at Birmingham Dental School there is reported to be a shortage of suitable patients who are volunteering for their dental care to be undertaken by a student under the supervision of a member of staff.

Quality of care

As with the salaried PDS the Dental Hospital operates a clinical governance scheme within the framework laid down by South Birmingham PCT of which the dental hospital is a part.

Summary of issues relating to Primary care

- There is less than optimum take up of services by the population of Birmingham East and North
- General Dental Practitioners are disaffected regarding their relationship with the NHS but feel that they would like a closer relationship with the PCT
- The quality programme must capture the elements of care such as treatment planning and effective prevention which could make a difference to oral health
- There is insufficient interaction between the three main groups of providers of primary dental care to make for a seamless service for the patient
- The workforce is heavily dependant on the continuation of the presence of the dental school and hospital as a provider of new graduates

- There is insufficient development of the dental team to deliver some aspects of health promotion and dental care.

Secondary and tertiary dental care

Secondary dental care is provided for BEN residents from a number of providers but mainly from Birmingham Dental Hospital, Heart of England Foundation trust and University Hospital Trust Birmingham. The Dental Hospital managed by the South Birmingham PCT provider arm provides the widest range of services covering all the main dental specialities.

These are:

- Restorative dentistry, including the mono-specialities of Periodontology, Prosthodontics
- Oral Surgery
- Orthodontics
- Paediatric Dentistry
- Oral medicine
- Oral Pathology

The Dental Hospital is conveniently situated for Birmingham residents and this is reflected in the referrals and attendances for all specialties at the hospital. The following charts were prepared in support of the development of the outline business case for the new Dental School and hospital and are a result of research undertaken by the University of Keele.^{xxii}

Charts showing attendances by postcode across the West Midlands.
The light areas on the map indicate higher attendances

Figure 1. Prevalence of Attendance by Postcode

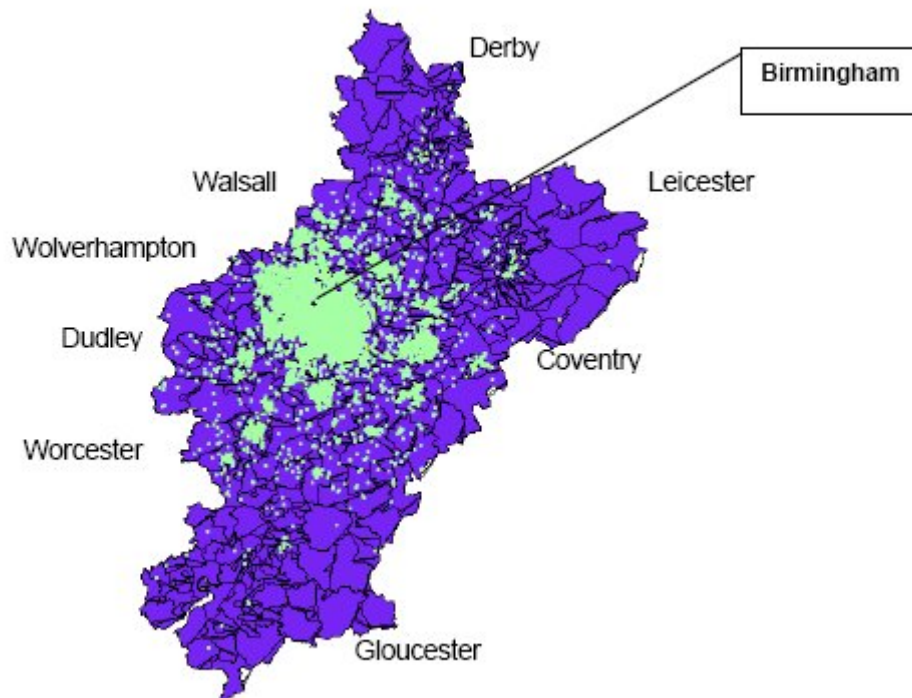


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Hereford & Worcestershire	3.2	6.4	4.4
Other	2.4	3.8	2.6

Consultants and managers at the hospital relate that many referrals across the speciality boundaries received are inappropriate for a variety of reasons.

Research prior to 2006^{xxiii} funded by the Dental Public Health section of the Public Health Network has concluded that the reasons for referrals, ranged from economic through to lack of knowledge and skill on behalf of the referring practitioner.

There is strong anecdotal evidence that referrals have increased since the introduction of the new contract. As yet this has not been definitely substantiated due to data collection and collation problems at the Dental hospital. However, given the disaffection of the profession over the introduction of the new GDS contract, it is more than plausible the dentists do not feel motivated to take on additional more complex work when there is an alternative available to them of referral to secondary care

General Dental Practitioners report that they would welcome additional support in specialist services

Effectiveness of secondary care services

Birmingham Dental Hospital has to meet the same 18 week referral to treatment criteria as every other secondary care provider. This undoubtedly improves access to services in many ways but because most of the specialities within the dental hospital work from a relatively small work force pool, the ability to recruit additional staff members to undertake additional work to reduce the waiting lists is limited, space within the hospital is also limited so physical capacity is also an issue. If the waiting time cannot be reduced to 18 weeks because of these constraints it is likely that in some specialities the dental hospital will raise the bar for acceptance of referrals.

Without the development of alternative routes of care for patients, there is a risk that the only alternative for some patients will be to seek care privately or not be able to access it at all.

In addition, some patients may now be discharged to a primary care dentist who does not necessarily have the wherewithal to treat the patient on to the standard required to maintain their oral health.

Quality of care

The specialities within the dental hospital operate to strict clinical governance guidelines, adhere to infection control procedures common throughout the secondary care sector and have incident reporting

procedures in line with the best practice; it is at the interface between secondary and primary care that patients are most likely to receive a less than excellent quality of care.

If a dentist refers a patient who he or she feels is beyond his skill to treat but the patient is not accepted for care at the dental hospital there is currently no systematised way of ensuring that the patient accesses a good quality of care. There are no recognised routes for redirecting the patient to specialised care in the

community, there is no way of ensuring that the referring practitioner is offered training and support to develop skills if appropriate, there is no way of collating data for rejected referrals to develop a case for alternative provision.

Infrastructure issues

An Outline Business Case has been submitted to the Strategic Health Authority to replace the current building with a new build. The case is based on the following: The current facilities are old and in need of significant investment to tackle the backlog maintenance liability (£12.5m at 2004 prices). In addition, the current facilities are cramped and the overall layout is not conducive to the delivery of modern dental clinical and teaching services.

The key shortcomings of the current services and facilities are summarised as:

- Without substantial improvements there will be severe difficulty in recruiting both hospital and university staff to an isolated unit unable to provide 21st century facilities for treatment, research, teaching;
- Expansion of training in any members of the dental team cannot take place within the restrictions of the current facilities;
- The option to invest in additional specialist or primary care services within the building to meet changing requirements does not exist within the current facilities;
- Eventually if there is no redevelopment it is likely that the Dental School and Hospital will close.

Workforce issues

Most of the specialities within the Dental Hospital and School are small nationally and are dogged with the issues which inhibit robust services. Succession planning is difficult, skill mix is hard to develop and the differential between remuneration of basic career grade posts and the earnings in General Dental Practice can be damaging to recruitment.

With regard to PCDs the Dental Hospital provides training for dental nurses, hygienists, therapists and technicians. Although the career structure is clear and within the agenda for change programme again the differential between remuneration within the hospital and outside can be negative particularly with regard to hygienists and therapists

Activity

Patients within the Birmingham area have higher access rates to secondary dental care than other areas in the West Midlands as shown in the table below which shows the access rates by the old SHA areas in three of the speciality areas provided by the Birmingham Dental Hospital.

Table 15. Access Rates (attendance per 10,000 of the population)

	West Midlands South	Shropshire Staffordshire	Birmingham and The Black Country
Restorative Dentistry	2.64	2.58	6.20
Periodontics	1.46	1.02	2.46
Oral Medicine	1.08	0.79	4.64

Over time this is predicted to increase as shown overleaf:

Table 17. Forecast Clinical Activity

Activity	Out-turn 2005/06	Out-turn 2006/07	Contracted 2007/08	Forecast 2011/12
Walk-in Attendances	37,671	35,486	37,671	37,671
Outpatient Attendances				
Teaching Clinics	26,528	27,324	26,528	26,528
Consultant Clinics	46,275	44,184	38,101	75,035
Day Cases	1,676	1,586	1,589	1,676
Total	112,150	108,580	103,889	140,911
Number of Dental Chair Spaces	178	178	178	165

(Note: Contracted figure for 2007/08 excludes Non Contract Attendances and Waiting List Initiatives; Forecast includes 6 Dental Chairs within the City Centre Outreach Facility)

General Anaesthetic services

General Anaesthetic services are an important part of services for people suffering from acute infection which does not respond to antibiotic treatment, some severely phobic patients, and some people with disabilities and children who cannot co-operate with extractions under local extraction. General anaesthetic services for children are supplied by Birmingham Dental hospital with support from Birmingham Children's hospital but since dental General Anaesthetics sessions can no longer take place at a site without intensive treatment facilities in case of emergency the dental hospital does not operate a GA service on site. A service for booked patients is commissioned once a week at a private hospital in Edgbaston Birmingham but there are no emergency services available here. Such emergency services are provided through the acute hospitals in Birmingham. There is anecdotal evidence that this does not always work as smoothly as it could and a review of the provision of GA services is now necessary.

Issues in secondary dental care

- There is strong evidence of a substantial increase in referrals to secondary care over the past few years which may have accelerated with the introduction of the new General Dental Services contract
 - The quality of referrals does not always allow proper prioritisation of patients
 - There is lack of clarity around which patients might be accepted for secondary care
 - There is a gap in the NHS dental service for conditions which are perhaps too complex for some individual general dental practitioners to treat in their own practice but are not suitable for referrals to a consultant led specialist service.
 - All the above can lead to be patients 'bouncing' round the system before receiving the treatment they need

- With regard to Birmingham Dental hospital and school there is a complex balance to made between maintaining the flow of referrals for teaching purposes and not overloading the capacity for secondary care
- The lack of additional capacity in some speciality areas makes meeting the 18 week target between referral and treatment challenging
- There is a need to review and the commissioning and provision of General Anaesthetic services.

Out of Hours service

The Out of Hours emergency dental service is commissioned from the salaried dental service and is run from premises at Birmingham Dental Hospital on a pan- Birmingham basis. Patients access the service via a specific phone number and are then triaged by NHS Direct. Attendances run at between 7 and 12 patients per session in the evenings and mornings at weekends and Bank holidays. Additional services were commissioned from a local practitioner at Christmas time but apart from that there has not been a capacity issue.

The Local Dental Committee have raised a number of issues about the Out of Hours service. Some of these have been resolved and the LDC is now canvassing opinion again from its members on whether they think the service is satisfactory. There have been very few patient complaints about this service.

Issues relating to Out of Hours

- Patient complaints and GDPs views need regular review with regard to this service.

Contribution of Private Dentistry to Dental services

Private dentistry is not an option for many patients In Birmingham East and North. The market does not support a great deal of private primary care dentistry and most practitioners in Birmingham East and North offer NHS care. However, it is difficult to find out how much private dentistry does take place PCT dentists do not have to declare the amount of private care they undertake.

Cosmetic dentistry is now very popular but the public is not always aware of the risks and benefits of such treatment. Some treatments e.g. bleaching of teeth are carried out outside of the dental surgery by non-dentists. When treatments go wrong the NHS can be called upon to rectify the situation.

Patients who call the PALS service are sometimes under the impression that some secondary care services can only be provided by paying privately. Although this sometimes is the case because most cosmetic dentistry is not available on the NHS ,some root canal therapy, extensive scaling and polishing of teeth and orthodontic treatment for patients with an occlusion graded with an Index of Orthodontic Need of 3.6 and above should be available under the NHS.

Extensive scaling and polishing presents a particular problem because there is very little availability of dental hygienists employed in the NHS to undertake this service in Birmingham East and North. Anecdotally, this can lead to referrals to the consultant led periodontology service at the dental hospital which are returned as inappropriate. The PALs service is sometimes contacted by patients who complain that they are told that the services of a dental hygienist are not available under the NHS or that to receive specialist gum services the only option available is to be referred for a private consultation with a private specialist.

Root canal therapy presents a slightly different problem. Modern techniques in root canal therapy require investment in specific and quite extensive equipment and training. Dentists often feel that the time taken to provide root canal treatment is not properly remunerated under the NHS. This might lead to a rise in extractions rather than restoration.

Finally, oral surgery can present a particular challenge to dentist who qualified after the epidemic of dental caries passed. They have generally had less exposure to routine extractions and although they possess restorative skill unheard of by their forebears, they are not as familiar with techniques which older dentist would have considered being routine. This can result in referral for private treatment if the patient cannot access care within the NHS.

Summary of issues relating to private dentistry

- There is patient confusion about what is and is not available under the NHS.
- There is confusion amongst the public of the risks and benefits of cosmetic dentistry
- Some services which should be available under NHS contract are in reality only available under private contract.

Health Promotion and Health Improvement Programmes

The small oral health promotion programme in BEN has centred on very young children. A part-time pan-Birmingham oral health promotion co-ordinator is part of the Dental Public Health team and works with health visitors, children's centres, local children's groups and others who directly work with children. In addition this worker has provided drop in advice sessions at the central library in the health exchange there. This is part of a pan-Birmingham initiative.

In addition to this programme, University Hospital Trust and the Birmingham PCTs collaborated over several events were held during Mouth Cancer week in November 2007 and 2008 which culminated in a providing screening for oral cancer from a mobile health promotion unit on the Birmingham Bull Ring Markets site. Stall holders collaborated with this initiative in 2007 which gained favourable press coverage.

As noted earlier, there is little local information on adult dental health and there is a particular dearth of oral health information about socially excluded groups.

The current oral health promotion programme does not cover encouraging dental attendance amongst adults nor does it entirely cover the needs of the young population

Issues relating to oral health promotion

Issues relating to oral health promotion in Birmingham East and North

- More information is needed on the oral health status of adults and in particular marginalised sections of the community
- Increased investment is needed in the strategic capacity for oral health promotion
- An oral health promoting General Dental Practice scheme should be developed
- Good quality information should be provided to the local population on achieving oral health and in particular promoting dental attendance.

Section 3 : A Five Year Vision for Oral Health in Birmingham East and North

For the PCT and its contractors

- Oral health should be part of the mainstream concern for the PCT.
- Capacity to commission for oral health should be regularly reviewed by the PCT
- PCT will need to work in close partnership with its providers both in secondary and primary care whilst ensuring that achieves best value for money in terms of quality and cost effectiveness of services.

- The PCT will need to develop its relationship with GDPs building on the positive work that has been done so far.
- Commissioning oral health promotion will be part of the mainstream activity of the PCT and integrated with all other appropriate health promotion activity using a common risk factor approach.
- Promoting general health in General Dental Practice e.g. smoking cessation, will be a mainstream activity embraced by the dental team who will be rewarded for this activity
- Dental teams will take a reflective and pro-active part in continuous quality improvement and will be rewarded for doing so.
- Dental attendance will be promoted for all groups.
- There will be clear protocols for referral to specialist services including criteria for acceptance that will be clear to referring practitioner, specialist provider (in hospital or on the High Street) and the patient.
- Services provided by specialist providers will adhere to clear quality standards and specialist providers will usually be part of clinical networks which will help to regulate and maintain quality of care.

For the population of Birmingham East and North

- There will be an overall improvement in oral health for all groups.
- There will be access to good quality dental care for all groups in the community and the PCT will encourage maintenance of quality of care by working in genuine partnership with general dental practice.
- Patients and the public will play an integral part in developing quality standards and monitoring quality of care.
- Patients will know how to access services and be helped to make a choice between providers of dental services
- Patients will have a clear understanding of what treatment is available under the NHS and what is not and where applicable why it is not .
- Patients will be clear about how the patient charge system works and what the appropriate charges are.
- When referral for specialist care is necessary, patients will understand why they need to be referred and have a choice of providers,
- Patients will move seamlessly between services and wherever possible the patient will have a choice of being seen as close to home or work as is acceptable to them
- Patients with particular needs relating to social, psychological , medical or physical will all have access to high quality services which respect their needs and meet them appropriately

3.2 Oral Health Goals

3.2.1 Children

- In five years time oral health amongst five year olds should have been improved by 4 percentage points in Eastern Birmingham from the 35 percent of five year olds affected by decay in 2005/6

3.2.2 Adults

- All adults will have access to NHS dentistry if they want it. The percentage of Birmingham East and North residents accessing care anywhere within the NHS will be raised to at least 60%.

3.2.3 Elderly people

- All elderly people in residential and nursing homes will have been offered regular dental care and have a named dentist.

3.2.4 People with disabilities and or medically compromising conditions

- All those who have disabilities or medically compromising conditions will have access to dental services

3.2.5 Vulnerable adults and children

- Homeless people, looked after children, offenders and drug mis-users will all have ready access to care from high quality providers of service

3.2.6 Black and minority ethnic groups

- The particular needs of individual communities will have been assessed and commissioning strategies modified to meet the unmet needs identified.
- The regular programme of local oral health needs assessment will include regular reviews of the needs of Black and minority ethnic groups.

Section 4 - Commissioning strategies

All the strategies outlined below should be underpinned by ongoing needs assessment. In addition to the regular epidemiological assessments undertaken for children, this programme should include specific exercises to determine needs amongst groups who are least likely to access services including; vulnerable children, children with disabilities, people with special medical and social needs and people with disabilities (including vulnerable elderly people). Patients' views should be integral to the needs assessment process.

4.1 Health Improvement

- Ensure that Birmingham's water supply continues to be fluoridated.
- A common risk factor approach to oral health promotion should be developed.

Oral health input to other relevant health promoting programmes should be strengthened. In particular, the oral health input to programmes aimed at promoting breast-feeding, decreasing teenage pregnancy, tackling obesity, reducing smoking should be reviewed and potential for including oral health information will be thoroughly assessed. Individual programmes should be commissioned to be integrated into each of these themed areas and as other themes emerge, oral health promotion should be integrated into them in turn.

- The redundant school inspection programme should be replaced

A new scheme based on targeted telephone contacts with parents of children aged three and four years. This scheme would be based on the successful promotion of immunisation and cervical cytology schemes elsewhere in the City. The children would be offered appointments with a dentist local to them either in the salaried dental service or a GDP who adheres to quality standards agreed with the PCT

- General Dental Practitioners should be engaged in the implementing the 'Delivering Better Oral Health' programme.

This engagement should be commissioned with support from the Dental Public Health team.

- General Dental Practitioners should be fully engaged in the PCT smoking cessation programme.

This should be followed by engagement with other appropriate programmes of health promotion. Again this should be commissioned with support from the Dental Public Health Team.

- A public information campaign should be commissioned to encourage dental attendance

To overcome the public belief that NHS dentistry no longer exists to any great extent, a public information campaign for Birmingham East and North residents should be commissioned to promote dental attendance. This should include use of the local media and will include information on patient charges and what treatments can be expected of the NHS and what not.

- An ongoing programme to raise awareness of oral cancer should be commissioned.

In terms of prevention this programme should focus on the younger population and will work with community alcohol and drugs programmes, services for homeless people, and those in prison. This should supplement the annual campaign to raise awareness which is sponsored nationally by the British Dental Health Foundation. In addition there will be a background programme to facilitate earlier detection of disease by informing the public and professionals of the signs and symptoms of early cancer.

- Oral health should be included in all care-plans.

The PCT should work with partners in health and social care to raise the awareness of oral health, facilitate an audit of the current position, and work towards the goal of the inclusion of oral health in all care plans. This should be supported by training programmes for carers and the provision of quality assured services both in the community and in hospital where necessary as day stay for sedation and general anaesthetic services are appropriate.

- A one-off programme to raise awareness of the risks and benefits of cosmetic dentistry should be commissioned and evaluated

A campaign run in partnership with the Local Dental Committee should be implemented to raise awareness of the risks and benefits of cosmetic dentistry.

4.2 Service Delivery

Primary Care-Quality and Access

In order to address both quality and access to dental services, the PCT should continue to actively explore the development of a Dental Practice Accreditation scheme whereby practices are accredited having

achieved clear quality standards set by the PCT on behalf of the public, after consultation with patients and dentists.

The scheme is based on unlocking dentists' capacity to develop continuous improvement within their practices by rewarding them both financially and by recognition from the PCT. In terms of the overall expenditure on dentistry within the PCT, the sums of money involved are relatively small, but the return in the form of enhanced relationships between the PCT and providers; dental practitioners and their teams' job satisfaction; and patient satisfaction with their dental care, are potentially large.

Accredited General Dental Practitioners would receive a remuneration package to reward them for providing in depth treatment planning services, preventative services and participating in general and oral health promotion programmes. The scheme would have the following features:

The overall aim would be to ensure that patients can be assured that dentists are providing services which they can trust and dentists would be able to provide services they can be proud of. The PCT and dentists should be able to develop a business relationship firmly based on greater trust and the desire to move towards a common goal of improving the health of the population. An initial assessment would be made of the practices strengths and weaknesses and a funding made available to assist the practice to reach the standard required. The initial assessment would be transparent to the dentist and involve dentists, patients and managers. A plan and a timescale would be agreed to meet the new standards and the practice would become accredited and display a certificate to that effect. A recurrent sum would then be paid to practice to maintain the standard required. If the standard was not met the additional funding would be withdrawn.

The basic standards required would be:

- Practice premises will be attractive, obviously clean, appropriately equipped, and adhering to all legal requirements including the Disability Discrimination Act and the staff friendly, welcoming and accommodating.
- Every practice will be computerised and the majority will have access to the NHS net. This will ensure that communications between practices, patients, secondary care providers and the PCT are all as efficient as possible.
- At the first appointment, a patient will have their oral health needs assessed, taking into account their social circumstances, their medical history and their dental history. A treatment plan will be developed in conjunction with the patient and choices will be offered where appropriate with information to help the patient make their decision.
- The dentist and patient will agree a goal for the patient's oral health and progress towards that goal will be measured at the end of the treatment plan.
- Patients will be able to trust that the dental advice they receive is thoughtfully given and appropriate to them. They will be able to ask for second opinion without feeling that they will lose their place on the dentists list.
- Patients will be involved in both the practice accreditation process and in maintaining and monitoring standards in accredited practices via patient forums and encouragement to actively use compliment and complaint procedures.

The scheme could be promoted to patients as part of a general campaign to encourage dental attendance and would enable dentists to promote their own practices as being of a high quality. Patients would also be able to choose a dentist who could provide services in which they have a particular interest.

It is envisaged that all practices would be encouraged to achieve accreditation and as the standards are achievable and funding is available, it would be expected that eventually most would do so but to enable

the Trust, General Dental Practitioners and patients to assess the benefits of the scheme, piloting the programme would be an essential first step.

This development should be progressed in tandem with commissioning additional units of dental activity to expand the capacity of dentists to see more patients.

Commissioning and Developing Robust Practices for the Future

In order to address issues that have arisen in the past when small practices close or single handed practitioners or are affected by illness or incapacity, the PCT will encourage small practices to develop arrangements with other local providers to ensure robust peer review, audit and cover arrangements. A 'Sale of Practice Policy' should be regularly reviewed in the light of changing circumstances and the legal position of the PCT. The PCT could also work with the LDC to arrange 'arms length' support for local

General Dental Practices to develop business plans and explore informal partnerships of practices to jointly bid for services both in primary care and for specialist services.

Monitoring Quality

If the practice accreditation scheme is developed, in the interim, non-accredited practices quality will be monitored as it is now, as part of the contract monitoring process. For accredited practices, this would also be true but patients will be part of the quality monitoring process. Mystery shoppers, complaints and compliments, and reports from patient forums will all form part of the quality monitoring process as will practice reports. Initially, accredited practices would be visited by the quality team, at least annually.

The dental clinical governance support team should be reviewed and strengthened as necessary.

Specialist or semi-specialist specialist services

Commissioning and providing training and support

Where dentists lack the skills and or confidence to undertake procedures which could be in other circumstances could be undertaken in primary care, they should be offered a learning needs assessment and signposted to training opportunities to extend their knowledge and skills. These training opportunities should follow an adult learning style and aim to build confidence and skills in area in which the dental practitioner is less experienced.

Where primary care practitioners cannot provide a service which should be available under the NHS, referral centres specialising in those treatments should be commissioned. These treatments fall under the following broad categories:

1. Care for some patients with complex special needs (medical, social, psychological, physical)
2. Treatments requiring technical clinical skills beyond those of the referring practitioner. e.g. Some root canal therapy and some oral surgery
3. Treatments requiring facilities and or staffing above and beyond those in the patients' own GDP own practices.

Where appropriate, these services should include consultant advice and/or treatment as at present but a significant number of referrals will be made to new intermediate care centres which will have the dual function of providing appropriate and timely care for patients needing more complex services but would also provide training for General Dental Practitioners and their staff to allow them to gain skills which would help them to deliver some more complex treatments in their own practices and also possibly providing training for students.

New centres

Within five years a centre or centres could be commissioned to provide a flexible mix of the most needed specialist services in the community.

Centres should be staffed by either Specialists or Dentists with a Special Interest who are linked to consultant services by a clinical network.

In addition dental hygienists could work on prescription in these centres to provide an intermediate care service for patients requiring intensive scaling, polishing and oral hygiene instruction but not yet requiring the advice of or treatment from a specialist in Periodontology.

Finally, the feasibility and effectiveness of an expert patient programme should be explored for those with complex oral care needs to help them look after their own mouths and to know when they should seek specialist advice and care. Inclusion of oral health in other expert patient programmes will be explored.

Secondary Care

The commissioning of a new Dental School and Hospital should be supported and the consultants in both acute hospitals and Birmingham Dental Hospital will play active part in clinical networks.

Workforce

The PCT will continue to work closely with the SHA Workforce Deanery to ensure that the workforce remains robust and well trained. The possibility of expanding the in house training programme of protected learning time will be explored.

The development of the new Dental School should be supported.

Summary and Conclusions

This strategy is designed to address the oral health issues facing Birmingham East and North PCT. It lays out a model for significantly improving oral health by using health promotion effectively and transforming primary, secondary and tertiary care. It can mainly be achieved within the current financial envelope but consideration needs to be given to the commissioning and dental public health capacity needed to implement the plans described.

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