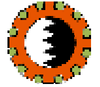

ACCESS TO DENTISTS

11th January 2005

Report to City Council

Access to NHS Dentists

Further copies of this report can be obtained from:

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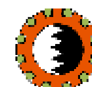

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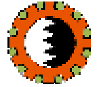
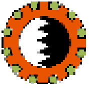


Preface

By Councillor Deirdre Alden
Chairman, Health Overview and Scrutiny Committee

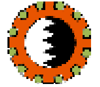
I would like to thank the members of the Health Overview and Scrutiny Committee for their input into this report. The Committee has a heavy workload, with frequent meetings and long agendas, and the members' hard work is very much appreciated.

My thanks also go to the Health Scrutiny Officers who have worked on this report, in particular Narinder Saggu an



1: Summary

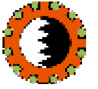
1.1

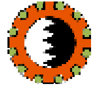


ACCESS TO DENTISTS

1.13 Dentists who de-register former NHS patients are not obliged to help them find another one. Nor are private dentists expected to give advice or "sign post" new patients who want to register - but who cannot afford private dental care. At present, almost no-one seems to take responsibility for actively directing the public to patient information services such as NHS Direct or Patient Advice and Liaison Services (PALS) or for promoting these services as a source of advice about NHS dentists in their area or elsewhere. Unlike general practitioners, there is no system which requires dentists to take on patients if they are having difficulty registering locally.

1.14 Once registered, waiting times to see a dentist and patients ratings of the quality of dental care compared with the national picture appear to be satisfactory and well within locally defint3ef





an NHS dentist to get registered?

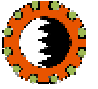
- To what extent will the proposed changes in government policy address inequalities in access where these arise?

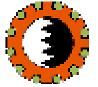
2.2 Terms of Reference

2.2.1 The Terms of Reference for the review are attached at Appendix 1.

2.2.2 The key objectives of the review are listed below and our findings are structured according to these:

- the process by which patients register for dental treatment;
- the proportion of patients who are not registered with

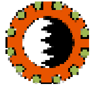




2.5 Critique of Methodology

2.5.1 Due mainly to a large work programme, the Committee decided that this review would be a short, focussed analysis as opposed to a comprehensive major review. The exercise was conducted in a relatively short time scale and therefore provides an overview rather than an in depth analysis of all the issues.

2.5.2 Another reason for the Committee's approach was that we learned that dentistry was on the threshold of important policy changes. The implementation of the new contractual arrangements between dentists and PCTs from October 2005 is intended to lead to significant improvements in the availability of dental provision and access to this provision. A major scrutiny review was therefore deemed premature. The Committee may revisit the matter in the future.



3: FINDINGS

3.1 Oral health in Birmingham

3.1.1 Oral health has improved significantly over the past 40 years. However significant variations remain in the City due largely to socio-economic disparities.

3.1.2 The 2003 National Survey of Child Dental Health shows that tooth decay in 12-15 year olds is at its lowest level since surveys began. According to the World Health Organisation, 12 year olds in England now have the best dental health in Europe. Adult oral health has also improved since the 1960's[1].

3.1.3 This is the result of advances in medical science over the last few decades which has led to an improved understanding of how to prevent tooth decay. The use of fluoride toothpaste, fluoridation of water supplies, better nutrition and medical advances in dentistry have helped improve oral health.

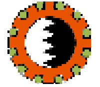
3.1.4 The fluoridation of Birmingham's water supply makes a positive difference to oral health in our City. However, poor oral health is still more prevalent in some communities than others. Up to four times as many 5 year old children have decayed teeth in parts of Aston and Sutton Coldfield.

3.1.5 This can be attributed to a number of factors including levels of sugar in food and dietary habits of certain communities. In the past, problems had been identified amongst families in the South Asian Muslim Community and particularly Pakistani and Bangladeshi families, however, the Committee was informed that proactive and preventative work had been undertaken through projects such as Sure Start to reverse these trends. The same factors that lead to tooth decay are also linked to obesity.

3.1.6 In communities where children's needs are greater, dentists need more time to spend with families to encourage regular attendance and prevent further disease.

3.1.7 For adults, as the population affected by post-war epidemic of dental disease grows older, their dental needs become more complex. Fewer teeth are being removed whilst more fillings are being updated and more crowns and bridges are being fitted by dentists. This places additional demands on dental

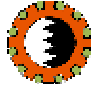
[1] NHS Dentistry: Delivering the Change. Report of the Chief Dental Officer. July 2004



services.

3.1.8 Specialist skills and knowledge are required from dentists if dental treatment is to be performed safely and effectively. Dentists also need to spend more time with older patients to conduct thorough examinations, plan treatments and conduct more complex work.

3.1.9 Demographic changes and movement of the local population across the City creates challenges on the availability of dental provision and access to it.

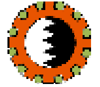


3.3 Registering for Treatment and access to an NHS dentist

3.3.1 Some people view their dentist in a similar way to their GP. They visit the same practice regularly, usually near to where they live or work.

3.3.2 The main way to gain access to a dentist is to register with a local practice.

3.3.3 Dentists can choose whether to register someone or not, or whether to take them as a private patient or an NHS patient. Dentists can also specify that they will only register certain



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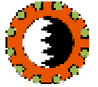
3.3.9 The Committee's survey showed that of those respondents that had registered, or tried to register, with an NHS Dentist within the last five years over 50% were aware of NHS Direct. Only 24% of respondents were



patients with an increased likelihood of developing oral cancers. These patients will require much more frequent check-ups. The Committee noted that there may be others who do not fall in these risk categories, and felt it was important that such patients did not "fall through the net".

3.3.16 In order for less frequent appointments to work then a system needs to be developed in order to track those patients that have not received a check-up recently. This is particularly relevant for the extreme group of patients that might require check-ups every two years.

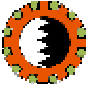
3.4 Number of dentists in Birmingham and variations in availability/access

3.4.1 Birmingham currently has 181 dental practices in the City and out of these, 118 were accepting new NHS patients. From the 118 accepting NHS patients some were only accepting children and/or patients paying partial charges. (source: *Survey of Dental Practices 2004, data provided Birmingham Shared Services Agency).*

3.4.2 Of the 429 dentists in the City, 25 are "salaried dentists" working for the Personal Dental Service. The Personal Dental Service operates 19 public access centres. This consists of 17 clinics held in fixed locations, including one at the Birmingham Dental Hospital and two mobile clinics. A further dental service at the Boots store in the City Centre is due to close shortly.

3.4.3 A map showing the location of dentists across Birmingham is attached at appendix 4.

3.4.4 From the information provided to the Committee, on the whole, it appeared that the City was well served by dentists with a sufficient number of practices identified in each PCT



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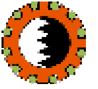

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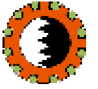
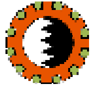




ACCESS TO DENTISTS

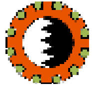
Table 5: Comparison of percentage of the population registered with an NHS dentist across the core cities
Source: Calculated from Dental Practice Board data by PCT

	Percentage of population registered with a dentist
Bristol	46.6%
Leeds	41.4%
Liverpool	38.3%
Manchester	41.5%
Newcastle	56.3%
Sheffield	43.7%
Nottingham	50.3%
Birmingham	**51.0%**
England - National average	**45.0%**

3.5.4 Access to NHS dentists for Looked After Children was of particular interest to the Committee. The Committee was pleased to note that the Council's Performance Plan 2003-4 contains targets and data on the numbers of Looked After Children who have had a dental check in the last 12 months. Performance against these targets is monitored quarterly.

3.5.5 In requesting data from the Council's Social Care and Health Directorate, the Committee learnt that this is the first year local authorities are required to collect this data for submission to the Department of Health. Whilst initially there were difficulties in recording this information, these issues were currently being resolved with some data being collected manually. Unfortunately the data that was shared with the Committee was difficult to analyse correctly and gave an incoherent picture.

3.5.6 This was partly due to the fact that data is collected at the 6-monthly review date for each child, and under-reports the number of check ups between assessment times. Also, at the end of each year discrepancies are corrected manually and the revised data would not be ready until April 2005.



of dental treatment and how this varies across the City

3.7.1 The Committee considered it worthwhile to commission its own independent survey of patient experiences to see how easy or difficult they had found it to register with a local NHS dentist. The survey was conducted by a market research company, CSR Survey Ltd which surveyed a total of 200 people in 8 wards - Sutton Four Oaks, Yardley South, Northfield, Harborne, Aston, Sparkhill, Washwood Heath and Soho (quota sample of 25 in each ward).

3.7.2 A copy of the questionnaire which was designed to be used in the survey is attached at Appendix 3.

3.7.3 The company was asked to provide quotas of respondents for each of the wards, representative of data on age, sex, gender and ethnicity as reported in the 2001 Census.

3.7.4 The main findings of the survey were :-

- One hundred and thirty respondents (64%) of the people interviewed claimed to currently be registered with an NHS dentist.
- Of those one hundred and thirty, one hundred and nineteen (92%) were registered as NHS patients whilst eight (6%) were registered as private patients. The remainder did not know if they were NHS patients or not.
- One hundred and eleven (70%) patients registered as NHS patients had been registered with their dentist for more than five years.
- Only seven NHS patients had been told that their dentist intended to stop seeing NHS patients in the future, and only three of these had been given information about registering with another NHS dentist.
- Only twenty three (24%) NHS patients overall claimed to know where to find information if they did need to register with another dentist.
- Of the eight respondents registered as private patients, only three were registered privately as a preference. The others suggested their dentist no longer saw NHS patients or had been unable to find an NHS dentist.

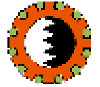


Table 7: Patient survey scores - Heard of NHS Direct? (2003)	
	Have you heard of NHS Direct? (Primary care trust surveys, Healthcare Commission 2003)
South Birmingham PCT	77
North Birmingham PCT	80
Eastern Birmingham PCT	67
Heart of Birmingham (t) PCT	60
Threshold score for best 20% of PCTs	78

3.7.8 For most of the PCT areas, any publicising of NHS Direct at that time appeared to have less impact than in other areas nationally. The Committee believes publicising NHS Direct and its services is crucial if current inequities in access to NHS dentists in Birmingham are to be addressed.

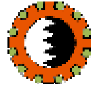
3.8 Plans to address access and availability of NHS dentists – national policy drivers

3.8.1 In recent years, there has been a national drive to modernise dentistry and deliver improvements in access, availability and quality of care. Some of the key policy drivers are outlined below.

3.8.2 The **NHS Plan** published in July 2000, set out a plan for investment and reform for the NHS as a whole. In September 2000 the Government published **Modernising NHS Dentistry - Implementing the NHS Plan** which set out how it would address problems of access to NHS dentistry, and how it would tackle oral health issues and issues of quality.

3.8.3 Included in "Modernising NHS Dentistry" were plans to:

- Improve the availability of NHS dentistry;
- Expand the role of NHS Direct;
- Investment to modernise NHS dental practices and reward dentists' commitment to the NHS;
- Set up Dental Access Centres where patients who are not registered with a dentist can receive NHS dental care;
- Give patients better access to information on the range, quality and cost of NHS treatment.



3.8.4 The Health Select Committee, in its report in March 2001, considered that insufficient progress had been made in implementing the plans set out in "NHS Dentistry - Delivering the Change", and that urgent action was required in addressing inequities in access. It recommended that a strategy, much longer term than "Modernising NHS Dentistry" was needed, and that the remuneration system for General Dental Practitioners was at the heart of the problem.

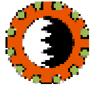
3.8.5 In August 2002, the **NHS Dentistry: Options for Change** report proposed a new NHS dental service for England. This report drew on the findings of a working group led by the then Chief Dental Officer, Dame Margaret Seward.

3.8.6 The report outlined ways to work within NHS structures to achieve new standards of care, supported by a new payments system, together with proposals for a modern workforce structure. Key elements of the proposals included:

- Giving Primary Care Trusts (PCTs) the responsibility to ensure that NHS dental care is available on a regular basis for all those who want it and live within the PCT area; that is, the local commissioning of NHS services;
- New forms of contracting between General Dental Practitioners and the NHS. Different models would be tested with the aim of providing a menu of arrangements - not a 'one-size-fits-all' approach or simply receiving a fee for each intervention;
- Simplifying the system of charges and making them more transparent;
- Setting up a separate Primary Dental Care Workforce Review;
- Improving the patient's experience of trying to enter the NHS system and giving patients a standard oral health assessment.

3.8.7 The **Health and Social Care (Community Health and Standards) Act 2003** provides the legislative framework for taking Options for Change forward. PCTs will for the first time be given a duty to secure or provide primary dental services to the extent that they consider reasonable within their area. To meet their new responsibilities, they will assess local oral health needs. Local commissioning is intended from October 2005.

3.8.8 The Audit Commission's report **Dentistry - Primary dental care services in England and Wales** was published in September 2002. It focused on recommending a new



payment system, where PCTs would be enabled to negotiate local contracts, implementing national standards, for NHS dental healthcare. Central to this was ensuring that PCTs have the expertise and capacity to plan for, and shape, primary dental care services and to involve local General Dental Practitioners.

3.8.9 The **Primary Care Dental Workforce Review** was published in February 2004. This involved detailed modelling of demand and supply for the dental workforce in England. The overall conclusions of the review are detailed in the table below (Table 8). Both the higher projection (steady-state scenario - current flows and patterns will not change) and lower projection (baseline scenario - accounting for factors which will evolve in the future) of shortages in dental hours and dentists include the factoring in of demographic and oral health trends, numbers studying dentistry, and different 'mixes' of treatments.

Table 8: National gap in supply of dentists.

(Report of the Primary Care Dental Workforce Review Feb 2004)

	Undersupply in hours (million)	Undersupply as WTE dentists	Undersupply as % of demand
2001	1.5	1,050	5
2003 (current)	2.7	1,850	9
2011 (lower projection)	5.0	3,640	16
2011 (higher protection)	7.1	5,100	21

3.8.10 This estimated shortfall in supply (estimated as between 16-21% of demand by 2011), coupled with the above series of policy changes, has culminated in the report by the Chief Dental Officer in July 2004 - **NHS Dentistry: Delivering the Change.** This document aims to improve NHS dentistry

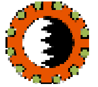
PCTs. For dentists, there will be greater flexibility and no item of service (allowing for decisions to be made based on clinical need), no requirement for out of hours provision and a new patient charges system. The aim is to improve incentives for dentists to provide NHS treatment, and ultimately to reverse a widespread move of dentists to the private sector, largely due to disillusionment in the old contract, which began in the 1990s.

3.8.13 The Government is committed to recruiting an extra 1000 dentists (whole time equivalents) by October 2005. Although many will come from overseas and an increase in National provision of Dentists will take some time to achieve.

3.9 Local implementation of plans

3.9.1 In hearing evidence from Mrs. Ros Hamburger, Dental Public Health Consultant, the Committee learnt that the new General Dental Service (GDS) contract heralds a new era in dentistry in Birmingham. It enables care to be provided on a more pro-active basis rather than reacting to poor dental health. The intention is to address some of the geographical variations of provision and create equity between the different categories of patients.

3.9.2 Dentist incomes will be based on4 14 1 Tf5.80101 Tw t 745.e8n:-0.0021



analysis.

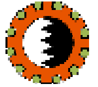
- Develop sound quality standards and monitoring mechanisms by using the Dental Reference Service constructively, acting on and disseminating the findings of the Audit and Peer review and checking that clinical governance systems are in place.
- Identify and fill service gaps as they arise by maintaining the epidemiological programme, integrating dental commissioning with other NHS commissioning and learning from patient surveys, patient complaints, dentists comments and comments from other professionals.
- Maintain the workforce in sufficient numbers by supporting undergraduate education, tailoring post-graduate education for dentists to meet the needs of the local population and ensuring professional training is available for specialist and rare conditions.

3.9.8 PCT plans to meet the national priorities locally are already underway. A "needs assessment" has been carried out for each PCT area, and local strategies for each PCT are expected to be published early next year.

3.9.9 Having said this, the Committee was also alerted to the publication of a report from the National Audit Office: Reforming Dentistry – ensuring effective management of risks (November 2004). This suggested that significant risks would have to be managed if the new contractual arrangements are to be effective and provide value for money. There was some scepticism about how the new contract will work in practice, whether it contained sufficient incentives and what the processes were for ensuring that dentists did not reduce their NHS commitments. The report also highlighted capacity issues for PCTs (in terms of expertise and resources) in order to take on their new responsibilities.

3.9.10 In light of this, the Committee believed it would need to be reassured that PCTs are delivering on the new contract. It therefore considered it appropriate that regular progress reports to be submitted to the Committee, by the PCTs, on the implementation of the GDP contract.

3.9.11 Alongside the implementation of the GDP contract, the Commit-4.5q-6(char. that PB)4.1(tri)4.1(t)-2.28(ghamhas bommprehns



service - the Birmingham Personal Dental Service - operates at evenings and weekends. The School of Dentistry trains undergraduate and postgraduate dentists. It is estimated that between 40-50% of dentists working in Birmingham trained at Birmingham Dental School.

3.9.13 There are three main patient flows at the Birmingham Dental Hospital, all of which include NHS patients:

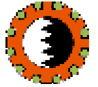
a) Specialist care - referral to consultants (which is largely not driven by the number of dental practitioners available elsewhere in Birmingham).

b) Work undertaken by students (this work would normally be done by general practitioners but is available free of charge - apart from prescription charges, and charges for some other treatments e.g. dentures). This work is dependent on the number of students at the School of Dentistry and there are some limits placed on the number of patients who can be seen.

c) Front door emergency services (from toothache to injuries) - this can be affected by the number of dentists elsewhere.

3.9.14 At the time of writing, the Dental Hospital and School was consulting on proposed changes for relocation and changes to service provision. The Health Overview and Scrutiny Committee was involved in discussions about these changes and, developing its response as part of the public consultation process.

3.9.15 A significant part of addressing the national shortage of dentists was the training of dental therapists, nurses and hygienists. Referrals to these professionals were made on prescription by dental practitioners. By developing a “skills escalator” for a range of dental professionals, it is hoped that the demand for dental care can be resourced more efficiently and effectively.



4: Conclusions and recommendations

4.1.1 NHS dentistry both in Birmingham and nationally is currently subject to important change.

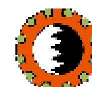
4.1.2 Modernisation of dentistry has been long overdue, however oral health in Birmingham, access to NHS dentistry and the quality of care is not such a significant issues as it has been in other parts of the country.

4.1.3 Nevertheless there are some variations in the process for accessing an NHS dentist and patient information on registering with a dentist is not widely available.

4.1.4 Some confusion is as a result of the different categories and patient lists used by dentists as well as the requirement for people to pay for treatment, even though receiving an NHS service.

4.1.5 Although Birmingham does not have any "deserts" i.e. areas where there is no provision and access, there are a few areas where there is very restricted choice. However, a significant percentage of the population (51%) is registered with an NHS dentist – higher than the national average (45%).

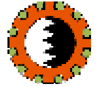
4.1.6 Birmingham is fortunate not to have experienced the shortage of dentists as experienced nationally and this is a largely due to having a school of dentistry in the City.ely available.25ns Pros-chT7 c0



- communicating and informing the general public about their rights and responsibilities,
- the processes for registering and accessing dental services and
- the measures of quality and standards of care that patients can expect.

4.1.10 The onset of the GDS offers a significant opportunity to address some of these issues. The Health Overview and Scrutiny Committee therefore recommends that:

	Recommendation	Responsibility	Completion Date
R1	The PCTs actively promote NHS Direct and local PALS services as a source of information and advice on registering for dental care, and that such information is made widely available in community venues across the City.	PCT Chief Executives	July 05
R2	The PCTs, working in conjunction with the Birmingham Shared Services Agency, consider developing a system of allocation that would enable patients to secure registration with an NHS dentists following 3 unsuccessful attempts.	PCT Chief Executives	July 05
R3	The PCTs conduct further surveys in their area to identify particular population groups that may not be registered or may be experiencing difficulties with accessing NHS dental care.	PCT Chief Executives	December 05
R4	The PCTs report to the Health Overview and Scrutiny Committee in six months time describing progress on the implementation of the General Dental Practitioners Contract.	PCT Chief Executives	July 05



ACCESS TO DENTISTS

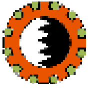
Link Officer	Dr Jacky Chambers
Lead Review Officer	Narinder Saggu/ Namita Srivastava

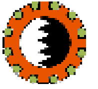
2.3 Council Departments Expected to Contribute

Contact / Department	Contribution Expected

2.4 External Organisations Expected to Contribute

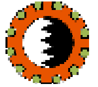
Contact / Organisation	Contribution Expected
Consultant in Dental Public Health, Heart of	





ACCESS TO DENTISTS

http://www.nhs.uk/england/dentists/

ACCESS TO DENTISTS

3a. Are you registered as a private patient because: (READ OUT)

Your dentist no longer sees NHS patients	1 – Go to Q3b
You have tried to register with an NHS dentist but couldn't find one	2 – Go to Q3b
You prefer to be seen as a private patient	3 – Go to Q7a

3b. Has your dentist given you any information about what to do if you want to register with another NHS dentist?

Yes	1
No	2

3c. Would you know where to go to get this information if you needed to?

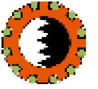
Yes	1
No	2

Check if Q5-6 are appropriate (codes 1 or 2 at Q1c). If not go to Q7a

For respondents that have no dentist
4a. Have you tried to register yourself or a member of your family with an NHS dentist in your area?

Yes	1 – Go to Q5a
No	2 – Go to 7a

Q5 & 6 are for those who have tried to register with a dentist (code 1 at Q4a) and those who have changed dentist in the last five years (code 1 or 2 at Q1c)



Appendix 4: Location map of NHS dentists in the City