DRAFT

Bolton Primary Care Trust

Oral Health Strategy

Document for Consultation

April 2006

DRAFT DOCUMENT

Bolton Primary Care Trust

ORAL HEALTH STRATEGY

CONTENTS

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1. Introduction and Context

The report of the Chief Dental Officer – NHS Dentistry: Delivering Change launched in July 2004, sets the national context for reforming NHS dental services. It describes a vision that focuses on greater access to NHS dental services; disease prevention/improved oral health and reforming and improving NHS dental services.

In considering progress in improving oral health, the report recognises that whilst oral health in England has improved progressively over the years, the pattern of improvement has not been the same across all sections of society. In particular the report notes that:

> 'Poor dental health and poverty are also inextricably linked and children in parts of the north of England have, on average, twice as much dental decay as others'

(i) Why do we need an oral health strategy?

The purpose of developing this document is to look at and explain the steps we need to take to improve oral health in Bolton. As part of this work we also need to consider and agree clear plans for the development of local dental services to meet identified needs of the population.

The changing role of PCTs in the commissioning of dental services is important. New contractual arrangements introduced in 2004/2005, gave Dental Practitioners the option of transferring from a national, to local contract negotiated through their PCT and in September 2005 new draft dental regulations were launched. These changes include the devolution of financial resources for local contract negotiations with GDPs within a nationally designed framework. In addition, it is anticipated that PCTs will, within the next 18 months be given responsibility for the total NHS budget for dentistry.

It is important therefore, that we prepare for the changes and describe and document our plans so that we can:

- be clear about investments to support locally agreed priorities, thereby giving professionals and the public opportunity to influence what we do

- be accountable for, and transparent in, monitoring progress towards achievements
- have a clear framework for implementation of policies that support longer term aims

(ii) Who has been involved in developing this document?

In developing this document the PCT has worked closely with the Bolton Local Dental Committee, PCT Community Dental Services, the North Western Deanery and the Royal Bolton Hospital Trust.

(iii) Guiding Principles

Acknowledging the national vision and guided by local health needs the following overarching principles for improving oral health in Bolton have been agreed:

- to offer improved access to quality dental care
- to target services to reduce oral health inequalities
- to understand patient expectation and improve the patient experience
- to modernise the infrastructure i.e. Buildings/Information Systems
- to develop the workforce and improve working lives of dentists and their team

2. Who is the strategy for?

In this section some important general characteristics of the Bolton PCT population, which are relevant to oral health and oral health care provision, are identified, and information relating to oral health status is summarised.

(i) The PCT population

Approximately people 261,037 live in Borough of Bolton when the last national census was taken in 2001. Considering trend data, no large fluctuations in the size of the population of Bolton are expected for the foreseeable future. The age profile of the population of Bolton is similar to the national profile (shown in Fig 1).

Fig 1

Over the next five years a large increase in the number of people aged 60–69 years is expected with a smaller increase in the numbers aged 40-49 years. Decreases in the number of people aged 30-39 years, and

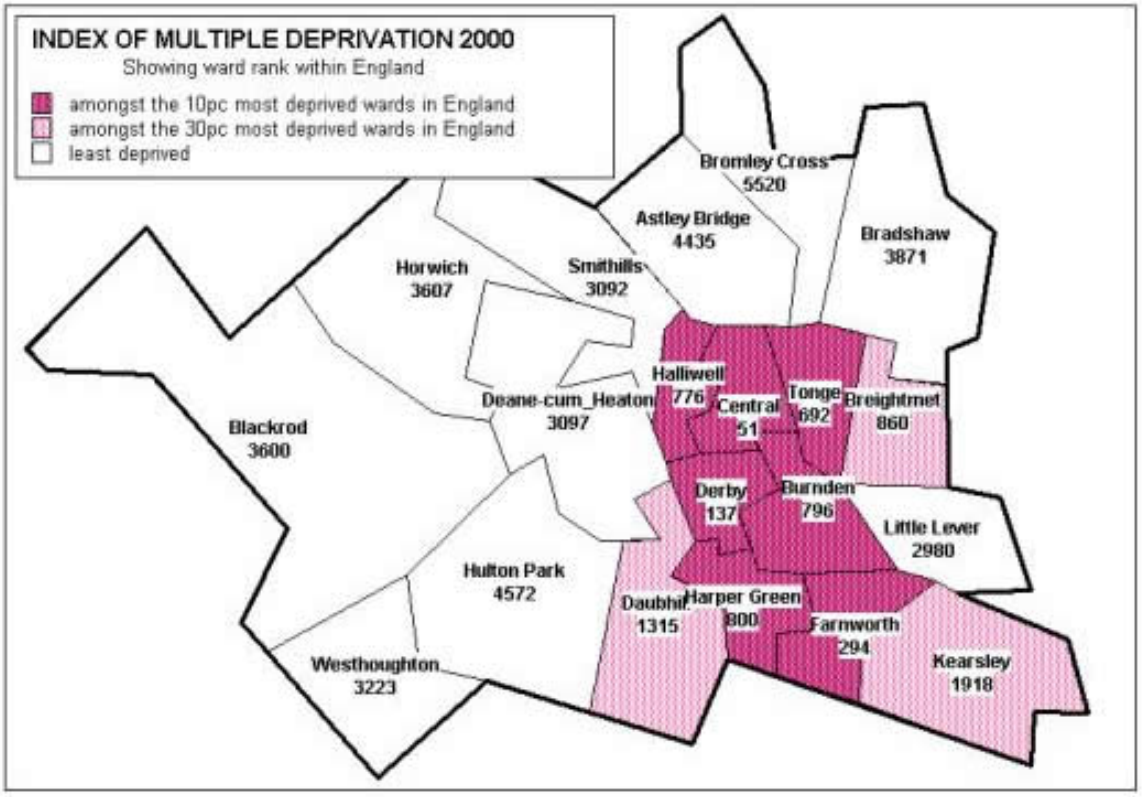
children, are also expected.

One in five Bolton residents in 2001 were experiencing some form of long-term illness, health problem or disability that limits their daily activities or their work.

In recent years there has been a change in industrial activity in the Borough of Bolton. Whilst the numbers of people working in distribution, hotels and restaurants have risen, those working in manufacturing have decreased compared with the early 1990s. On average fewer people who live in the Borough of Bolton are in the highest socio-economic class as defined by the Office of National Statistics, when compared with the average for England.

Unemployment levels are only just above the national average (3.5 per cent) at 3.9 per cent, but this masks an unemployment level in ethnic minority communities of twice the average. High levels of deprivation exist in inner Bolton. Seven of Bolton's wards are in the fall in the lowest 10% in the country. High proportions of children in some two inner wards have more than 70% children who receive means tested benefits. This is illustrated in Fig 2.

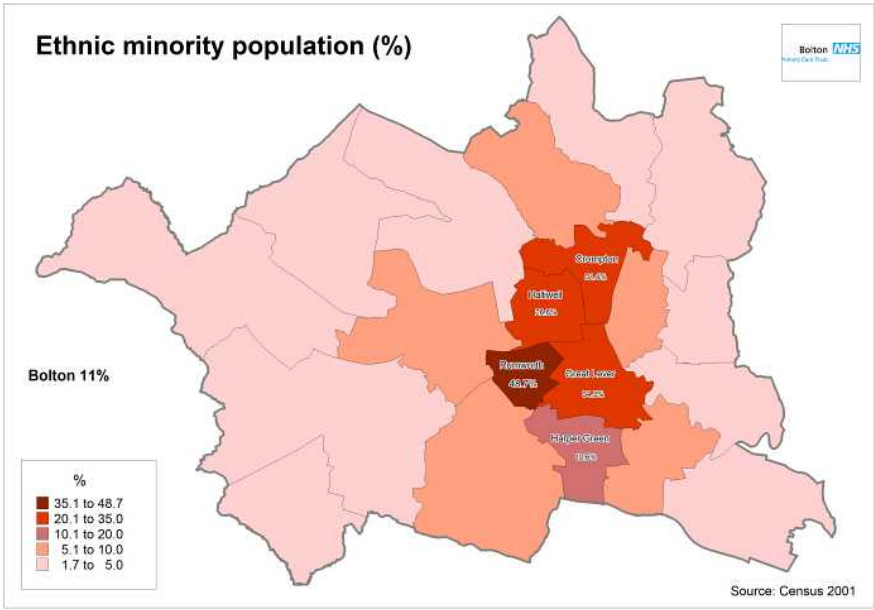
Fig 2



In 2001 approximately 11% (28,671) of the population of the Borough of Bolton were reported to be from non-white ethnic groups. Over half of this minority group were of Indian origin. A growth in the number of people from both Indian and Pakistani groups was seen between the census carried out in 1991 and that carried out in 2001.

The ethnic minority population is concentrated in 10 electoral wards in the Borough of Bolton (shown in Fig 3). It is particularly high in Rumworth ward, where almost half of the resident population is from an ethnic minority. The ethnic minority population in Bolton is relatively young. In 2001 less than 2,500 people from ethnic minority backgrounds were aged over 50 and less than 800 of people were of retirement age.

Fig 3



(ii) Oral health status

Dental caries - children

Currently children living in Bolton have the highest level of dental caries in Greater Manchester Strategic Health Authority area. The most recent statistic (2003/2004) for the average number of decayed missing and filled teeth in five year-old children is 3.23 in Bolton. This compares poorly with the average statistic for Greater Manchester (2.42), the North West (2.13) and England (1.49). The children surveyed had between 0 to 18 teeth affected by decay. Ten percent of children had 9 or decayed missing or filled teeth and eight percent reported that they had toothache on the day they were surveyed. Also eight in 100 children surveyed had

evidence of sepsis in their mouths.

Fig 4 shows three Department of Health targets which relate to dental caries in children.

Fig 4 - *Department of Health national caries targets 2003 for England*

- 5 year olds should have no more than an average of 1.0 tooth with decay experience
- 70% 5 year olds should have no decay experience
- 12 year olds should have no more than an average of 1.0 teeth with decay experience

The prevalence of dental caries in children aged five years in Bolton in 2003/2004 exceeded the second Department of Health target by 100%. This is illustrated in Fig 5. Dental prevalence statistics have been consistently high in Bolton for the last decade.

Considering older children, who have permanent teeth, the most recent statistics available show that, on average, 12 year old children in Bolton have higher levels of decay than England, but that they are relatively no worse than other 12 year olds in the North West. Decay levels in Bolton are only just higher than the national target. This is illustrated in Fig 6.

Fig 5

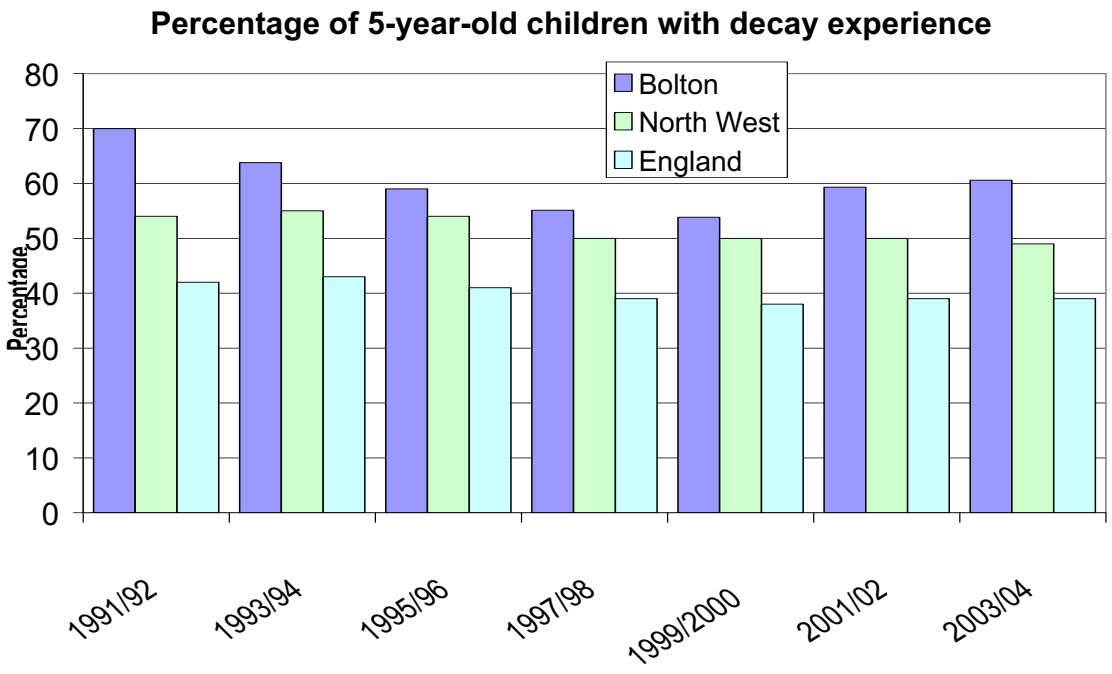
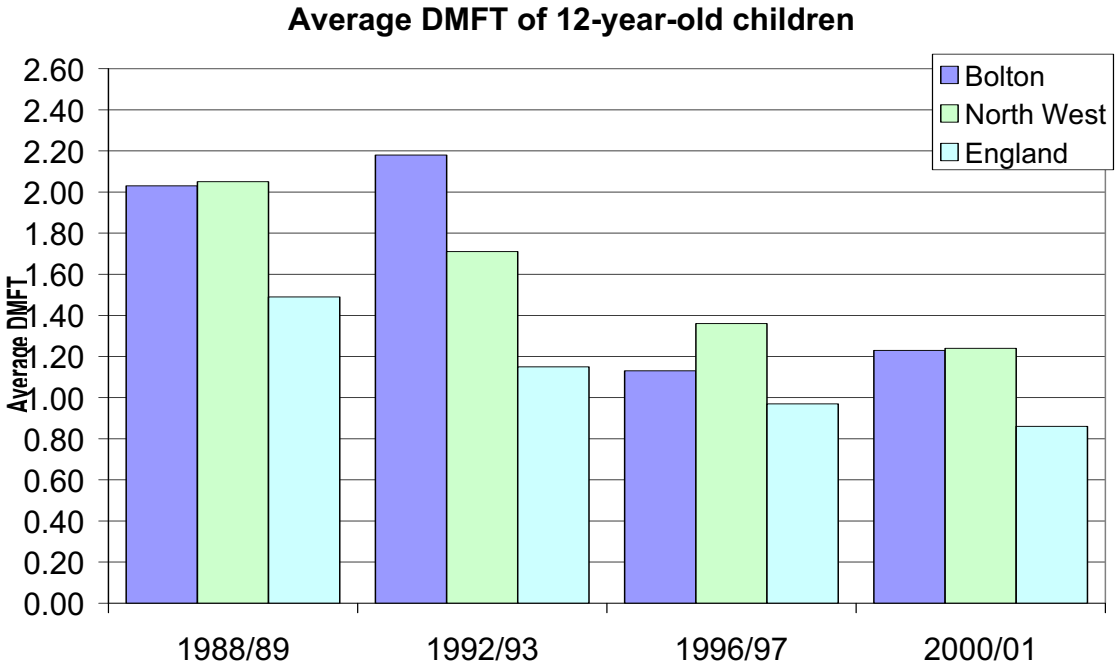

Percentage of 5-year-old children with decay experience
Bolton
North West
England
Percentage
80
70
60
50
40
30
20
10
0
1991/92
1993/94
1995/96
1997/98
1999/2000
2001/02
2003/04

Fig 6



Department of Health target

Dental caries in adults

There are no local dental caries prevalence data available for adults in Bolton PCT. However, it is known that the burden of dental caries in adults in Bolton on the NHS is marked. Almost £6 million was spent on NHS adult dental treatment in Bolton in 2004, the majority of which will be due to dental caries and their sequelae.

Four in ten of the claims made for patients over 18 years in 2004 included a filling. Also in 2004, eight out of one hundred claims included an extraction. The majority of these extractions will be due to either dental caries or periodontal disease. Slightly higher proportions of claims in 2003 included an extraction and teeth filled. In 2004 more than 3,911 claims were made by Bolton PCT dentists for the provision of dentures.

National data collected in the UK Adult Dental Health Survey in 1998 demonstrated a marked increase in the proportion of dentate adults compared with previous surveys. In general terms the population is expected to fall into three groups in terms of treatment need:

- Those born before 1935, many of whom have lost their teeth and will need dentures
- Those born between 1935 and 1965 many of whom have heavily restored teeth who will have high need for complex care
- Those born after 1965 who benefited from fluoride toothpaste and have low treatment needs.

It is therefore likely that there will be a need for the provision of restorative dentistry (fillings and dentures) for the foreseeable future.

Periodontal disease

No local data are available relating to the prevalence of periodontal disease in Bolton. The Adult Dental Health Survey carried out in 1998 found 54% of the adult population had some degree of periodontal disease. Four percent had advanced periodontal disease. It is estimated that 106,418 people living in the Bolton PCT area will have some degree of periodontal disease, and in 7887 this disease will be severe. The Dental Practice Board has records of only 3767 claims made by Bolton NHS dentists for periodontal treatment in patients aged 18 and over in the year 2004.

Oral cancer

In 2002 to 2004 there were 28 deaths caused by oral cancer. Twenty-three were male. This equates to 9 per year and to3.46 per 100,000 population per year.

Cancer deaths in the Greater Manchester & Cheshire Cancer Network, 1996-2001, amounted to 688 (465 males). Approx 115 per year

In 2003, there were 1592 oral cancer deaths in the UK (1018 males). This equates to 2.67 per 100,000 per year.

Malocclusion

Since 1994 data relating to the definite orthodontic treatment need of 12 and 14 year olds has been collected at four yearly intervals at the same time as data relating to caries, through the British Association of Community dentistry co-

ordinated surveys. Orthodontic treatment need of patients not wearing an orthodontic appliance (brace) and not having worn and orthodontic appliance, is assessed using a modified version of the commonly used Index of Orthodontic Treatment Need (IOTN). Demand is assessed as those subjects who are deemed to be in need of orthodontic treatment and would like to receive it.

More complex orthodontic cases needing specialist care can be treated in specialist practices or the hospital service. Current waiting times for treatment provided by Bolton Hospitals NHS Trust from referral to first appointment is less than 13 weeks the subsequent waiting time for treatment is currently in excess of 21 months.

It should be noted that the new dental regulations to be implemented from April 2006, redefines the eligibility criteria for access to NHS orthodontic treatment. Thereby requiring a re-evaluation of need and impact assessment of service provision.

Conditions requiring secondary oral and maxillofacial surgery care.

A variety of procedures provided by Bolton Hospitals NHS Trust are carried out for patients with oral and maxillofacial conditions.. In the year April 2004 to March 2005 326 procedures involving the surgical removal of a tooth were carried out along with 194 simple extractions. The level of congenital deformities requiring oral surgical management or numbers of cases of dental trauma cannot currently be estimated.

3. CURRENT SERVICES

Dental services are provided at three levels

- general dental services provided by Independent dental practitioners
- community PCT dental services for defined services around vulnerable groups
- hospital services for more specialist care re orthodontics and oral surgery

(i) General Practice

There is a mixed economy in respect of how dental practices operate in terms of NHS and private dental work. Certain practices rely nearly exclusively on NHS funding, whereas others operate a mix of private and NHS work, treating a mix of NHS fee-paying adults, exempt adults and children. There are very few, if any, dental businesses operating as a completely private dental business independent of the NHS.

The majority of practices working under a local contract for the provision of Personal Dental Services (PDS) are accepting new patients with an agreed 10% growth in patient list size by the end of 2005/2006. The majority of practices working under General Dental Services (GDS) contracts are likely to continue to register children for NHS care, but not fee-paying adults.

The current numbers of practices and dentists in Bolton is detailed below:

	Practices	Dentists (headcount)	
	Nos	Nos	%
PDS	19	47	56.6
GDS	17	31	37.3
Ortho Only	3	5	6
Total	39	83	100

On average, Bolton Borough has about the same number of dentists per 100,000 population (3.14) as the national average.

New Regulations

New dental regulations launched in draft in September 2005 will make changes to the future provision of general dental services. These will be implemented from April 2006. The new regulations:

- redefines the currency of dental activity from Items of Service to Units of Dental Activity (UDAs). UDAs measure courses of treatment with the aim of giving dentists more time/flexibility to secure patients dental health
- redefines eligibility for NHS orthodontic treatment using the Index of Orthodontic Treatment Need
- introduces changes to the provision of urgent and emergency services with the PCT having responsibility for the provision of Out of Hours care
- removes the requirement for dentists to hold registered lists of patients. This is with the aim that patients will be accepted for courses of treatments at a dentist of their choice.
- devolves funding for general dental services to PCTs. This means that any release of resources will be retained locally and can be reinvested in targeted areas for improving oral health.

The PCT is working closely with the Local Dental Committee and dentists on the implementation of the new regulations.

Access to Services

Registration rates have been the proxy for assessing improved access to dental services and patient complaints and enquiries are monitored as part of our approach to assessing service need. NHS registration rates of children in Bolton approximates to the UK national average. The child (under 18) registration rate for Bolton is 54.9% as at March 2005 – the Greater Manchester average is 49.1% and the England average is 54%. The adult (18 & over) registration rate for Bolton is 45.6% as at March 2005 - the Gtr Manchester average is 38.8% and the England average is 38.7%.

Bolton PCT Registrations @ March 05			
	Child (0-17)	Adult (18 & over)	Total
Nos.	35,160	89,953	125,113
% pop	54.9%	45.6%	47.9%

The PCT Patient Advice and Liaison Service (PALS) handle contact data (each month 1 in 500 of Bolton population) and NHS Direct contact information (each month 1 in 2,000 of Bolton population). Dental related enquiries account for ca. 40% of PALS contact data.

(ii) Out of Hours Emergency Dental Services

Current contractual arrangements for dentists working under PDS or GDS include responsibility for the 24 hour care of their patients including urgent or emergency care that may arise outside of normal working hours. However under the new

dental regulations PCTs will assume responsibility for Out of Hours emergency dental services. Dental Leads across Greater Manchester have been meeting to consider the impact of this change and have looked at options for service delivery. Guidance recommends that PCTs should work on a group/sector basis across wider geographic areas whilst being cognizant of demand, travel, choice, value for money etc.

Most PCTs already provide an Emergency Dental Service (EDS) that operates out side of normal working hours. In Bolton the service is provided seven days a week (in total 21 hours at 3 hours per day) with two dentists working from Lever Chambers. There is a requirement to review local arrangements for Emergency Dental Services as part of implementation of the new GDS regulations.

(iv) Rotational Treatment Scheme (RoTS).

In an attempt to provide urgent dental care during normal hours, in 2004/2005 the PCT set up a Rotational Treatment Scheme (RoTS)

The RoTS scheme involves nine dentists and the provision of 81 treatment slots each week for simple palliative care for patients experiencing dental pain. In the main the demand for these slots has matched capacity except in Westhoughton where the slots have not been fully utilized and have consequently been reduced. This RoTS service has had a limited impact on the numbers of patients attending the EDS at Lever Chambers.

The type of patient attending for urgent care at either EDS or RoTS is predominantly those who are unregistered and only want occasional care. Registering these patients with a dentist is unlikely to change behavioural patterns.

An evaluation and review of the RoT Scheme will be undertaken as part of the review of emergency care required by the new GDS regulations.

(v) Community Dental Services

The role of the PCT Community Dental Service (CDS) is to provide a comprehensive service to priority groups of patients namely:

- People with special needs, eg anyone with learning or physical disability, mental health problems, dental phobia and those with high dental treatment needs
- People who are unable to access treatments through general dental services
- People with health problems eg serious infections (including HIV/AIDS and Hepatitis) or chronic medical conditions
- School children and students up to the age of 19

Clinics are held across a variety of locations across the town.

The CDS currently has a waiting list for patients referred by non salaried dental practitioners for general anaesthesia and dental treatment under inhalation sedation. At present this list is in excess of **200** for tooth extraction under general anaesthetic and ca. **146** for treatment under inhalation sedation. This means that the next available appointment for tooth extraction of a young child with pain is in three months time.

The majority of children waiting for treatment under inhalation sedation may, because of delays, end up requiring extractions rather than restorative care.

There is currently a 52 week waiting list for relative anaesthesia.

(vi) Hospital Oral Surgery

There are currently long waiting times at Royal Bolton Hospital for Oral Surgery. An analysis of activity may identify alternative options for managing demand eg patients could be worked up in primary care ready for surgery prior to referral.

(vi) Orthodontic Services – Hospital and Primary Care

As at December 2005 there were **59** patients waiting for eighteen months to start a course of treatment at Royal Bolton Hospital. Some treatments require routine care and extraction of teeth under local anaesthesia in primary care prior to specialist treatment.

The waiting times in the 3 GDS Orthodontic Only practices range from **5/6** weeks for one practice, to **6-9** months for the second, and to **12** months for the third

Between 1999 and 2004 the absolute expenditure on orthodontic services has risen by 67%.

There is a rapid growing demand within the population for orthodontic treatment and a corresponding increase in provision of treatment from dentists who specialise in orthodontic care.

Implementation of the new Dental Regulations changes the criteria for access to NHS orthodontic care and this will impact on future provision of services. An impact assessment will be undertaken during 2006/2007.

(viii) Sedation

Currently 7 Bolton dental practices provide a limited level of children's sedation services. One PDS practice is funded to treat approx 200 children's sedation cases per annum including taking referrals from other practices. In addition, one PDS practice is specifically funded to provide adult sedation services on referral – providing approximately 92 sessions per annum.

(ix) General Anesthesia

In April 2004, Royal Bolton Hospital took over the provision of anaesthetic cover for paediatric lists run by the PCT provider service. A Service Level Agreement was drawn up for 90 sessions per year. Work is continuing in liaison with the Hospital for development and improvement of this Service against activity and quality measures. Recent changes include the relocation to a 'child friendly' theatre, changes in pain relief pre and post operatively and review and development of patient pathways.

(x) Prevention

A major factor in improved oral health is water fluoridation and the PCT Oral Health Promotion Strategy makes a commitment to work towards achieving this. In the absence of water fluoridation alternative methods of topical fluoride delivery will continue to be implemented.

Bolton Oral Health Promotion Strategy summarises key initiatives for action with the aim of reducing inequalities and improving oral health of people in Bolton PCT. The strategy includes specific objectives and associated outcome measures eg reducing dental caries with quantifiable target measures to reduce dmft in 5 and 10 year olds.

Actions are primarily targeted in Sure Start and poorer dental health areas and include:

- recruiting nurseries and schools onto the Brush Bus Scheme; Sure Start staff continued work to improve oral health particularly regarding drinks and bottles; develop the Health Visitors role in the Brushing for Life Programme
- offering training for staff, parents and carers and recruiting schools onto 3 year health promotion programmes
- targeted work in schools and centers for children and adults with special needs

- develop initiatives to address the needs of ethnic minority groups and appropriate information for asylum seekers and other groups such as the homeless
- develop and identify oral health needs of the elderly population

There is a lack of routine information available on activities in GDS/PDS services on health promotion or ill health prevention. A piece of work has been identified associated with developing a consistent approach to health promotion activity in general practice.

Whilst the new GDS regulations include an element for prevention activity in general practices as part of level one UDA, in itself it does not offer incentives for significant development at practice level. However over time and when the full impact of implementation is known opportunities for evidence-based developments will be explored.

4. Infrastructure

Workforce

There are three priority areas associated with workforce development in dental services that are key to supporting implementation of this strategy. These are:

- reshape the workforce to support the development of local dental services with the aim of transferring more services into community settings; improving waiting times and access
- support the development of dental practices; individual development of dentists and their teams and maximize opportunities to support practices in the transition towards new ways of working under the new dental regulations
- support dentists and their teams with robust arrangements for education and development around evidence based practice.

Buildings

The development of a wider range of services based in the community will rely on major development and modernization of healthcare premises. The PCT Estates Development Programme includes plans for 7 new Primary Care Resource Centres across the borough with the first ' Hall'ith Wood' scheduled to complete in 2007 and the final Centre planned for 2013. Smaller Satellite Centres are also planned, targeted in areas of need.

These Centres will allow the opportunity for local health service providers including GPs, dentists, pharmacists etc to work from modern purpose built premises. Professional groups and local providers will be invited to participate in estates planning.

Information Systems

The vision for Information systems development in dental practice is for the utilization of a single system across practices that is compatible with PCT and hospital systems to enable improved data collection; allow clinical audit and practice development and implementation of national initiatives eg Choose and Book.

5. Summary and conclusions

Oral Health

- Over the next five years we expect larger numbers of 60 to 69 year olds in the population of Bolton. This may mean that a larger proportion of dental patients present treatment challenges.
- One in five Bolton residents may find it physically difficult to access dental services and may have medical conditions that make dental treatment complicated.
- High levels of deprivation in inner Bolton added to high levels of oral disease may reflect the need for targeted prevention efforts.
- In addressing equality and diversity, the ethnic minority population is concentrated into 10 electoral wards in Bolton. In some of these wards deprivation is comparatively higher than the rest of Bolton. This issue may impact on access, and have implications for commissioning and provision of preventive and treatment services.
- Levels of dental caries in five year olds, on average, are 3 times the Department of Health target.
- Twelve year old caries levels are only slightly higher than the Department of Health target.
- Restorative dentistry (fillings and dentures) will be needed at least, at the current level for the foreseeable future.
- Bolton has a higher rate of oral cancer when compared with the average for the UK.
- Needs assessment for orthodontic services will need to be reviewed in line with revised eligibility criteria in the new dental regulations
- Further needs assessment is required relating to oral cancer, oral and dental trauma and congenital deformities affecting the mouth and face.

Service Provision

- The number of dentists per capita in Bolton is similar to the national average but oral health needs are greater.
- Patients report difficulties in accessing NHS dental services.
- The number of patients registered with Bolton dentists is slightly under half of the number in the population.
- Further data is required which describes the proportion of the population receiving dental care through private arrangements.
- Currently slightly over half of the former GDS practices have adopted a new way of working. The majority of these are accepting new patients.

- Currently palliative care is provided at the Out of Hours service and the Rotational Occasional Treatment Scheme (RoTs). Currently approximately 500 patients are seen in the out of hours service per month. The RoTs scheme provides a further 81 treatment slots per week.
- The Community Dental Service (CDS) provides dental care for patients from vulnerable groups, and for patients requiring treatment under general anaesthesia or sedation. Waiting lists for treatment provided by the CDS are excessive.
- Alternative facilities for the provision of treatment under sedation have been commissioned by the PCT.
- An Oral and Maxillofacial Surgery service which provides secondary surgical care is currently pressured.
- The waiting list for Consultant led treatment provided in a hospital setting is excessive.
- There are some concerns relating to the management of the hospital based service which provides exodontia under general anaesthesia.

6. Action Plan

A series of actions required for implementation of this strategy is attached at Appendix 1 to this document.

7. Summary of Priorities

Priority areas for action are listed below.

Improve Access to Quality Dental Care	• undertake an impact assessment of how implementation of the new dental regulations will impact on patient access to primary dental services • undertake impact assessment of how new dental regulations will impact on access to orthodontic services • improve orthodontic waiting list management • review and redesign as appropriate, Out of Hours dental services/Rotational Treatment Scheme and Emergency Dental Services • review and assess access to dental care for vulnerable groups including needs assessment for domiciliary care • undertake needs assessment and review eligibility criteria for IV and inhalation sedation and review training and accreditation • improve waiting list management for access to General Anaesthesia and continue to work with the hospital to review and improve activity and quality of sessions.
Improve Oral Ill Health Prevention	• support water fluoridation and targeted evidence based fluoride schemes • implement local Oral Health Promotion Strategy • undertake impact and local implementation of Oral Health Plan
Target services to Reduce Oral Health Inequalities	• undertake a borough-wide oral health census of 5 year olds • develop approach for dental needs assessment including work to reduce incidence of disease eg reduced oral cancer rates • continue to undertake access/oral health initiatives targeted in deprived areas and in ethnic minority communities
Understand Patient Expectation and Improve the Patient Experience	• use local surveys to understand patient expectations eg practice annual audits; patient survey through the Emergency Dental Service • provide information to patients on what they can expect to receive from NHS dental services from April 2006 when new regulations and charges are implemented
Modernise Premises and Information	• engage with local dental practices in the PCT Estates Development Programme

Systems	• review surgery inspection 'check-list' and undertake rolling programme of premises inspection • work with dental practices for initiation of national development for IT.
Develop the Workforce and Improve the Working Lives of Dentists and their Teams	• Explore and develop roles for Dentists with Special Interests • Support skill mix in practice and PCT dental services to further the implementation of access initiatives and strategy development

8. Resources

In line with other primary care contracts, historically primary dental services were funded centrally from non-cash limited resources. Whilst this posed minimal financial risk for PCTs, it meant that there was little flexibility in the way services were commissioned.

New General Dental Services (GDS) Regulations

During the period of negotiation and consultation on the new GDS regulations, many dental practices opted to provide services under new locally commissioned Primary Dental Services (PDS) contracts. As in other areas, Bolton experienced a considerable interest and 17 PDS pilots were established early in 2005. In moving to PDS, the PCT received devolved budgets for the delivery of primary care dental services for those practices involved.

The new GDS regulations (to be implemented form April 2006) require the harmonisation of contractual arrangement between PDS and current GDS practices.

From April 2006, the PCT will have the entire devolved budget for NHS primary care dentistry and the responsibility for ensuring continued delivery and development of dental services. This change allows PCTs the opportunity to redesign dental services to match the needs of their population.

Full devolution of budgets carries associated financial risks in ensuring the resources are used effectively to meet clinical and performance targets. An area for careful management is associated with patient charges. The Department of Health has endeavoured to ensure the changes to patient treatment bandings correlates with patient charge income, however this is yet to be tested. PCTs across Greater Manchester will work together to manage this.

Fluoridation

Greater Manchester PCTs are currently working together and pooling resources to support a public consultation on water fluoridation. Water fluoridation is a major contributor to improved oral health. Financial implications associated with water fluoridation will be for local consideration.

ORAL HEALTH STRATEGY
Action Plan

APPENDIX 1

Guiding Principle (from para (iii) page 3 of main strategy document)	Service or Priority Area	Vision (working towards the next 5 years)	Actions and process measures
A. Improved access to quality dental care	1. General services • routine • unscheduled care • out of hours care emergency care	Patients will be able to access services at a dentist of their choice and at a time to suit their convenience for routine and unscheduled care. Unscheduled care will be provided as an integral part of daytime services. Out of hours emergency care will be provided. Unscheduled and emergency care will include a full treatment plan for necessary treatment required to improve oral health. Where patients need referral onto another service they will be able to discuss choice of provider with their dentist and book an appointment at their convenience Patients will be seen within agreed waiting times. There will be a mixed provision of primary dental care via Independent and PCT direct provision	• improved activity data available through general practice and secondary care to inform service planning • impact assessment undertaken of new dental regulations on delivery of routine and unscheduled care including EDS, with agreed definitions for unscheduled and emergency care • model developed for provision of out of hours emergency care • activity profiles show increased prevention and reduction in restorative treatment • reshaped workforce and new roles developed for dentists and skill mix introduced in dental practice (see also Workforce Development section) • patient satisfaction surveys and complaints monitoring shows improved trends towards better access
	2. Vulnerable Groups	Evidence from robust service monitoring of user experience that services are accessible	• eligibility criteria in place for all special needs groups including domiciliary care • language and translation services in place

		and tailored to meet the special needs of vulnerable groups including: growing elderly population; homeless; asylum seekers; people with disability; substance misuse; mental health problems; dental phobia; learning disability and HIV/AIDS and Hep Patients seen and treated within agreed waiting time standards There will be mixed provision of Independent and PCT direct service provision	• workforce shaped to meet needs of vulnerable groups including development of DpwSI • waiting times monitored and improved for GA and sedation to within national standards (by 2008)
	3. Orthodontics	Orthodontic services will be provided within eligibility criteria for NHS care as defined by the new dental regulations Patients will be assessed and treated within agreed waiting time standards	• impact assessment of revised eligibility criteria for orthodontic services • audit of referrals to hospital and practices to inform service planning • coding and data set review • work with partners to establish shared waiting list across primary and secondary care • eligibility criteria agreed for access to secondary care and specialist provision in community settings exploring DpwSI • waiting times to be met within national standards – 18 weeks from first assessment and treatment (by 2008)
	4. Oral Surgery	Patients requiring oral surgery will be able to access care within agreed waiting times and will have choice of provider.	• establish Integrated Clinical Assessment and Treatment Service for oral surgery in a community setting with developed DpwSI undertaking defined oral surgery

		Specialist DpwSI roles will be developed in community settings for defined oral surgery procedures. Specialist complex treatments on the hospital site	• audit of referrals and coding and data set review will inform service planning • waiting times will be monitored to ensure they are maintained within national standards
	5. IV and Inhalation Sedation	Patients will be able to access IV or Inhalation Sedation where their dentist has assessed that this is necessary to undertake a course of treatment to maintain their oral health. Access and waiting times will be much improved and will be within agreed standard waiting times There will be a mixed provision across Independent and PCT managed services.	• additional dentists to be trained for the provision of sedation • training and accreditation to be reviewed • needs assessment process to be reviewed and eligibility criteria agreed • waiting times will be monitored to ensure maintained within national standards
	6. General Anaesthesia	Patients assessed as requiring GA will be able to access services provided in a hospital setting with full clinical back-up. Waiting times for GA will be much improved	• review eligibility criteria, waiting times and SLA for hospital sessions to improve access. • Waiting times met within national standards
	7. Prevention (Oral ill health)	Evidenced-based prevention and oral health promotion services in place and impact assessment demonstrates improvements in oral health	• water fluoridation initiated or targeted evidence based fluoride scheme in place • evidence based prevention activity agreed to NICE guidelines

			• consistent approach to dental risk assessment (caries; periodontal disease and oral cancer) implemented and patients recall based on need eg smokers; betel users and alcohol dependent recalled at agreed intervals • PCT Oral Health Promotion Strategy milestone being met • prevention initiatives implemented with collaboration between dental practices and PCT dental services in targeted areas • impact assessment shows trends for increased prevention activity and reduction in recall and restorative activity • dmft and prevalence rates improved • review impact of new Dental Regulations on the role of dentists in wider ill health prevention initiatives; agree guidelines and consistent application • high oral cancer rates in Bolton investigated, service improvements identified and implemented to improve against base-line

Guiding Principle (from para (iii) page 3 of the main strategy document)	**Service or Priority Area**	**Vision (working towards the next 5 years)**	**Action and Process Measures**
B. Target services to reduce oral health inequalities	1. Public Health - Evidence of Need	A robust public health led system in place to assess and measure dental health needs in the local population – including epidemiology; aggregation of individual patient data; waiting times and user experience	• borough-wide oral health census of 5 year olds undertaken (2005/2006 and 2010/2011) and shows improved position against base-line • approach developed for dental needs assessment including work to reduce incidence of disease eg reduced oral cancer rates • public oral health measures defined and inform service planning
	2. Public Health – Deprivation	A robust system is in place to measure how deprivation influences dental disease, access to services and user preference	• borough-wide census informs service planning • service developments, access initiatives targeted to specific localities based on robust evidence based needs assessment • dental health status improved in targeted localities against specified outcome measures eg dmft and other quality measures in targeted population improved against base-line
	3. Public Health – Ethnic Minority Groups	Evidence from robust service monitoring and user experience that dental services are accessible and tailored to meet cultural and language needs	• Race Equality Assessment on proposed service developments undertaken • Targeted work in collaboration with local dental practices in ethnic communities to improve oral health in children eg improving feeding; weaning and diet • Dental health status in Ethnic Minority Communities improving against base-line

Guiding Principle (from para (iii) page 3 of the main strategy document)	**Service or Priority Area**	**Vision (working towards the next 5 years)**	**Action and Process Measures**
C. Understand patient expectation improve the patient experience	1. Patient Feedback mechanisms: PALS Complaints Surveys Research	There will be robust local processes in place for patients to influence proposals for service developments and for them to raise concerns/comments about service delivery	• all dental service providers (Practice and PCT) will undertake annual audit of patient experience and make changes where appropriate • patient satisfaction feedback shared through PCT Learning Forum • all dental service providers including practices develop and operate complaints procedure and maintain register of complaints • rising levels of patient satisfaction recorded and reduced number of complaints received • PCT survey undertaken to identify patients needs/preferences to inform service planning • Risk management training in place for practices and mechanisms for reporting adverse incidents in place in line with national policy • Improved information to patients on what they can expect to receive from NHS dental services
	2. Views from Public and Patient Involvement reps: Choice Ease of access Comfortable/clean environment Quality clinical care Reasonable waiting times	Delivery of dental services meets patients expectations and choice	• patients have access to up to date and accessible information on choice of dental services and choice of most appropriate treatment and waiting times • information provided in a style to suit need eg translated/interpretation • framework for monitoring dental services will include indicators to measure clinical care and environment see also sections A, D and E

Guiding Principle (from para (iii) page 3 of the main strategy document)	Service or Priority Area	Vision (working towards the next 5 years)	Action and Process Measure
D. Modernise the infrastructure ie buildings and Information Systems	1. PCT Estates Development programme	A wider range of dental services provided by Independent and PCT dental services will be available provided from purpose built facilities as part of the PCT Estates Development Programme including routine and unscheduled care; extended oral surgery; orthodontics etc Range and location of services targeted to meet population needs.	• Estates planning for dental services led by agreed service developments for a wider range of dental services in community settings and to improve the health care environment/patient experience • Dental representatives (PCT and GDS/PDS) involved in Estates planning
	2. Disability Discrimination Act	All sites providing NHS dental services meet DDA requirements and arrangement to support Independent Practitioners in place	• Premises assessments undertaken and reports prepared for all premises providing dental services and work to meet DDA standards quantified with priorities identified • Continue arrangements for Independent Practices to use Lever Chambers (or in future other locality suites) where necessary to treat patients with special needs.
	3. Surgery Standards	All sites providing NHS dental services meet statutory health and safety and quality standards related to premises; facilities; clinical protocols; cross infection; hygiene; clinical waste; patient areas	• Surgery Inspection check list reviewed and amended to include changes in statutory requirements and quality measures • Evidence of statutory requirements by staff and patient surveys • Programme of surgery inspections undertaken on a 3 year rolling programme with base-line assessment against standards • Data definitions agreed and activity monitoring and data collection automated

	4. Dental Practice Information Systems	All practices and dental service providers use compatible (single system) information management systems capable of interface with other NHS computer systems to support: Choose and Book Audit Collection of clinical activity Performance monitoring Practice management and organisational development	• Choose and Book developed in practices and PCT dental services
Guiding Principle (from para (iii) page 3 of the main strategy document)	**Service or Priority Area**	**Vision (working towards the next 5 years)**	**Action and Process Measures**
E. Develop the workforce and improve the working lives of dentist and their teams	1. Reshaped workforce to support the development and transfer of services into community settings to waiting times and access to dental care	There will be new roles developed for dentists and their teams – dentists will be able to take on new special interest roles eg minor oral surgery and other members of the dental care teams supported to develop enhanced skills. Alternative employment options will be available where appropriate to improve recruitment and retention of dental workforce in targeted areas	• Workforce development plans developed based on service needs • DpwSI roles to be explored and developed in eg oral surgery; orthodontics • Other dental care professional roles developed eg therapists • Dental training practices supported and developed
	2. Support practice development and support individual development of dentists and their teams	All practices use consistent approach for practice development plans supported by individual Personal	• support practices in the initial development of practice plans including annual review including PDPs for all staff

		Development Plans for dentists and their staff Education and peer support arrangements will be in place	• Plans shared with the PCT to inform service planning • All practices comply with national statutory employment requirements and good practice related to IWL eg flexible working • Practice monitoring framework in place related to the Healthcare Commission Standards • Dentists undertake minimum PDP activity in line with national requirements • Annual appraisal process in place • Audit and peer review undertaken • Explore flexibilities in new regulations related to protected time for education
	3. Implement new GDS regulations maximising opportunities to support dentists in the transition	Dental regulations applied to support the development and implementation of the oral health strategy and improve working lives of dentists. Local flexibilities in place to support dentists and their teams to reshape delivery of care	• flexible employment packages developed • flexible retirement and return to work policy in place • work in partnership with dentists and LDC on contract implementation
	4. Evidence based practice	Agencies and professional groups worked together to develop clinical pathways and protocols in line with national recommendations and to meet local needs. Robust arrangements in place for education on evidence based practice across professional groups. Activity monitoring confirms consistent approach	• general practice performance framework in place • education programmes in place • shared understanding of efficacy of evidence based practice • implementation plan for NICE guidance implementation