HEALTH SCRUTINY PANEL

Final Report – Dental Health

1.0 PURPOSE OF THE REPORT

1.1 To present the findings of the Health Scrutiny Panel's review of Dental Health.

2.0 RECOMMENDATIONS ([1])

(1) That the Local Education Authority (LEA) work with the PCT to incorporate dental and other healthcare facilities in schools under the "Building Schools for the Future" and "Extended Schools" programmes.

(2) That the LEA put an item on the agenda for the next meeting of each school governing body asking Governors to consider:

- Developing a "Brush Bus" scheme to encourage children to brush their teeth in school, building on the experience from the north east
- Implementing a reward scheme for healthy eating at lunchtimes

(3) That the Sure Start local programmes develop "Brush Bus" schemes.

(4) That the Council's Asylum Seeker Support Service work with partner agencies to pool resources via a one stop shop health information service for asylum seekers and refugees.

(5) That the PCT begins detailed discussions with the Local Dental Committee (LDC) about the roll out of the modernising dentistry agenda to ensure that NHS dentistry in Middlesbrough is not compromised.

(6) That the PCT reports back to the Panel in six months time on the progress made in the discussions with the LDC.

[1] Recommendations 1 – 4 are for consideration by the Executive
Recommendations 5 – 14 are for information only

(7) That the PCT appoint a dentist to its Professional Executive Committee in order to enhance the role of dentistry within the decision making process of the NHS.

(8) That the PCT commission a review of dental surgeries in Middlesbrough in order to identify those that do not provide acceptable standards of access for disabled people. The PCT should bring forward proposals for upgrading them or providing alternative facilities, for example by co-locating dental surgeries with GPs and other health professionals under the LIFT programme.

(9) That the Working Group looking at issues around dental treatment under general anaesthetic in hospitals brings forward proposals for reducing waiting times and reports back to the Panel in six months on the progress made.

(10) That the Community Dental Service investigates the use of mobile clinics to increase access to services where dental registration is low and further promotes its home visit service for older people.

(11) That the PCT publish culturally appropriate material relating to:

- Understanding how the NHS works
- The need to book appointments
- How to cancel appointments
- The need for punctuality
- Basic dental hygiene

(12) That the LDC publish culturally appropriate material about the services they provide.

(13) That the PCT and the Strategic Health Authority commission a credible research study into all aspects of fluoridation of water before undertaking a public information campaign and public consultation about whether to add fluoride to the water supply.

(14) That the National Care Standards Commission and the Office for Water Regulation (OFWAT) be informed of the Panel's concerns about being unable to speak to independent care providers and Northumbrian Water respectively.

3.0 BACKGROUND

3.1 The Health Scrutiny Panel was established in January 2003 to scrutinise health issues, including all aspects of the National Health Service (NHS), under the Health and Social Care Act 2001.

4.0 AIMS OF THE REVIEW

4.1 The drivers for the Panel's review of dental health were:

- The Government's announcement that responsibility for commissioning dental services is to be handed over to Primary Care Trusts in April 2005 and that £65 million will be invested in improving access to quality dental services.

- In January 2002 the Northern and Yorkshire Public Health Observatory (now the North East Public Health Observatory) published a report about the dental health of five-year old children in the region. Within the former Tees health Authority area, the report showed that children in Middlesbrough experienced the highest:

    - levels of tooth decay
    - levels of active untreated decay
    - average number of decayed, missing or filled teeth

- Another report from the Observatory published in July 2002 identified dental health as the second most common health need of asylum seekers and refugees.

- The House of Commons Health Select Committee reviewed dental health in 2001 and concluded that generally residents of care homes and people with learning difficulties have poor dental health and experience difficulties accessing dental services.

- There is a target for Social Services Departments in respect of the dental health of looked after children.

4.2 The aim of the review was to evaluate:

- access to general and community dental services in Middlesbrough and how the modernising dentistry agenda is being delivered in Middlesbrough.

- the dental health of school age children and children looked after.

- access to dental health services for residents of care homes and people with learning difficulties.

- access to dental health services for asylum seekers and refugees.

5.0 TERMS OF REFERENCE

5.1 The terms of reference of the review were:

- the availability of general and community dental services

- the dental health of:

    - school age children
    - children looked after
    - residents of care homes
    - people with a learning disability

- cultural attitudes to dental health and dental services for asylum seekers

6.0 MEMBERSHIP OF THE PANEL

6.1 The membership of the Panel was:

Councillors E Dryden (Chair), Mrs H Pearson (Vice-Chair), S Biswas, G Cole, J Elder, E Lancaster, F McIntyre, B Taylor and K Walker.

7.0 METHODS OF INVESTIGATION

7.1 The Panel met formally between October 2003 and April 2004 and a detailed record of the topics discussed is available on the Committee Management System (COMMIS) accessible from the Councils website.

7.2 In January 2004, the Panel hosted a seminar for all Health Scrutiny Councillors in the Tees Valley at the about dental health in the Tees Valley and the modernisation of dentistry agenda.

7.3 During the review, the Panel gathered evidence from:

Malcolm Smith – Modernising Dentistry Advisor, County Durham and Tees Valley Public Health Network
Peter Mercer – Associate Director, Modernising Dentistry Team, NHS Modernisation Agency
John Wilkinson – Director, North East Public Health Observatory
Judi Breckon – Clinical Director, Tees Community Dental Service
Avrille McCann – Middlesbrough Healthy Schools Scheme Manager
Angela Blower – Middlesbrough LEA Catering Manager
Sally Robinson – Team Manager, Middlesbrough Social Services
Chris Nugent – Children Looked After Health Co-ordinator
Wendy McGee – Community Dental Service Health Promotion Unit
Geraldine Nuttall – Specialist Nurse, Haven Medical Practice
Rob Lemmon – Chair, Teesside Local Dental Committee
Yvonne Watson – Middlesbrough Primary Care Trust
David Landes – Dental Health Lead, County Durham and Tees Valley Strategic Health Authority
Jane Jones – National Pure Water Association
Ray Lowry – British Fluoridation Society
Biniam Araia – North of England Refugee Service

Peter Kelly – Director of Health Improvement, Middlesbrough PCT

8.0 FINDINGS

8.1 Availability of General Dentistry

8.1.1 There has been little change to working practices in dentistry since the creation of the NHS in 1948. Dentists are essentially self-employed entrepreneurs, raising their own private capital to finance premises and equipment with which to conduct their businesses.

8.1.2 The payment that dentists receive for treating patients under the NHS is based on the principle of piecework and income is based on a set of national tariffs for individual treatments carried out, with patients paying a proportion of the cost of treatment. The current payment system is considered to have become outdated and inappropriate, having been characterised as providing a "perverse incentive" to maximise the amount of treatment given to patients in order to maximise income.

8.1.3 Across the country, there has been an increasing trend for dentists to shift the balance of their work away from the NHS towards private treatment as income from the NHS has failed to keep pace with increasing costs. This has created a perception of "crisis" around access to NHS dentistry in some parts of the country and there has been plenty of media coverage about the difficulties that patients can experience in finding a dentist that will treat them under the NHS. There is anecdotal evidence about difficulties in accessing out of hours and emergency dental care, despite the availability of advice through NHS Direct.

8.1.4 To begin to tackle these issues the Government established an "Options for Change" Working Group that reported in August 2002. The Working Group set out a range of proposals for modernising NHS dentistry that had been worked up by task groups representing a wide range of dentists and other stakeholders. The proposals from the Working Group were taken forward by the Government in the Health and Social Care (Community Health and Standards) Act 2003 which provides a framework for a new NHS dental service, led by Primary Care Trusts (PCTs), that is responsive to local needs.

8.1.5 The main thrust of the new arrangements is that from April 2005, PCTs will commission dental services either through contracts with individual dentists or through directly employed dental health care professionals. The idea is that the focus of the new service will be on preventative measures to combat dental disease and tackle oral health inequalities, particularly in children. Dentists will no longer be contracted to or paid by the NHS and there will be a simplified payment structure for treatment. The future vision is for dentists to spend more time providing oral health assessments and offering advice about disease prevention, lifestyle and treatment options.

8.1.6 Many dental practices in Middlesbrough are located in older properties that are essentially converted residential dwellings. These tend to offer a poor

environment for patients and can act as a barrier to physical access. The future vision for premises is that larger practices will be developed that provide good access to a range of specialist skills but remain cost effective.

8.1.7 The NHS Modernisation Agency is managing a number of pilot sites around the country to turn the strategy in to reality and to disseminate good practice and learning. The Agency has a key role to play in supporting PCTs and Local Dental Committees to achieve consensus about how the new arrangements will be implemented locally and to support colleagues through change. The health scrutiny process has a significant role to play in influencing the level of services to be provided based on local need.

8.1.8 The pilot sites are focussing on issues such as:

- simpler methods of remunerating dentists for dental care
- using ICT to improve services and communication
- developing the skill mix and extending dental care teams
- improving facilities to support multi-disciplinary work in appropriate settings
- improving the patient experience
- devolving the budget for dental care to the local NHS

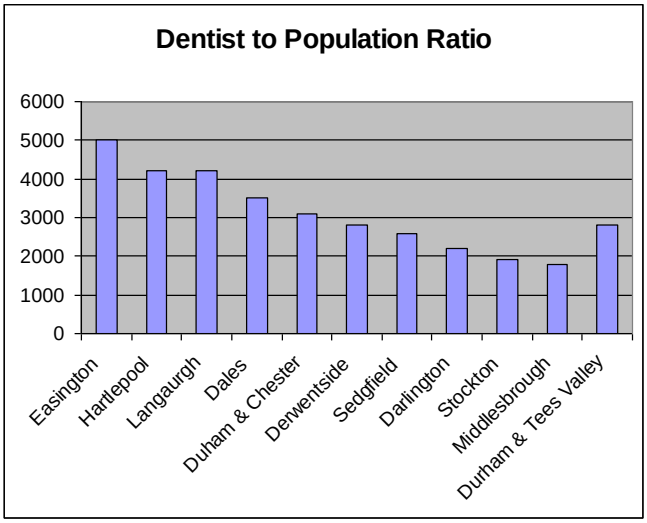
8.1.9 Early lessons from the field sites were noted as follows:

- stakeholders were working with a common purpose
- mechanisms were needed to accommodate vocational training
- dentists did not want others negotiating on their behalf.

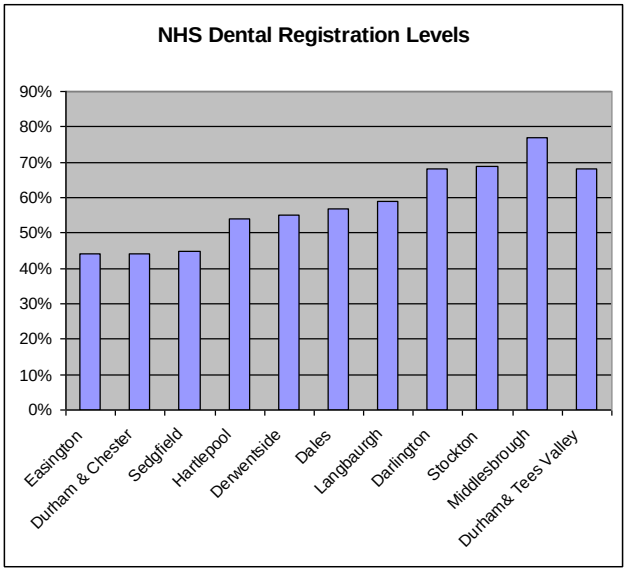
8.1.10 Experience from the pilot sites will inform the development of Service Level Agreements that reward new ways of working and keep things simple.

8.1.11 Evidence from the Tees Local Dental Committee is that discussions with the PCT are yet to start and that much of the detail about how dental health services in Middlesbrough will look in the new era remains unresolved. There is a likelihood of many dentists moving into the private sector if issues relating to the expansion of preventative care, workforce and resources for improving access remain unresolved. Dentists are concerned that the modernising agenda has been developed to fit a national model but that Middlesbrough does not fit that model because it has good access to NHS dentistry. Dentists are worried that the plan to make dentistry better may in fact have the opposite effect in Middlesbrough.

8.1.12 Compared to other areas of the north east, Middlesbrough has the highest ratio of dentists relative to population as shown in Table 1:



8.1.13 The percentage of the population registered with a dentist in Middlesbrough is also the highest compared to north east neighbours as shown in Table 2:



8.2 <u>Availability of Community Dentistry</u>

8.2.1 Following a review of Community Dental Services across the Tees Valley in 2002, services are managed on a Tees-wide basis. The Service:

- monitors the dental health of all age groups.
- screens the teeth of children in state funded schools at ages 5, 12 and 14 as part of a national data programme.
- provides dental health promotion and preventative programmes in schools such as the promotion of healthy drinks.

- provides a full range of dental treatment for patients with special needs, specialist general anaesthesia and sedation services

- acts as a “safety net” for people who can't or won't register with a dentist.

8.2.2 The Community Dental Service seeks to actively improve oral health by:

- working with Sure Start to target oral health promotion towards schools with a dmft (decayed, missed or filled teeth) of 1.5 and above.

- providing vocational training for dental health professionals.

- sharing experience and developing clinical attachment with dental health colleagues.

8.2.3 Patients needing routine extractions or restorative work under general anaesthetic (GA) are referred to James Cook University Hospital as current Department of Health guidance indicates that this should only be administered in a hospital setting where care facilities are available. Access to hospital theatre time and ward beds is limited and there is insufficient capacity in hospitals to cope with the number of referrals.

8.2.4 Theatre time is busy in acute hospitals and there are limited sessions that can be allocated for dental care under GA. Only 5 or 6 patients (extractions only) can be seen or 4 patients (extractions and fillings) at each outpatient list and only 2 patients can be treated for restorative/extraction care on the inpatient list. Patients are currently waiting between 6 to 9 months to be allocated an outpatient appointment at James Cook University Hospital and waiting times are similar at University Hospital of North Tees. Around 400 patients that have been referred to the CDS from their family dentist for this type of care are currently awaiting an appointment.

8.2.5 A Tees-wide group of representatives from PCTs, hospital GA and Community Dental Service staff meets to review the options available to address dental GA requirements on a regular basis.

8.2.6 The Community Dental Service also serves the travelling community if they use established sites and schools. The Service faces challenges to raise the awareness of the homeless of the services it provides.

8.2.7 Home visits are available for older people and there is scope for extending the promotion of this service.

8.3 <u>Dental Health of School Age Children</u>

8.3.1 In 2002, the Northern and Yorkshire Public Health Observatory reported that within the former Tees Health Authority area, 5-year old children in Middlesbrough had:

- The highest percentage with tooth decay (55%)

- The highest percentage of untreated decay (47%)
- The highest average (dmft) (2.31)

8.3.2 In contrast, only 37% of 5-year olds in Hartlepool showed evidence of tooth decay, 33% had untreated decay and there was an average dmft of 1.03.

8.3.3 A study in 2003 showed that 14-year old children across the Middlesbrough and Langbaurgh PCT areas had an average dmft of 2.18, compared to an average across the north east of 1.67 and an average in Hartlepool of 1.06.

8.3.4 The Observatory report noted that Hartlepool has a water supply that contains a natural level of fluoride of nearly one part per million. Seven PCT areas in the region have fluoridated water supplies and six of these are in the ten with the lowest percentage of children with decay and the lowest levels of dmft.

8.3.5 Dental care that children receive for decay is divided between treatment by extraction or treatment by restoration. Ideally, the proportion of decay treated by restoration and filling of teeth should be very much higher than the proportion of teeth extracted. The Observatory noted that Middlesbrough has a high level of extraction (24%).

8.3.6 In relation to dental health, the Observatory concluded that:

- In areas with the poorest levels of dental health urgent consideration should be given to introducing a range of oral health promotion measures including water fluoridation; fluoridated milk; and distribution of fluoride toothpaste.

- Oral health promotion should always be based and delivered on a multi-disciplinary basis wherever possible and should be included in community initiatives aimed at improving the health of those in the most deprived areas.

- Healthcare and other professionals should have oral health included in their basic training and continuing professional development.

- The reduction of sugar consumption should be included as part of promoting good nutrition and a healthy diet and the availability of healthier choices such as the provision of sugar-free snacks, drinks and medicines should be promoted.

- Culturally appropriate resources should be produced to address the poorer level of dental health of young children in the Asian community.

- Dental practices should be encouraged and supported to adopt a more preventive/restorative approach to treating young children, and should consider the flexibility that the Personal Dental service scheme provides.

- Community dental services should consider making care more accessible for children who are not taken to a dentist by their parents, including the

wider use of mobile surgeries or provision of transport from school to clinic.

- All Primary Care Trusts should ensure that they have access to dental public health advice in order to plan the most effective way to improve the oral health of their community and reduce inequalities.

8.3.7 Dental health is incorporated in to the “healthy eating” theme of the Healthy Schools Scheme. All schools in Middlesbrough have joined the Scheme. Within schools, fruit is on sale daily and crisps, sweets and fizzy drinks are not sold. Some schools do not allow pupils to leave school premises at lunchtimes and this further reduces their consumption of sugary items during the day. Middlesbrough PCT is promoting the drinking of water by distributing free water bottles to all pupils in Middlesbrough schools.

8.3.8 Good diet contributes to good dental health. A balanced school lunch menu is provided that includes healthy options and the Panel heard that the uptake of healthier options can be increased through schemes that reward pupils for selecting healthy choices.

8.3.9 Dental health of school age children is particularly poor in East Middlesbrough and from 18 March free fruit has been available for all 4 to 7 year olds in schools within the community. Ormesby School runs a small-scale dental health project that emerged from an examination of the reasons for pupil's absence from school. A common reason given for absence was “attending dental appointments” and agreement had been reached with local dentists that appointments would not be given to children in school time. As part of a Year 7 Health Programme a project had been devised to raise the profile on dental health care covering aspects such as healthy eating. The School considered that as part of the Extended Schools initiative, there was scope to develop facilities within schools for dentists and hygienists to assist with diagnosis.

8.3.10 The Panel heard that another local authority in the north east had piloted a “brush bus” initiative that encouraged children to brush their teeth in school, particularly after breakfast clubs and at lunchtimes.

8.4 <u>Dental Health of Children Looked After</u>

8.4.1 The Children Act 1989 places specific duties on Councils with social services responsibilities to promote the health of children looked after, including undertaking health assessments for all children looked after within the context of a Department of Health policy document entitled “Promoting the Health of Children Looked After”.

8.4.2 Middlesbrough PCT has appointed a Nurse Co-ordinator who has a health promotion appointment with all children that become looked after. This appointment includes information about whether the child is registered with a dentist and when the child was last seen. Children looked after are provided with toothpaste and a toothbrush. Where children are registered with a

dentist, every effort is made to keep continuity with that dentist throughout the looked after period. If a child has not seen a dentist in the previous six months, foster carers or residential social workers will arrange an early appointment for the child. Health records of children looked after are maintained and are discussed at looked after reviews.

8.4.3 Social Services Authorities have a performance indicator about the percentage of children looked after for at least 12 months that have had their teeth checked in the last 12 months. Current performance in Middlesbrough is 95%.

8.5 Residents of Care Homes

8.5.1 Letters were sent on behalf of the Panel to each of the independent care providers in Middlesbrough inviting them to take part in the review and to give evidence about the dental health services available for their residents. No responses were received and the Panel was therefore unable to complete this aspect of the review.

8.6 Dental Health of People with Learning Difficulties

8.6.1 Community Dental Services for Middlesbrough are provided at the Woodlands Road Clinic. Oral health promotion for children with learning and physical difficulties is provided in schools and includes a needs assessment that is completed with teachers to produce a special needs programme. This programme is currently being piloted at Beverly School and a second programme is to commence at Priory Woods.

8.6.2 Although the CDS provides services for people with physical disabilities, the problems associated with access to many general dental practices need to be tackled.

8.7 Cultural Attitudes to Dental Health and Dental Health of Asylum Seekers and Refugees

8.7.1 Established ethnic groups in Middlesbrough tend to make their own arrangements to register with a dentist. The Panel was unclear as to how many dentists in Middlesbrough were of an ethnic origin. The Northern and Yorkshire public health observatory considered that Asian children suffered particularly poor dental health. There was no evidence that poor dental health or access to services was an issue for any other group.

8.7.2 The main access point for health services for asylum seekers and refugees is the Haven Medical Practice. The practice was set up in October 2002 and was established to ease the workload pressures on GPs and dentists to cope with complex healthcare requirements and the need for interpreting services. Since October 2002, all asylum seekers disbursed to Middlesbrough have

been registered with the Practice. Registration is arranged through housing providers. Although some larger families are accommodated in the outlying areas of Middlesbrough, most asylum seekers and refugees are housed in the central area of the town. There are three main housing providers, including Middlesbrough Council.

8.7.3 The Haven Practice offers specialist services that include an overall health assessment usually arranged within two weeks of arrival in Middlesbrough. Children of asylum seekers and refugees are issued with a “brushing for life” pack

8.7.4 Currently only two dental practices in Middlesbrough provide treatment to asylum seekers and 800 people have been registered with them practices by the Haven Practice. Once registered, people can book appointments either directly with the dentist or through the Haven Practice.

8.7.5 The main reasons given by dentists for not accepting asylum seekers or refugees on to their lists are the need for interpreters and problems associated with appointments not being kept. The Haven Practice and the North of England Refugee Service explained that the likely reasons for non-attendance were:

- other appointments with solicitors or immigration officials.
- mental health problems.
- the need for interpreters; and
- cultural differences around appointment keeping.

8.7.6 Very often people do not appreciate the time-limited nature of healthcare appointments in the UK and this was an issue with GPs and dentists who felt that asylum seekers and refugees often took up too much time.

8.7.7 In this context, there is scope for developing an education programme for asylum seekers and refugees based around:

- an understanding of how the NHS works.
- how to book an appointment and avoid turning up expecting to be seen.
- how to cancel appointments.
- the need for punctuality.
- basic dental hygiene.

8.7.8 The National Asylum Seeker Support Service (NASS) issues asylum seekers with an HC2 Form that entitles them to receive free NHS services whilst their application is being processed. The Form is renewable every six months. The Panel heard that if for any reason NASS support is stopped, the right to care is terminated. GPs usually continue to give treatment without requesting to see the HC2 Form, but dentists tend to request the Form on each visit. Without the HC2 Form treatment is expensive and anecdotal evidence was

received about people borrowing money to pay for treatment. Whilst people with a support network might find this acceptable, individuals can find this challenging.

8.7.9 It was estimated that 40% of people who have their NASS support stopped subsequently had it reinstated because the decision to stop support is made in error. There is a minimum of 4 weeks to sort out problems, which can cause problems for individuals who lose their entitlement to free care.

8.7.10 Problems with providing interpreters have largely been resolved. The PCT funds a service that is provided by Everyday Language Solutions that covers approximately 80% of the languages required. Language Line also provides a telephone service when required. Interpretation is essential for accurate communication, especially with regard to effective diagnosis and treatment. It is not considered generally appropriate for family and friends to interpret as this can compromise patient confidentiality. It also places children in a potentially harmful position if they are interpreting for their parents or relatives about a sensitive medical issue.

8.7.11 Inevitably dental hygiene varies from person to person and those from developed countries are more likely to have had dental checks rather than those who have been isolated from previous treatment.

8.7.12 The first contacts for asylum seekers and refugees are the housing providers. Further support for this section of the community is provided through the North of England Refugee Service and the Haven Medical Practice. The Panel felt that there was scope for the Council's Asylum Seeker Support Service to work with these partners to develop a "one stop shop" approach to healthcare for asylum seekers and refugees.

8.8 Fluoridation of Water

8.8.1 Although not contained in the original terms of reference of the review, fluoridation of water was an issue that emerged early on as a topic that the Panel should address in the context of dental health in Middlesbrough.

8.8.2 Prior to the passing of The Water Act in November 2003, the power to decide to add fluoride to water rested with individual water companies. Some parts of the country have received fluoridated water supplies since the 1960s. The Act has switched responsibility for fluoridation from water companies to Strategic Health Authorities (SHAs). In a press statement accompanying the Act, Environment Minister Elliot Morley is quoted as saying:

"Fluoridation of water is capable of reducing inequalities in oral health, but the Government is not seeking to put in place a centrally directed, national fluoridation programme, local communities will have the right to choose."

8.8.3 The legislation requires SHAs to take into account public opinion before taking a decision to fluoridate the water supply. If an SHA decides to have fluoride added to the water supply, the Water Act requires it to publish report every

four years about the effects on the health of people living in the area affected. The position of the County Durham and Tees Valley Strategic Health Authority is that if PCTs decide to pursue fluoridation, then the SHA will undertake extensive consultation in accordance with Government guidance about the consultation process that is due to be issued in the summer.

8.8.4 A letter was sent on behalf of the Panel to Northumbrian Water inviting the company to take part in the review and to give evidence about the technical aspects of fluoridation. No response was received and the Panel was not able to complete that aspect of the review.

8.8.5 There has been a long running argument over the potential benefits and potential harms of adding fluoride to water supplies that has lasted for many years. The Panel recognised that adding fluoride to water is only one means of combating poor dental health.

8.8.6 The Panel heard evidence from the PCT and the British Fluoridation Society that the available scientific evidence supports fluoridation and that there is no clear correlation between fluoride in water and the negative health effects claimed by opponents. The British Fluoridation Society attributes the lower levels of tooth decay that occur elsewhere to the natural or artificial fluoridation of the water supply and believe that the available evidence is sufficient to justify a case for fluoridation of water in the Middlesbrough area. This view is supported by Middlesbrough PCT and, anecdotally, by the Directors of Public Health across County Durham and the Tees Valley.

8.8.7 Opposing fluoridation of water, the National Pure Water Association believes that the potential negative health effects for the majority outweigh the benefits to a few and that enforced medication is unethical. The Association pointed out that there are differences between the compounds of fluoride that occur naturally (usually with calcium) and the compounds of fluoride artificially added (hexafluorosilicic acid or disodium hexafluorosilicate) and commented on how those products were derived. The Association commented on a number of potential negative health effects that it attributed to excess intake of fluoride.

8.8.8 The North East Public Health Observatory noted a lack of high quality research around the issue of water fluoridation. The latest study carried out by the NHS Centre for Reviews and Dissemination at the University of York (known as the York Review) was published in 2000.

8.8.9 The York Review examined over 700 relevant papers published between 1951 and 2000. The Review criticised many studies for a “lack of appropriate analysis” and the poor quality of diagnostic data to secure confidence in the results. The impact of separating out the impact of fluoride in water from other factors such as diet and general oral hygiene was another concern.

8.8.10 The Review raised the issue about how good the evidence has to be in order for a mass public health measure to go ahead.

9.0 CONCLUSIONS

- Under the “Building Schools for the Future” and the “Extended Schools” programmes, the Local Education Authority should consider working with the PCT to incorporate dental and other healthcare facilities in schools (recommendation 1 refers)

- School governing bodies should consider (recommendation 2 refers):

    - developing a “brush bus” scheme, building on the experience from other areas in the North East.

    - implementing a reward scheme for healthy eating at lunchtime

- The Sure Start local programmes should consider developing “brush bus” schemes (recommendation 3 refers)

- A number of services exist to provide information and support to asylum seekers and refugees, but there appears to be little co-ordination of services. The Council’s Asylum Seeker Service should consider working with partners to pool resources via a “one stop shop health information service for asylum seekers and refugees (recommendation 4 refers)

- The Panel is concerned that the Governments’ plans for modernising dentistry may not lead to a better service for NHS patients in Middlesbrough. Details about how the new arrangements will be rolled out locally is not yet available and the PCT should begin detailed discussions with the Local Dental Committee to ensure that access to NHS dentistry is not compromised. The Panel should receive a further report from the PCT in six months time on the detail that has emerged from the discussions (recommendations 5 and 6)

- The PCT should consider appointing a dentist to its Professional Executive Committee in order to enhance the role of dentistry within the decision making process of the NHS (recommendation 7 refers)

- Physical access to some dental surgeries in Middlesbrough is poor. The PCT should commission a review of dental practices to identify those premises that don’t meet acceptable standards of access for those with a physical disability. Proposals should be brought forward for upgrading them or providing alternative facilities. The PCT and dentists should be encouraged to co-locate dental surgeries with GPs and other health professionals through the LIFT programme (recommendation 8 refers)

- The Working Group looking at dental treatment in hospitals under GA should bring forward proposals for reducing the waiting times (recommendation 9 refers)

- The Panel believes that access difficulties are a disincentive for some communities to visit a dentist. The Community Dental Service should investigate this and evaluate the use of mobile dental clinics in those communities where dental registration is low (recommendation 10 refers)

- The PCT should publish culturally appropriate material relating to (recommendation 11 refers):

    - an understanding of how the NHS works.
    - how to book an appointment and avoid turning up expecting to be seen.
    - how to cancel appointments.
    - the need for punctuality.
    - basic dental hygiene.

- Dentists should publish written material in a variety of languages about the services they provide (recommendation 12 refers)

- Panel members have formed a range of opinions about whether fluoride should be added to the water supply. Based on the outcome of the York Review, the PCT and the Strategic Health Authority should commission a credible research study of all the issues around fluoridation of water before undertaking a public education campaign and a public consultation exercise under the Water Act (recommendation 13 refers)

- The Panel is concerned that it was unable to speak to independent care providers about services for residents of care homes and Northumbria Water about water fluoridation during the review. The concerns should be passed on to the Care Standards Commission and OFWAT respectively (recommendation 14 refers)

10.0 ACKNOWLEDGEMENTS

10.1 In addition to those that gave evidence during the review, the Panel is grateful to Julie Bennington (Governance Officer) and Tim Gilling (Health Scrutiny Officer) for their assistance during the review.

COUNCILLOR EDDIE DRYDEN,
CHAIR, HEALTH SCRUTINY PANEL

BACKGROUND PAPERS

NHS Dentistry: Options for Change – Department of Health - August 2002

An Evolving Modernisation of Dentistry Agenda – Chief Dental Officer's Digest Supplement - May 2003

Promoting the Health of Children Looked After – Department of Health
The Water Act 2003

Dental Fluorosis: Smile Please, But Don't Say Cheese – National Pure Water Association

Should Fluoride be Added to London's Water? – London Assembly Health Committee – November 2003

Minutes and notes of meetings held on the Councils COMMIS system