EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE (PRIMARY DENTAL SERVICES) (MISCELLANEOUS AMENDMENTS) REGULATIONS 2011

2011 No. 1182

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 This instrument makes provision for implementing the Capitation and Quality Scheme, which is a pilot scheme to inform the future development of a new national contract for the provision of NHS dental services. It provides for Primary Care Trusts and dental services contractors to elect to enter into Capitation and Quality Scheme Agreements to trial new mechanisms for remuneration for contractors who elect to participate in the Scheme through payments for capitation and quality in accordance with a new Dental Outcomes Quality Framework, rather than for just activity. The Scheme is intended to run until 2013, when it will then be evaluated to help determine appropriate provisions for a new national contract for NHS dental services to improve oral health outcomes.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None.

4. Legislative Context

4.1 These regulations make provision to make a temporary variation of the scheme under which NHS dental services are provided by some existing providers of NHS dental services under Part 5 of the National Health Service Act 2006 ("the Act"). This is to enable the Secretary of State to run a targeted pilot scheme under his powers in the Act to provide dental services. Under this scheme, contractors who elect to participate in the Scheme are selected, subject to certain eligibility criteria, to enter approved Capitation and Quality Scheme Agreements to trial new methods of remunerating dentists to focus on maintaining and improving oral health rather than on treatment only. This is in the light of recent national surveys that show that two-thirds of adults and children are now free of visible tooth decay. This is the first occasion on which the relevant regulation-making powers in Part 5 of "the Act" have been exercised in this way.

4.2 NHS primary dental services are provided under Part 5 of the Act, and regulations made under that Part prescribe the mandatory contractual terms that must be contained in primary dental services contracts between Primary Care Trusts and dental services providers. This instrument suspends specified mandatory terms of

the standard primary dental services contracts where a contractor and a Primary Care Trust elect to enter into a Capitation and Quality Scheme Agreement. The terms and conditions suspended by this instrument are to be replaced in the contractor's primary dental services contract by temporary terms and conditions set out in the National Health Service (Dental Services) (Capitation and Quality Scheme Agreements) Directions 2011("the Directions") (Appendix 1) These temporary arrangements are part of a scheme involving approximately 80 contractors which is to end on 31st March 2013 and which is explained in greater detail in paragraphs 7.2 and 7.3 below. The powers used to set the temporary terms and conditions are the Secretary of State's direction-making powers in section 8 of the Act, and those directions are in respect of his powers under section 3 of the Act which include a power to provide dental services (see section 3(1)(c)).

4.3 Each PCT is required under section 99 of the Act to provide primary dental services within its area, or to secure their provision within its area to the extent that it considers necessary. PCTs provide NHS dental services by entering into either a general dental services contract (GDS Contract) made under section 100 of the Act, or a personal dental services agreement (PDS agreement) made under section 107 of the Act, with a contractor. These contracts and agreements are governed by the National Health Service (General Dental Services Contracts) Regulations 2005 (2005/3361) and the National Health Service (Personal Dental Services Agreements) Regulations 2005 (2005/3373) which set out the mandatory terms which must be included in a GDS contract or a PDS agreement, though parties are free to include any other terms provided they do not cut across the statutory mandatory terms. Currently, those providing NHS primary dental services are remunerated under either GDS contracts or PDS agreements on the basis of being obliged to deliver a specified number of "units of dental activity" (UDAs) for a specified payment in a financial year. The government is considering how to move from the UDA system for payments for NHS services to a system based on registration, capitation and quality instead of UDAs.

4.4 In order to design such a system, the Department first needs to understand how these payments influence the behaviour of patients and dentists. The Department therefore wishes to temporarily vary a number of GDS contracts and PDS agreements so as to make payments based on registration, capitation and quality rather than UDAs. We are using powers to vary terms in the contracts and the agreements which have the same effect as six provisions within the PDS and GDS regulations and which are replaced for the duration of a Capitation and Quality Scheme Agreement with terms having the same effect as those set out in the Capitation & Quality Scheme Arrangement Directions and the Capitation & Quality Scheme Statement of Financial Entitlements (SFE).

4.5 The Capitation & Quality Scheme Arrangement Directions direct PCTs to run Capitation and Quality Scheme Agreements up until 31 March 2013. It is anticipated that no more than 80 of these agreements will be made. Participation in the scheme is voluntary for both PCTs and contract holders. To put this number in context, there are some 9,000 NHS primary dental care contracts in England.

4.6 It is the intention that no PDS agreement or GDS contract holder is disadvantaged solely because they take part in a Capitation & Quality Scheme Arrangement. The elements of the Capitation & Quality Scheme SFE relating to superannuation, seniority payments, vocational training payments, pay for maternity, paternity and adoption leave, pay for long-term sickness absence and reimbursement of non-domestic rates are unchanged from the underlying Personal Dental Services Statement of Financial Entitlements and the General Dental Services Statement of Financial Entitlements which set out the payment mechanisms and other entitlements for providers of NHS dental services.

4.7 In addition, minor amendments are made to the contractual terms which a GDS contract and PDS agreement must have in respect of the specified grounds that a contractor may not refuse to provide treatment and the time period in respect of termination of a contract on the death of a contractor

5. Territorial Extent and Application

5.1 This instrument applies to England only.

6. European Convention on Human Rights

As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

- What is being done and why

7.1 A specific commitment to introduce a new NHS dentistry contract that focused on achieving good health and increasing access to NHS dentistry, with an additional focus on the oral health of schoolchildren was made in the Coalition Agreement. In December 2010, the government announced its proposals to pilot changes to the dental contract. This was confirmed in a Ministerial announcement on 11 April 2011.

7.2 The scheme will test four variations on the mechanism of paying for dental services:

(a) Some pilots will receive a fixed contract amount, which will be the same as their contract value going into the pilot, and in return will be expected to deliver all the NHS care they believe is clinically necessary for their patients. The intention of these pilots is to inform work to determine the appropriate size of a dentist's patient list and to calculate an appropriate daily capitation value for patients.

(b) Some pilots will have their payments adjusted based on the number of patients that are under their care, weighted for age, sex and deprivation. This weighted capitation payment will cover all NHS care. The intention

of these pilots is to determine how treatment patterns change when a capitation system is used, rather than one based on course of treatment.

(c) Some pilots will have their payments adjusted based on the number of patients that are under their care (weighted for age, sex and deprivation) but this weighted capitation payment will cover only routine NHS care. There will be a fixed contract amount for complex care. The intention of these pilots is to determine how access to and delivery of complex care is affected by capitation.

(d) Across the three variations above, the majority of pilots will also have 10% of their contract value dependent on performance against a Dental Quality and Outcomes Framework (DQOF) (Appendix 2). The intention is to determine how effective payments for quality are in terms of incentivising dentists to achieve improvement in patients' oral health and in patient experience.

(e) The payment mechanisms for making these payments are set out in the Capitation and Quality Scheme Agreements Statement of Financial Entitlements which will be published on the Department of Health Website www.dh.gov.uk.

7.3 As well as payment mechanisms, the pilots will also be evaluated to determine how a national contract might be implemented:

(a) A new Oral Health Assessment will be tested by dentists to ensure it supports the improvement of oral health, drives appropriate care planning and is not overly bureaucratic to conduct.

(b) The structure, measures and target levels in the DQOF will be tested to ensure it drives improvements in oral health and patient experience and to enable the Department to set the appropriate quality standards for future reform of the dental contract system.

(c) The commissioning, information, IT and infrastructure requirements of running a new contract based on capitation and quality will be evaluated to enable the cost implications to be assessed properly.

7.4 Risks to the implementation of the new policy are mitigated by limiting the number of pilot practices and the degree to which income of those taking part in pilots and expenditure by PCTs hosting pilots can vary as set out in paragraphs 10.2 and 10.4 below. The pilots will run for a limited period and there is no commitment to taking these provisions beyond the pilot stage. The pilot programme is funded from an existing programme budget and all other costs will be met by the practices or host PCTs from existing allocations.

- Consolidation

7.5 As the majority of dental practices are not involved in the pilots, it is necessary to maintain the PDS and GDS Regulations to run alongside these new regulations. As part of any further work to develop a national contract after the pilots, a decision will be made as

7.6 Amendments are required to the contractual terms which a GDS contract and PDS Agreement must have in respect of the specified grounds that a contractor may not refuse to provide treatment. This is an updating provision to ensure consistency with the modern terminology used in respect of equality issues. The time period in respect of termination of a contract on the death of a contractor is increased from 7 to 28 days to allow a smoother transition for those affected by a death in service. The change has been discussed and agreed with representatives of the dental profession.

8. Consultation outcome

8.1 Throughout the work on the reform of the dental contract, the two main stakeholder groups have been engaged and consulted:

(a) The dental profession has been engaged through representatives from the British Dental Association (BDA) being on the National Steering Group that shapes the work on the programme. In addition, the BDA has seen and agreed the draft documentation on contract models for testing under the Capitation & Quality Scheme, the payment mechanism and the SFE. Comments received from the BDA have been taken into account when the documents have been finalised. Involvement of the BDA in the process will continue when the Capitation & Quality Scheme begins.

(b) Patients have been represented by the consumer advice organisation *Which?*, who have been represented on the National Steering Group. It should be noted that there is no change to a patient's entitlements or the level of patient charges for patients treated under the Capitation & Quality Scheme.

9. Guidance

9.1 Those PCTs and contract holders involved in the Capitation & Quality Scheme will receive the following support and guidance:

(a) Training events will be held for all those taking part in the scheme to familiarise them with the Oral Health Assessment, the payment mechanisms, new IT software and the evaluation and monitoring requirements of the scheme

(b) Guidance documents will be produced to explain the scheme, payment mechanism and SFE

(c) The DH will provide a team to support all the sites where the scheme is running.

9.2 A Patient Information Leaflet titled Oral Health Assessment – Patient Information (Appendix 3) has been produced to explain the improved Oral Health Assessment

to patients which will be published on the Department's website, and will be required to be displayed in practices of participating contractors.

10. Impact

10.1 The impact on business, charities or voluntary bodies is negligible.

10.2 The impact on the public sector is a different payment mechanism for the providing dental services for those taking part in the scheme. The impact has been limited by capping the amount that a contract holder's income can vary from their contract value before they entered the scheme – 98% to 102% in terms of changes due to capitation and 90% to 102% in terms of changes due to quality.

10.3 An Impact Assessment has not been prepared for this instrument.

10.4 One of the purposes of the Capitation & Quality Scheme, which affects less than 1% of dental practices, is to assess the potential impact of a national scheme on businesses, charities voluntary bodies, the public sector, patients, dentists and minority groups in order to inform the proposals for eventual reform of dental contracts, which will require separate primary legislation.

11. Regulating small business

11.1 The legislation does not apply to small businesses.

12. Monitoring & review

12.1 The Capitation & Quality Scheme will be evaluated after the first year to determine its effect on a range of areas, including changes in the oral health of patients, the number of patients accessing NHS dentistry, changes in the payments made to contract holders, patient experience and satisfaction, the impact on patient charge revenue and the impact on the use of the dental workforce.

13. Contact

David Lye at the Department of Health, Tel: 020 7633 7911 or email David.Lye@dh.gsi.gov.uk can answer any queries regarding the instrument. Alternatively, Helen Miscampbell at the Department of Health, Tel: 020 7633 7170 or email: Helen.Miscampbell@dh.gsi.gov.uk can be contacted.

Appendix 1

DIRECTIONS

THE NATIONAL HEALTH SERVICE ACT 2006

The National Health Service (Dental Services) (Capitation and Quality Scheme Agreements) Directions 2011

The Secretary of State for Health makes the following Directions in exercise of the powers conferred by sections 8 and 272(7) and (8) of the National Health Service Act 2006(a).

PART 1

GENERAL

Citation, commencement, duration and application

1.—(1) These Directions may be cited as the National Health Service (Dental Services) (Capitation and Quality Scheme Agreements) Directions 2011 and come into force on 1st June 2011.

(2) These Directions will cease to have effect on 1st April 2013.

(3) These Directions are given to Primary Care Trusts in England.

Interpretation

2.—(1) In these Directions—

"the Act" means the National Health Service Act 2006;

"Capitation and Quality Scheme Agreement" means an agreement which forms a temporary part of a GDS contract or PDS agreement and which is entered into as part of the Capitation and Quality Scheme and in accordance with these Directions;

"Capitation and Quality Scheme" means the scheme of that name that the Secretary of State has developed to assist in continuing to promote and secure improvement in the provision of dental services in accordance with the Act;

"contractor" means a person or persons other than a Primary Care Trust, who is a party, or are parties, to a GDS contract or a PDS agreement;

"GDS contract" means a general dental services contract;

"GDS Contracts Regulations" means the National Health Service (General Dental Services Contracts) Regulations 2005(b);

"GDS SFE" means the General Dental Services Statement of Financial Entitlements(c);

(a) 2006 c.14. *See* section 275(1) for the definitions of "prescribed" and "regulations", which are relevant to the powers being exercised.

(b) S.I.2005/3361. Amendments have been made by S.I.2006/563, 2007/544, 2008/528, 1514, and 1700, 2009/309 and 462 and 2010/22 and 1181.

(c) General Dental Services Statement of Financial Entitlements signed on 31st March 2009 published on the Department of Health website www.dh.gov.uk Gateway number 11583, as amended by the General Dental Services Statement of Financial Entitlements (Amendment) Directions 2010 signed on 8th April 2010 published on the Department of Health website www.dh.gov.uk Gateway number 13872, and the General Dental Services Statement of Financial Entitlements and the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2011 published on the Department of Health website www.dh.gov.uk.

"the NAAV" means the negotiated annual agreement value of a PDS agreement determined by section 2 of the PDS SFE;

"the NACV" means the negotiated annual contract value of a GDS contract determined by section 2 of the GDS SFE;

"overall business value" means the turnover of a practice in respect of the provision of dental services, whether provided as NHS services or otherwise, in a financial year;

"participant" means a contractor who is a party, or are parties, to a Capitation and Quality Scheme Agreement;

"PDS agreement" means an agreement under which primary dental services are provided under section 107 of the Act;

"PDS Agreements Regulations" means the National Health Service (Personal Dental Services Agreements) Regulations 2005(a); and

"the PDS SFE" means the Personal Dental Services Statement of Financial Entitlements Directions(b).

(2) Expressions used in Part 3 and whichever of the GDS Contracts Regulations or the PDS Agreements Regulations applies to a participant's Capitation and Quality Scheme Agreement have the same meaning in both contexts.

PART 2

CAPITATION AND QUALITY SCHEME AGREEMENTS

Directions to Primary Care Trusts

3.—(1) A Primary Care Trust must, where requested to do so, consider entering into a Capitation and Quality Scheme Agreement with a contractor but may only do so where the Secretary of State has approved the proposal for the contractor and the Primary Care Trust to participate in the Capitation and Quality Scheme.

(2) A Primary Care Trust may only enter into a Capitation and Quality Scheme Agreement where the Secretary of State's approval to enter into that Agreement has been obtained and the conditions in paragraph (3) apply.

(3) The conditions referred to in paragraph (2) are—

(a) the Secretary of State has approved the proposed Capitation and Quality Scheme Agreement as being suitable to assist in the continuing promotion and development of primary dental services in order to secure such services;

(b) the contractor meets the eligibility conditions specified in direction 4; and

(c) the Primary Care Trust satisfies itself that the contractor understands the objectives of participating in the Capitation and Quality Scheme and understands the requirements being placed upon the contractor as a consequence of entering into the Capitation and Quality Scheme Agreement.

(4) The Capitation and Quality Scheme Agreement which the Primary Care Trust enters into—

(a) must be in writing;

(a) S.I. 2005/3373; as amended by S.I. 2006/563, 2007/544, 2008/528 and 1514, 2009/309 and 462 and 2010/22 and 1181.

(b) Personal Dental Services Statement of Financial Entitlements signed on 31st March 2009 published on the Department of Health website www.dh.gov.uk Gateway number 11583, as amended by the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2010 signed on 8th April 2010, published on the Department of Health website www.dh.gov.uk Gateway number 13872 and the General Dental Services Statement of Financial Entitlements and the Personal Dental Services Statement of Financial Entitlements (Amendment) Directions 2011 published on the Department of Health website www.dh.gov.uk.

(b) must contain terms that have the same effect as those terms and conditions specified in directions 5 to 13;

(c) must be of a duration that does not extend to any period after 31st March 2013; and

(d) must start at the beginning of a day and end at the end of a day.

Eligibility conditions

4.—(1) Primary Care Trusts must only enter into a Capitation and Quality Scheme Agreement with a contractor—

(a) where that contractor has entered into a PDS agreement or a GDS contract with that Primary Care Trust which subsists on 31st May 2011, and —

(i) that PDS agreement or, as the case may be, that GDS contract has—

(aa) at 31st December 2010 subsisted for a period of at least 3 years, and

(bb) immediately before the calendar month in which the Capitation and Quality Scheme Agreement is to commence a NAAV or, as the case may be, a NACV which is at least £100,000 per year,

(ii) where at least 80% of the NAAV of that PDS agreement or, as the case may be, the NACV of that GDS contract is attributed to units of dental activity,

(iii) in the case of a contractor with a PDS agreement, mandatory services are provided under that agreement, and

(iv) where the remuneration in respect of the NHS services provided under that PDS agreement or, as the case may be, GDS contract amounts to at least 60% of the overall business value of the practice;

(b) if it satisfies itself that the contractor continues to be eligible to enter an agreement or a contract pursuant to the conditions referred to —

(i) in the case of a contractor with a PDS agreement, in regulation 4(1)(general conditions relating to all agreements) and 5(1)(additional conditions relating to agreements with qualifying bodies) of the PDS Agreements Regulations,

(ii) in the case of a contractor with a GDS contract, in regulation 4(1) (general prescribed conditions relating to all contracts) and 5(1) (additional prescribed conditions relating to contracts with dental corporations) of the GDS Contracts Regulations; and

(c) if it satisfies itself that the contractor has equipment, facilities and systems in place which—

(i) enable the electronic transmission of data—

(aa) for the purposes of meeting the objectives of the Capitation and Quality Scheme,

(bb) in relation to the provision of dental services under the PDS agreement and the GDS contract, and

(cc) at such intervals as may be reasonably requested by the PCT to the NHS Business Services Authority(a), and

(ii) enable the effective monitoring and evaluation of the Capitation and Quality Scheme and the analysis of any data provided as a consequence of the Capitation and Quality Scheme Agreement.

(a) Established by the NHS Business Services Authority (Awdurdod Gwasanaethau Busnes y GIG) (Establishment and Constitution) Order 2005 (S.I.2005/2414).

Orthodontic activity

5. Where orthodontic services have been provided under the PDS agreement or the GDS contract held by the participant immediately before the commencement of a Capitation and Quality Scheme Agreement, the Primary Care Trust must—

(a) agree a value for that part of the NAAV or the NACV that is attributed to orthodontic activity with the participant; and

(b) record that value in writing in the Agreement.

Finance

6.—(1) Subject to paragraph (2), the Primary Care Trust must make payments to a participant in accordance with directions given by the Secretary of State made under section 109(4) of the Act where primary dental services are provided under a PDS agreement or, as the case may be, under section 103(1) of the Act where such services are provided under a GDS contract (**a**).

(2) Paragraph (1) is subject to any right the Primary Care Trust has to set off against an amount payable to the participant an amount that—

(a) is owed by the participant to the Primary Care Trust under the Capitation and Quality Scheme Agreement;

(b) has been paid to the participant owing to an error or in circumstances when it was not due; or

(c) may be withheld in accordance with these Directions and the Capitation and Quality Scheme Agreements Statement of Financial Entitlements (**b**).

Variation of a Capitation and Quality Scheme Agreement

7.—(1) Subject to paragraph (2), the Primary Care Trust must not vary the terms and conditions of the Capitation and Quality Scheme Agreement without the approval of the Secretary of State.

(2) The Primary Care Trust may vary the terms and conditions of the Capitation and Quality Scheme Agreement without the participant's consent but only to the extent that it is necessary to vary the PDS agreement or GDS contract so as to comply with the Act, any regulations made pursuant to the Act or any directions given by the Secretary of State pursuant to the Act.

Termination of a Capitation and Quality Scheme Agreement

8.—(1) The Primary Care Trust must give a period of not less than 3 months notice to the Secretary of State of any intention to withdraw from a Capitation and Quality Scheme Agreement.

(2) Subject to direction 9, the Primary Care Trust must make suitable provision for arrangements on termination of the Capitation and Quality Scheme Agreement whether by notice, termination or otherwise.

(3) The participant may withdraw from a Capitation and Quality Scheme Agreement but must give a period of not less than 3 months notice to the Primary Care Trust and the Secretary of State of any intention to do so.

(4) The Primary Care Trust may withdraw from the Capitation and Quality Scheme but must give a period of not less than 3 months notice to the participant of any intention to do.

(a) The Capitation and Quality Scheme Agreements Statement of Financial Entitlements published on the Department of Health website address www.dh.gov.uk.

(b) ibid

Provisions relating to cessation of the Capitation and Quality Scheme and termination of a Capitation and Quality Scheme Agreement

9.—(1) A Primary Care Trust must co-operate with the participant and take the necessary steps that are reasonably required to ensure that the participant may—

(a) on the cessation of the Capitation and Quality Scheme; or

(b) on termination of a Capitation and Quality Scheme Agreement in accordance with direction 8,

and subject to paragraph (2), continue to provide primary dental services in accordance with the PDS agreement, or as the case may be, GDS contract.

(2) Notwithstanding the provisions in paragraph (1), the Primary Care Trust, on cessation of the Capitation and Quality Scheme or termination of the Capitation and Quality Scheme Agreement, must co-operate with the participant to ensure that the PDS agreement or, as the case may be, the GDS contract continues to comply with the Act, any regulations made pursuant to the Act or any direction given by the Secretary of State pursuant to the Act.

(3) The terms and conditions of the Capitation and Quality Scheme Agreement do not override any obligations, rights, liabilities and duties which arise as a consequence of the terms and conditions of service which are required under the PDS Agreements Regulations and the GDS Contracts Regulations.

PART 3

OTHER REQUIRED TERMS BY VIRTUE OF DIRECTION 3(4)(b)

Patient Information Leaflet

10. The participant must include in the participant's patient information leaflet the additional information which is set out in "Oral Health Assessment – Patient Information" published by the Department of Health(a).

Records and information

11.—(1) The patient record must be kept in electronic form.

(2) The particular assessments in respect of the provision of primary dental services as specified in the Dental Quality Outcome Framework—

(a) must be completed and retained in electronic form; and

(b) details of those assessments must be returned in electronic form to the NHS Business Services Authority within 5 working days of completion.

(3) The participant must, at the request of the Primary Care Trust or to a person authorised in writing by the Primary Care Trust, provide in electronic form the information specified in paragraph (4).

(4) The information required under paragraph (3) is—

(a) details of any dental services provided privately to patients receiving services under the PDS agreement or, as the case may be, the GDS contract that are associated with services that are provided under the agreement or contract;

(b) costs of any appliances supplied or otherwise provided to patients receiving services under the PDS agreement or, as the case may be, the GDS contract; and

(a) "Oral Health Assessment – Patient Information" may be obtained from the Department of Health website address www.dh.gov.uk.

(c) details relating to laboratory costs associated with services provided under the PDS agreement or, as the case may be, the GDS contract.

Dental Quality Outcome Framework

12. The participant must meet the requirements set out in the document entitled "Dental Quality Outcome Framework" published by the Department of Health(a).

Breach

13. The Capitation and Quality Scheme Agreement must provide that breach of the terms or the conditions specified in these Directions by the Primary Care Trust or the participant may lead to termination of the Capitation and Quality Scheme Agreement.

Signed by authority of the Secretary of State for Health

27 April 2011.
Date

A member of the Senior Civil Service
Department of Health

(a) The Dental Quality and Outcomes Framework may be obtained from the Department of Health website address www.dh.gov.uk.

Appendix 2

Dental Quality and Outcomes Framework

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Dental Contract Pilots

Recent national surveys show that two-thirds of adults and children are now free of visible tooth decay; patients deserve a dental service that helps them maintain good oral health, and which focuses on improving the oral health of the remaining third, not one that is focused on treatment only.

The Government wants to enable dentists to exercise their professional judgment in working with patients to decide what care will be best to prevent ill-health and promote good oral health, whilst being accountable for the quality of the services they provide.

The Government wishes to put in place an NHS dental service delivering high quality clinically appropriate preventative, routine and complex care for those who choose it. As such, it plans to develop a new national contract based on registration, capitation and quality.

Our new contract proposals will give dentists a great deal more freedom to make their own decisions, using their own clinical judgment about what is in the best interests of their patients. The Dental Quality and Outcomes Framework (DQOF), which will measure the quality of their work, and the clinical outcomes they achieve, may provide a better way of holding them to account, than simply measuring the number of UDAs they carry out.

There will be a range of pilots, all of which essentially test ways of remunerating dentists not for the amount of treatment they carry out but for the number of patients they have in continuing care and for the quality of services they provide and the outcomes they achieve. The pilots will test how to develop a fair relationship between the annual contract value a practice receives and the number of registered patients for whom it should provide continuing care, and how to weight this capitation measure to reflect needs. The DQOF will be underpinned by the use of a standardised oral health assessment and the development of a comprehensive set of accredited clinical pathways.

The importance of using clinical protocols using available evidence and professional consensus is a pillar of Government policy, and in the context of dentistry has been highlighted by clinicians who are already pioneering quality frameworks.

The pilots will help us to test the DQOF in dental practice, and to develop and refine the systems which we can use to monitor quality and outcomes.

The requirements of the DQOF are additional to the statutory terms.

Why improve oral health?

Just as health is the desired outcome of the rest of the NHS, so health should now be the desired outcome for NHS dentistry. The two major dental diseases, dental caries and periodontal disease are predominantly preventable. Poor oral health impacts on general health and wellbeing and can prejudice an individual's ability to eat, speak and socialise normally.

Pilot Dental Quality & Outcomes Framework (DQOF)

Quality is a necessary part of future dental contracts and it will take time to get a quality system that is solely outcome based. Quality is defined as covering three domains:

- Clinical effectiveness
- Patient experience
- Safety

Work on quality indicators, and in particular outcome indicators, is relatively new in the NHS and even more so in dentistry. A Dental Clinical Effectiveness and Outcomes Group undertook the development of an initial wide range of potential quality indicators. These have contributed to the initial DQOF which will continue to be developed over the coming years. The framework will be underpinned by the development of a comprehensive set of accredited clinical pathways. The importance of developing clinical protocols and algorithms using available evidence and professional consensus has been highlighted by clinicians from both the Clinical and Effectiveness & Outcomes Groups and the Salford & Oldham project.

DQOF pilot payments

The DQOF pilot payments will represent 10% of the contract value and be comprised of 1000 points. The domains are weighted as follows;

- 60% (600 points) for Clinical Effectiveness
- 30% (300 points) for Patient Experience
- 10% (100 points) for Safety

Paying for the DQOF

The contract pilots will allow us to test a payment system based on the three domains to determine the best scoring system. Factors to be considered in determining the scoring system include:

- the weighting that should be given to quality

- the weighting of the components of the DQOF
- the extent to which external factors (e.g. the size of the practice) affects the quality scores.

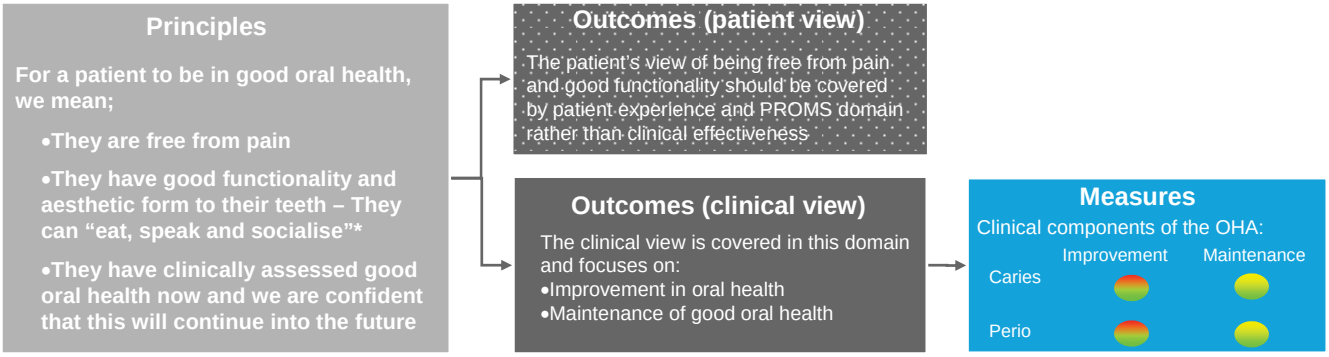
The weighting for payment based on performance against the DQOF will be determined by performance relative to peers. As we are working within a capped budget this approach allows the entirety of the budget to be used to reward improvements in oral health.

The Development of the DQOF

A working group was established to further progress the development of the DQOF. Membership included;

- Colette Bridgman - Consultant in Dental Public Health
- Richard Emms - BDA Representative
- Jane Moore - BDA Representative
- Eric Rooney - Consultant in Dental Public Health
- Sue Gregory - Deputy Chief Dental Officer, Department of Health
- Serbjit Kaur - Head of Quality and Standards, Dental Branch, Department of Health

The working group followed the process outlined below working back from first principles to define indicators that support the consensus within dentistry that good oral health is the ideal clinical outcome:



*(World Health Organisation 1982)

Shared Learning

A Department of Health initiated external stakeholder group developed and defined the Primary Dental Care Patient Assessment (PDCPA). The framework of the PDCPA will be used to underpin the DQOF.

In addition, a number of PCTs have tested blended contracts and have provided valuable learning regarding the use of clinical effectiveness quality measures as outcome measures. The Salford and Oldham primary dental care service redesign project, which used need and risk assessment tools (RAG scores) together with the care pathways, supports the proposal to use the four clinical domains and associated RAG scores to measure outcomes. The clinical indicators and outcome measures have captured improvement and deterioration. In particular colleagues from this project have found that using this approach has:

- Enabled the capture of oral health improvement as patients move RAG status. The project has learnt that, as some risk/modifying factors do not change, only the clinical components should be used as outcome measure

- Motivated dentists to deliver clinical care appropriate to need through robust, consistent clinical and risk assessment
- Incentivised dentists to perform detailed assessments and to value all patients the same through completing the same consistent, comprehensive assessment
- Aided communication with patients through the use of the RAG status.

Support & Training

Data collection

The full clinical dataset will automatically yield most of the indicators, with the majority of indicators being derived from the clinical activity in the Oral Health Assessment (OHA). The full data specification is being implemented with software suppliers to enable efficient data collection and reporting.

Training and support

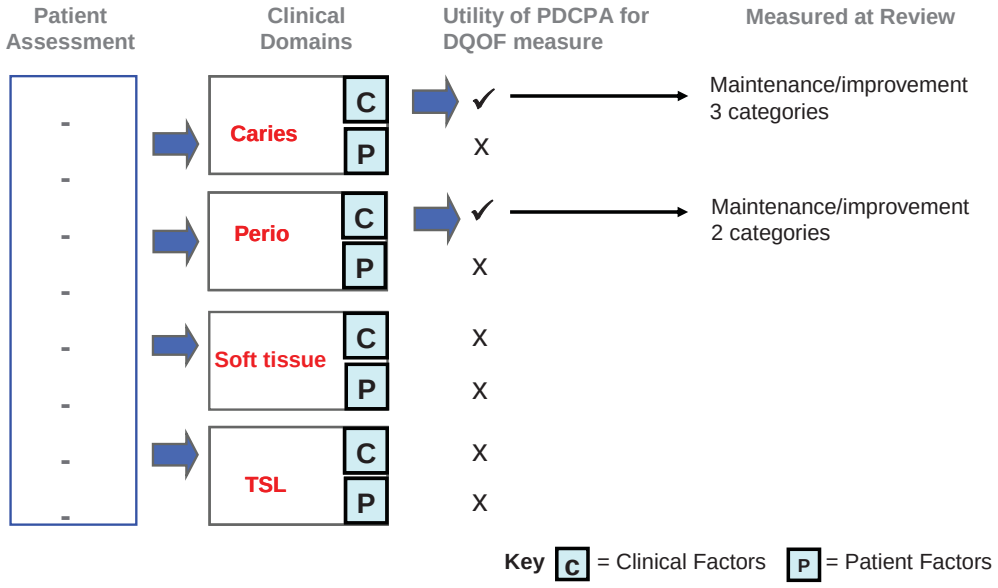
Support & training will be provided to pilot sites, which will include clear clinical definitions e.g. active decay and basic periodontal examination (BPE). Training will also be provided on the use of the OHA. The training and support will be provided through the pilot induction and training events.

Clinical Effectiveness and Outcomes

A key component of all pilots will be the implementation of the oral health assessment and a pathway approach to care, supported by evidence-based clinical guidelines where available. The PDCPA is a comprehensive assessment of a patient's oral health status carried out when a patient first visits a practice. It involves taking a full patient history and carrying out a thorough dental, intra-oral and extra-oral head and neck examination. Standardised information is collected which supports decisions about prevention, treatment and recall frequency.

The findings of the assessment can be described using a Red, Amber, Green (RAG) methodology. This is discussed between dentist and patient who then agree a personalised care plan and a defined care pathway. It enables an assessment of the patient's current status and patient modifying factors to determine risk of future disease, and should be refreshed at each review. It can also provide an assessment of need across a practice population. During piloting the utility of the PDCPA as an additional tool to weight capitation will be explored.

The clinical effectiveness outcome indicators included in the DQOF are based on the standardised PDCPA and the associated risk screening process. The clinical elements of the assessment will be used to inform quality and outcome payments.



The aim of the DQOF is to measure the maintenance or improvement of oral health with respect to caries and periodontal health. The risk screening process incorporates both clinical and patient modifying factors. For the purposes of the outcome measures, only the clinical factors are measured and evaluated. Clinical factors are objective and can be measured, recorded and improved by good care. Patient modifying factors can be subjective and some cannot be improved or changed by the dental team.

Clinical Effectiveness Outcome Indicators for payment (60%)

The following outcome indicators are derived from the clinical elements of the assessment based on the standardised NHS primary dental care patient assessment (PDCPA) and the associated risk screening process. The indicator information will be captured at oral health review and achievement of the indicator is described as either maintaining or improving a patient's condition.

If a contractor has no patients or survey returns for any particular indicator then they will score zero for that indicator. Where this happens for many contractors for any particular indicator the Secretary of State may amend the DQOF, in consultation with relevant bodies and contractors, in order to make its operation feasible.

Indicator		Points - Max:600
OI.01	Decayed teeth (dt) aged 5 years old and under, reduction in number of carious teeth/child	150
OI.02	Decayed Teeth (DT) aged 6 years old and over, reduction in number of carious teeth/child	150
OI.03	Decayed Teeth (DT) reduction in number of carious teeth/dentate adult	150
OI.04	Patients with BPE score improved or maintained at oral health review	75
OI.05	Patients with BPE of score 2 or more with sextant bleeding sites improved at oral health review	75

Clinical Effectiveness Outcome Indicator 1

Definition
Decayed teeth (dt) aged 5 years old and under, reduction in number of carious teeth/child.

Achievement threshold
50% Under 5s active decay (dt) improved or maintained
The achievement threshold allows for both the impact of patient and carers on attaining required outcomes and individual patients susceptibility.

Rationale
Dental caries is preventable and at early stages reversible. This indicator will monitor the primary dental care team's adoption of evidenced informed preventative advice and intervention and their impact on oral health.

Evidence
Delivering Better Oral Health (DBOH), evidence based prevention. Selected Cochrane reviews;

Marinho VC, Higgins JP, Sheiham A, Logan S. 2003. Fluoride toothpastes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews. Issue 2. Art. no: CD002278 DOI: 10.1002/14651858.

Marinho VCC, Higgins JPT, Logan S, Sheiham A. 2007. Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews. Issue 2. Art. no: CD002279. DOI: 10.1002/14651858.

NHS Dental Epidemiology programme survey of 5 year olds in 2007/08 reports that 69% of 5 year olds are caries free.

Reporting and Verification
Practices should record the indicator information through tooth level data in the OHA/oral health review(OHR). Achievement of the indicator is described as either maintaining or improving a patient's condition.

Measurement will be based on the most recent paired reviews (OHA & OHR, OHR & OHR) within the financial year.

Data Item: no caries, early caries, established caries, arrested caries
Age Range: 0 - 5 years
Exclusions: none
Verification: External verification is not required for piloting.

Clinical Effectiveness Outcome Indicator 2

Definition
Decayed Teeth (DT) aged 6 years old and over, reduction in number of carious teeth/child

Achievement threshold
75% of over 6's improved or maintained
The achievement threshold allows for both the impact of patient and carers on attaining required outcomes and individual patients susceptibility.

Rationale
Dental caries is preventable and at early stages reversible. This will monitor the primary dental care team's adoption of evidenced informed preventative advice and intervention and their impact on oral health.

Evidence
Delivering Better Oral Health (DBOH), evidenced based prevention toolkit. Selected Cochrane references; as above and

Ahovuo-Saloranta A, Hiiri A, Nordblad A, Worthington H, Mäkelä M. 2007. Pit and fissure sealants for preventing dental decay in the permanent teeth of children and adolescents. Cochrane Database of Systematic Reviews. Issue 2. Art. no: CD001830. DOI: 10.1002/14651858 CD001830 pub 2

Marinho VCC, Higgins JPT, Logan S, Sheiham A. 2007. Fluoride mouthrinses for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews. Issue 2. Art. no: CD002284. DOI: 10.1002/14651858.

NHS Dental Epidemiology programme survey of 12 year old children 2008/09 found 66.7% of 12 year olds with no caries experience.

Reporting and Verification
Practices should record the indicator information through the tooth level data in the oral health assessment/oral health review. Achievement of the indicator is described as either maintaining or improving a patient's condition.

Measurement will be based on most recent paired reviews (OHA & OHR, OHR & OHR) within the financial year

Data Item: no caries, early caries, established caries, arrested caries
Age Range: 6-18 years
Exclusions: none
Verification: External verification is not required for piloting.

Clinical Effectiveness Outcome Indicator 3

Definition
Decayed Teeth (DT) reduction in number of carious teeth/dentate adult

Achievement threshold
75% improved or maintained
The achievement threshold allows for both the impact of patient and carers on attaining required outcomes and individual patients susceptibility.

Rationale
Dental caries is preventable and at early stages reversible. This will monitor the primary dental care team's adoption of evidenced informed preventative advice and intervention and their impact on oral health.

Evidence
Delivering Better Oral Health (DBOH), evidence based prevention toolkit;

Baysan A, Lynch E, Ellwood R et al. 2001. Reversal of primary root caries using dentifrices containing 5,000 and 1,100 ppm fluoride. Caries Res. 35: 41–46.

Adult Dental Health survey 2009 reports that 72% of adults in England had no visible coronal caries.

Reporting and Verification
Practices should record the indicator information through the oral health assessment/oral health review. Achievement of the indicator is described as either maintaining or improving a patient's condition.

Measurement will be based on most recent paired reviews (OHA & OHR, OHR & OHR) within the financial year.

Data Item: no caries, early caries, established caries, arrested caries
Age Range: 19 years and older
Exclusions: edentate adults
Verification: External verification is not required for piloting.

Clinical Effectiveness Outcome Indicator 4

Definition
Patient Periodontal condition (measured using Basic Periodontal Examination (BPE) score) improved or maintained at oral health review

Achievement threshold
75% patients BPE score improved or maintained at oral health review
The achievement threshold allows for both the impact of patient and carers on attaining required outcomes and individual patients susceptibility. The achievement also takes into consideration that periodontal disease is not always reversible

Rationale
With early identification of a periodontal condition practitioners can improve and maintain BPE status. This will monitor the primary dental care team's adoption of the BPE and evidenced informed preventative advice and intervention.

Evidence
Delivering Better Oral Health (DBOH)evidence based prevention toolkit;

Guidelines for the management of patients with periodontal diseases. J Periodontol. 727: 1607–1611.

Nunn ME. 2003. Understanding the etiology of periodontitis: an overview of periodontal risk factors. Periodontology. 32: 11–23.

Albandar JM. 2002. Global risk factors and risk indicators for periodontal diseases. Periodontology. 29: 177–206.

Davies RM, Davies GM. 2005. Periodontal disease and general health. Dent Update. 32: 438–442.

Van der Weijden GA, Hioe KP. 2005. A systematic review of the effectiveness of self-performed mechanical plaque removal in adults with gingivitis using a manual toothbrush. J Clin Periodontol. 32(Suppl 6): 214–228.

Reporting and Verification
Practices should record the indicator information through the oral health assessment/oral health review. Achievement of the indicator is described as either maintaining or improving a patient's condition.

Measurement will be based on most recent paired reviews (OHA & OHR, OHR & OHR) within the financial year.

Data Item: BPE
Age Range: 19 years and older
Exclusions: edentate adults
Verification: External verification is not required for piloting

Clinical Effectiveness Outcome Indicator 5

Definition
Patient Periodontal condition of BPE 2 or more with sextant bleeding sites improved at oral health review

Achievement threshold
50% of patients with BPE 2 or more with sextant bleeding sites improved at oral health review
The achievement threshold reflects both the impact of patient and carers on attaining required outcomes and individual patient susceptibility. The achievement also takes into consideration that periodontal disease is not always reversible.

Rationale
With early identification of a periodontal condition and monitoring of sextant bleeding, practitioners can improve and maintain levels of gingival bleeding. This will monitor the primary dental care team's adoption of the BPE and evidenced informed preventative advice and intervention.

Evidence
Delivering Better Oral Health (DBOH), evidenced based prevention toolkit.
Baker P, Needleman I, 2010. Risk management in clinical practice. Part 10. Periodontology. British Dental Journal, vol 209 no 11 557-565

Reporting and Verification
Practices should record the indicator information through the oral health assessment/oral health review. Achievement of the indicator is described as improving a patient's condition.

Measurement will be based on most the recent paired reviews (OHA & OHR, OHR & OHR) within the financial year.

Data Item: BPE, Sextant Bleeding
Age Range: 19 years and older
Exclusions: edentate adults
Verification: External verification is not required for piloting

Patient Experience Indicators for payment (30%)

Patient experience indicators are a fundamental part of performance frameworks in healthcare and are important for delivery of a patient-centred service. The indicators are needed to help ensure that the service delivered is in line with patient expectations and that the outcomes are in line with what patients want and need. The methodology of collection is yet to be defined and will be dependent upon a statistically valid response.

If a contractor has no patients or survey returns for any particular indicator then they will score zero for that indicator. Where this happens for many contractors for any particular indicator the Secretary of State has the power to amend the DQOF, in consultation with relevant bodies and contractors, in order to make its operation feasible.

Indicator		Points - Max:300
PE.01	Patients reporting that they are able to speak & eat comfortably	**Max: 30** Level 1 45%-54% =15 Level 2 55%-100% =30
PE.02	Patients satisfied with the cleanliness of the dental practice	**Max: 30** Level 1 80%-89% = 15 Level 2 90%-100% = 30
PE.03	Patients satisfied with the helpfulness of practice staff	**Max: 30** Level 1 80%-89%= 15 Level 2 90%-100% = 30
PE.04	Patients reporting that they felt sufficiently involved in decisions about their care	**Max: 50** Level 1 70%-84% = 25 Level 2 85%-100% = 50
PE.05	Patients who would recommend the dental practice to a friend	**Max: 100** Level 1 70%-79% = 50 Level 2 80%-89%= 75 Level 3 90%-100%=100
PE.06	Patients reporting satisfaction with NHS dentistry received	**Max: 50** Level 1 80%-84% = 20 Level 2 85%-89% = 40 Level 3 90%-100% =50
PE.07	Patients satisfied with the time to get an appointment	**Max: 10** Level 1 70%- 84% = 5 Level 2 85%-100% =10

Patient Experience Indicator 1

Definition
Patient survey question “Are you able to speak and eat comfortably?”

Achievement threshold
% of patients reporting that they are able to speak & eat comfortably
Level 1 45%-54% =15
Level 2 55%-100% =30

Reporting and Verification
Patient Experience Indicators are to captured through the Dental Services patient survey
Verification: External verification is not required for piloting.

Patient Experience Indicator 2

Definition
Patient survey question “How satisfied were you with the cleanliness of the practice?”

Achievement threshold
% of patients satisfied with the cleanliness of the dental practice
Level 1 80%-89% = 15
Level 2 90%-100% = 30

Reporting and Verification
Patient Experience Indicators are to captured through the Dental Services patient survey
Verification: External verification is not required for piloting.

Patient Experience Indicator 3

Definition
Patient survey question “ How helpful were the staff at the practice?”

Achievement threshold
% of patients satisfied with the helpfulness of practice staff
Level 1 80%-89%= 15
Level 2 90%-100% = 30

Reporting and Verification
Patient Experience Indicators are to be captured through the Dental Services patient survey
Verification: External verification is not required for piloting.

Patient Experience Indicator 4

Definition
Patient survey question “Did you feel sufficiently involved in decisions about your care?”

Achievement threshold
% of patients reporting that they felt sufficiently involved in decisions about their care
Level 1 70%-84% = 25
Level 2 85%-100% = 50

Reporting and Verification
Patient Experience Indicators are to captured through the Dental Services patient survey
Verification: External verification is not required for piloting.

Patient Experience Indicator 5

Definition
Patient survey question “Would you recommend this practice to a friend?”

Achievement threshold
% of patients who would recommend the dental practice to a friend
Level 1 70%-79% = 50
Level 2 80%-89%= 75
Level 3 90%-100%=100

Reporting and Verification
Patient Experience Indicators are to captured through the Dental Services patient survey
Verification: External verification is not required for piloting.

Patient Experience Indicator 6

Definition
Patient survey question “How satisfied are you with the NHS dentistry received?”

Achievement threshold
% of patients reporting satisfaction with NHS dentistry received
Level 1 80%-84% = 20
Level 2 85%-89% = 40
Level 3 90%-100% =50

Reporting and Verification
Patient Experience Indicators are to be captured through the Dental Services patient survey
Verification: External verification is not required for piloting.

Patient Experience Indicator 7

Definition
Patient survey questions “How do you feel about the length of time taken to get an appointment?”

Achievement threshold
% of patients satisfied with the time to get an appointment
Level 1 70%- 84% = 5
Level 2 85%-100% =10

Reporting and Verification
Patient Experience Indicators are to captured through the Dental Services patient survey
Verification: External verification is not required for piloting.

Safety Indicators for payment (10%)

Safety quality measures will fall under the remit of the CQC and work with professional bodies such as the GDC. The dental profession and commissioners are committed to ensuring that clinical practice remains safe and that safety is a fundamental part of the service that is delivered.
Consequently, patient safety overall is not something that should be rewarded through a quality payment as all dentists should adhere to safe practices. However clinical aspects of patient safety can be monitored and rewarded through payment and payment will be made on the following indicator:

Indicator		Points – Max:100
SA.01	90% of patients for whom an up-to-date medical history is recorded at each oral health review	100

If a contractor has no patients or survey returns for any particular indicator then they will score zero for that indicator. Where this happens for many contractors for any particular indicator the Secretary of State may amend the DQOF, in consultation with relevant bodies and contractors, in order to make its operation feasible.

Safety Indicator 1
Definition
Patients for whom an up-to-date medical history is recorded at each oral health review

Achievement threshold
90% of patients for whom an up-to-date medical history is recorded at each oral health review

Rationale
The capture of a patient's past medical history is required under GDC standards of professional conduct; "Make and keep accurate and complete patient records, including a medical history, at the time you treat them."
Patients are significantly at risk if this is not conducted prior to treatment.

Evidence
D'Cruz L, 2010. Risk management in clinical practice. Part 1. Introduction. British Dental Journal. Volume 209, No 1 July 10

Reporting and Verification
Practices should record the indicator information through the oral health assessment/oral health review. Measurement will be based on all reviews within the financial year.

Data Item: PMH
Age Range: All
Exclusions: none
Verification: External verification is not required for piloting.

Indicators for monitoring overall quality (no payment)

It is proposed that the following quality indicators are monitored throughout the pilots to understand the impact of the change of system on clinical behaviour and patient perception.

Indicator	
CE.01	% of children aged 11 who have had an assessment of unerupted canines
CE.02	% of children aged 18 and under who have had fluoride varnish in the last year.
PE.08	Was the cost of treatment explained to you before your treatment started?
PE.09	Do you understand what you personally need to do to maintain and improve your oral health?
PE.10	Do you understand how healthy your teeth and gums are?

Clinical Effectiveness Indicator 1

Definition
% of children aged 11 who have had an assessment of unerupted canines

Rationale
Unidentified impacted canines, can pose risks to child oral health. Left impacted they can damage the roots of adjacent teeth. Early assessment and referral/ treatment can simplify or avoid future orthodontic intervention.

Reporting and Verification
Practices should record the indicator information through the oral health assessment/oral health review. Measurement will be based on all reviews within the financial year.

Data Item: Unerupted canines assessed
Age Range: Under 12 years old
Exclusions: none
Verification: External verification is not required for piloting.

Clinical Effectiveness Indicator 2

Definition
% of children aged 18 and under who have had fluoride varnish in the last year.

Rationale
Marinho VCC, Higgins JPT, Logan S, Sheiham A. 2007. Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews. Issue 2. Art. no: CD002279. DOI: 10.1002/14651858.

Reporting and Verification
Number of courses of treatment for child patients, aged 3 or above, where fluoride varnish was provided/The total number of courses of treatment scheduled for child patients, aged 3 or above, x 100%
Verification: External verification is not required for piloting.

Patient Experience Indicator 8

Patient survey questions “Was the cost of treatment explained to you before your treatment started?”

Reporting and Verification
Patient Experience Indicators are to be captured through the Dental Services patient survey
Verification: External verification is not required for piloting.

Patient Experience Indicator 9

Definition
Patient survey question “Do you understand what you personally need to do to maintain and improve your oral health?”

Reporting and Verification
Patient Experience Indicators are to be captured through the Dental Services patient survey
Verification: External verification is not required for piloting.

Patient Experience Indicator 10

Definition
Patient survey question “Do you understand how healthy your teeth and gums are?”

Reporting and Verification
Patient Experience Indicators are to be captured through the Dental Services patient survey
Verification: External verification is not required for piloting.

Appendix 3

Oral Health Assessment - Patient Information

Background

The Government is planning to change the existing contracts for NHS dentists. As part of this, it is running a trial, known as a "pilot", of the changes it wishes to make. Your practice is one of about 60 dental practices in England taking part in this pilot. The contract reforms will change the way dentists are paid. They should not affect the quality of the services you receive as a patient. During the pilot your dentist will still be expected to give you the treatment you need, and there is no change to the dental charges you should pay for the treatment you receive. If you have any concerns about this, please ask your dentist for advice.

Dentists in the pilot scheme have been asked to carry out a standard dental check up of their patients, called an Oral Health Assessment. It is likely to be more detailed than previous check-ups you have received. It may also take a little longer to carry out.

What does an Oral Health Assessment involve?

Your dentist will ask you about your medical and dental health, and about your diet, and whether you smoke and drink alcohol. Your dentist will examine you carefully to assess the health of your mouth, and discuss this with you, and discuss what you can do to maintain and improve your oral health.

Personal care plan, including next check-up

• Your dental team will discuss the results of their examination and the information you give them to develop a long-term personal care plan that will help both you and your dental team work together to maintain and improve your oral health.

• Your dental team can provide advice on how you can improve your oral hygiene and reduce your chances of developing oral disease (e.g. use of high fluoride toothpaste, flossing regularly and reducing your sugar intake). They will also provide treatment if you need it.

• Your dental team will ask you to come back for yur next check-up at a time that suits your dental needs. This might differ from the frequency of your previous dental check-ups, and will depend on your own oral health. .

Why is it important to provide detailed information to your dental team?

Providing accurate information will help your dental team make the best decisions and give you the care that you need.

Personal Details
Your dental team will want to know how they can contact you easily.

Medical History
• Your general health and oral health are linked and each can have an effect on one another so it is important to tell the dental team of any medical conditions you have. Your dentist will need to know what medication you are taking, as this may affect treatment you can be given.
• Telling your dentist about any allergies (e.g. penicillin, latex gloves) will help them avoid prescribing unsuitable drugs or using substances that may be harmful to you

Social History
• Smoking and excessive alcohol consumption increase your chances of developing mouth disease (e.g. mouth cancer)
• Eating lots of sugary foods can increase your chances of tooth decay
• Drinking lots of carbonated drinks (e.g. coca cola) can cause the enamel on your teeth to wear away
Your dental team can give you advice on how to reduce these risks

Concerns
• Telling your dental team if you are anxious or concerned about your visit to the dentist will help them to put you at your ease and find alternative methods of treating you

Dental History
• Knowledge of previous treatment and any current problems will help inform the care your dental team provides
• Your dental team will be able to assess your risk of future dental problems
• Your dental team can provide advice on how you can improve your oral hygiene and reduce your chances of developing oral disease (e.g. better brushing and flossing)