Lord Philip Hunt of Kings Heath, OBE, was appointed Minister of State for Quality at the Department of Health in January 2007 in succession to Lord Warner who retired from the Government at the end of last year. He will also speak for the Government on health matters in the House of Lords.

He previously worked at the Department as a Parliamenta-
ry Under Secretary of State be-
tween 1999 and 2003. In that ca-
pacity he was responsible for dentistry and gained the respect of many in the profession for the support he gave on issues of concern to dentists. Lord Hunt was appointed a life peer in July 1997, and in 1998 became a Gov-
ernment Whip and spokes-
person in the House of Lords on Education, Employment and Health. He resigned from the Government of the invasion of Iraq.

Lord Hunt’s NHS career be-
gan in 1972 when he joined the Oxford Regional Hospital Board as a works study officer, moving to Nuffield Orthopaedic Centre as hospital administrator in 1974. He was the first Chief Ex-
ecutive of the NHS Confeder-
a, and was also the Director of the National Association of Health Authorities and Trusts (NAHAT) on its formation in 1990. Prior to that he was Direc-
tor of its predecessor organisa-
tion, the National Association of

Questions covering a wide variety of dental topics were asked this week.

Patient charge revenue

Andrew Lansley, shadow health secretary asked: What representations had the Minister received from primary care trusts on the levels of patient charge income for NHS dental services in the 2006-07 financial year.

He was told by Health Minis-
ter, Rosie Winterton that no for-
mal representations had been received but some PCTs had raised concerns that the levels of patient charge revenue so far reported during the year were lower than originally expected. She claimed that a number of factors may have affected levels of charge income, including the annual number of UDA s com-
nissioned by PCTs, the time needed for new dental services to be commissioned and come into operation, the timeliness of the reports submitted by den-
tists on completed courses of treatment, changes in the mix of charge-paying and charge-exempt patients treated, and the incidence of certain charge-
free courses of treatment for patients who would normally pay charges. She said that the Department had provided guid-
ance to help PCTs and dentists understand the local factors that may affect patient charge revenue and the possible ac-
tions that can take to improve the posi-
tion.

Undeterred, Mr. Lansley asked a similar question two days later: What recent assess-
ment he had made of the differ-
ence between the originally an-
ticipated level and actual level of patient charge income.

The Minister neatly side-
stepped this one by saying that it was for PCTs to monitor and manage patient charge revenue

locally in the context of ma-
aging their overall net finan-
cial commitments. The Depart-
ment was not in a position to make a reliable estimate of pa-
tient charge revenue at na-
tional-level ahead of receiving final outcome data for the full financial year. The Information Centre for Health and Social Care would be publishing infor-
mation on income from dental patient charges in due course.

Oral Health

Adrian Sanders, the Lib-
Dem MP for Torbay wanted to know what proportion of the NHS bud-get was spent on the promotion of improved den-
tal/oral hygiene in 2005-06.

Mr. Sanders returned to the fray by asking if the Minister would ensure that dentists are paid a fee for each filling they undertake on the NHS. He re-
ceived a dusty answer from the Ms Winterton who said there were no plans to return to a fee-
per-item remuneration system.

The Minister replied that oral health promotion could take the form of educational and awareness campaigns aimed at popu-
lation groups, or personal in-
formation and advice given by dentists, hygienists or other members of dental teams in the course of treating individual pa-
tients. Information on local oral health promotion campaigns was not collected centrally, how-
ever, although, over the period 2005 to 2006 the Department contrib-
uted £1.1 million to pilot the “Brushing for Life” scheme intended to get families with young children into the habit of brushing their teeth regularly with fluoride toothpaste.

Nur was it possible to quan-
tify what proportion of the ac-
activity, supported the nearly bil-
on gross budget in 2005-06 for NHS primary dental care serv-
ices, contributed to raising aware-
ness of oral hygiene and the pre-
tention of dental disease. One of the Government’s objectives in introducing from April 2008 local commissioning arrange-
ments for primary dental care services and changing the basis of remuneration for dental practices away from item of ser-
vice fees was to give dentists more scope to focus on preven-
tative care. Primary care trusts are also now required to provi-
de oral health promotion pro-
grames to the extent that they consider it necessary to meet all reasonable requirements with-
in their areas. To assist them we published an oral health plan for England, “Choosing Better Oral Health” in November 2005,

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ceived a dusty answer from the Ms Winterton who said there were no plans to return to a fee-
per-item remuneration system. Adding a little spin she contin-
ued: “The contractual arrange-
ments introduced in April 2006 give den-tists the stability of an agreed annual contract sum, in return for carrying out an agreed number of courses of treatment, with a weighting for relative complexity, over the course of the year. This is de-
signed to support dentists in carrying out simpler, more clin-
ically appropriate courses of treatment without financial detrimen-t. It also responds to long-standing representations from dentists and from the British Dental Association crit-
icising the treadmill nature of the former fee-per-item sys-
tem.”