Greater Glasgow NHS Board

Board Meeting
Tuesday 20 April 2004 **Board Paper No. 04/25**

Director of Planning & Community Care

MODERNISING NHS DENTAL SERVICES IN SCOTLAND SCOTTISH EXECUTIVE CONSULTATION PAPER

Recommendation

Members are asked to agree

(a) the report as a response to the Scottish Executive consultation paper

(b) to submit the report to the Scottish Executive

1. Introduction

1.1 Greater Glasgow NHS Board welcomes the opportunity to contribute to the Scottish Executive's consultation on "Modernising NHS Dental Services in Scotland". The Board agrees with much of its analysis, principles and proposals.

1.2 The Board accepts that the present General Dental Service (GDS) system is no longer in tune with the realities and complexities involved in the delivery of modern dentistry and that arguably the resources are not having the correct strategic impact. Similarly the Board is concerned at what it perceives to be the widespread disillusionment amongst general dental practitioners about the current system. Consequently, it recognises the need for change but encourages the Executive when implementing any new proposals to do so in concert with the profession and to phase change over time to minimise any risk of destabilisation.

2. Overall Aims

2.1 The overall aims of any attempt to modernise dental services should be to secure:

- A greater emphasis on prevention
- Improved quality of treatment and care across the whole population
- Better access for all to NHS dentistry

- A partnership approach with other professionals and local communities and individuals
- A method of financing NHS dentistry, which is fair, equitable, affordable and sustainable for patients and dentists alike.

2.2 These aims should form the core of the Executive's plans but need to be combined with measures, which challenge and change the prevailing culture in respect of oral health amongst the population.

2.3 Further the scope of the Executive's ambitions should be extended to include secondary care as for example oral maxillofacial services and the functions of the dental hospital and to link with proposals for education and learning and research. The Board is anxious to ensure that all sections of the NHS dental service work in a co-ordinated fashion.

3. Prevention

3.1 This NHS Board's major concern is to ensure that the oral health of its resident population is improved and maintained. Given our historical poor standards of oral health, there is much to be achieved for all age groups and particularly so for individuals who currently have the poorest oral health. The design of any modern dental service needs to have prevention at its heart, with children a priority. However it is recognised that, for the foreseeable future, focus and resources will also have to be directed to restoration and repair. Nonetheless, prevention has to assume greater prominence in a modern dental service. This Board has already supported the introduction of significant new initiatives both directly through for example OHATs and indirectly through encouraging better dietary habits. To be more effective this activity needs to be extended through universal application of preventive measures e.g. fissure sealants, in a series of innovative ways and settings. This approach should be endorsed and incorporated by the Executive as part of its comprehensive approach to creating a modern dental service.

3.2 While GDPs should be enabled to take responsibility for prevention, the vision should be that progressively the bulk of routine dental services would be delivered by Professions Complementary to Dentistry (PCDs) working in dental centres and in various community settings. The dentists of the future will concentrate on diagnosis, the more technically demanding aspects of dental treatment, and research into oral diseases. PCDs working within a dental team will be empowered to provide preventive care and advice without the need for a dentist's prescription. Suitably trained PCDs will also be empowered to conduct dental inspections of pre-school and school children and other clinical epidemiology. This contribution should be explicitly acknowledged as a key part of modern dental system.

4. Access

4.1 On the issue of access the Board's principal concern is:

- Firstly to ensure in the immediate future that the present level of access to NHS primary care dental services in Greater Glasgow is not further reduced
- Secondly to increase access both generally and to underrepresented groups to NHS dental services.

4.2 The Board recognises that the greatest asset of the NHS dental services that must be retained are its GDPs. In Greater Glasgow 90% of all dental treatment is provided by GDPs. The Board wishes to avoid the pattern evident in some other parts of Scotland of reduced access to NHS dental services and wants to secure GDPs within the NHS for the benefits of the population. The NHS Board believes that in any modern dental service of the future GDS will remain responsible for the vast proportion of dental care and advice provided.

4.3 Apart from the remuneration system (which is dealt with separately below) the retention of GDPs in the NHS service can be enhanced in a number of ways. One of these revolves around risk sharing. GDPs are not only independent contractors but are small businesses. A critical way of retaining them within the NHS may be to adopt a different approach towards risk management. At present many dentists feel that risk falls entirely to them with practices being privately owned and managed. In future the NHS could assume a greater share of the risk involved in operating a GDP practice in return for contributions to NHS services. This could include, over time, growing recognition of the historical investment made by GDPs. Some examples are given below.

4.4 Infrastructure Support

Support for practice infrastructure should be paid separately leaving dentists more able to provide appropriate treatment. The NHS should assume greater responsibility for the provision of buildings fit for purpose for the delivery of dental services.

4.5 Similarly GDPs should receive greater assistance with their IT costs. Extended use of IT has the potential to improve the administration of dental practices and improve record keeping. Transfer of patient records to follow patients would be helpful and this would be greatly facilitated by the development of a national patient record system.

4.6 Incentives in Deprived Areas

The suggestion in the consultation paper of incentive payments for GDP services in deprived areas is welcomed whether in the form of enhanced practice allowances or infrastructure support.

4.7 Mixed Payment Methods

As well as practice allowances other payment methods for GDPs should be encouraged to provide alternative income streams and means of delivering

services in short supply. This could include for example sessional payments for services for children and sedation.

4.8 Developing a Comprehensive Dental Health System

Within Greater Glasgow some in the population are not well served by the current dental service. These include children, people with special needs and older people. In the present circumstances the optimum way to address these service gaps is through a combination of Community Dental Service (CDS) and salaried dentists. The consultation paper refers to the CDS as "GDS for special needs groups". In Greater Glasgow the CDS service historically has been disproportionately small and the salaried option until recently under utilised. However, they are both vital parts of any local system, and it is the view of this Board that a modern dental service should be constructed of a mix of complimentary service inputs with CDS and salaried dentists working alongside the GDS to meet the full range of dental needs in the conurbation. The Executive requires to support development of the public health dental service component on an equitable basis. However, it is recognised that such service development needs to be managed in a way that does not destabilise the GDP system.

4.9 Furthermore the development of the CDS and salaried services will offer alternative types of employment to the GDS for newly qualified dentists providing a further means of retaining them locally.

4.10 Workforce Planning

This should embrace dentists and PCDs. Whilst the Executive's recent revised workforce projections are welcomed it is important that they reflect the requirements of the modern dental service envisaged.

5. Remuneration

5.1 The present remuneration system links patients' charges with dentists' remuneration. The Board believes that this traditional approach should be changed to simplify patient charges and to allow the introduction of a new formula to determine dentist's remuneration.

5.2 Dentists express mixed views about the current system – some like the Item of Service system. Others believe that this system is the reason for their unease regarding continued participation in the NHS. Some feel that the 'treadmill' is the most cost effective system but suggest that it is under-resourced. Others believe that the treadmill system sacrifices quality in favour of quantity.

5.3 Patients are unaware of the real complexity of the Statement of Dental Remuneration. Patients would, however, appreciate the transparency of a simplified charges system or the total removal of all charges. There are split views in this latter issue. On the one hand the deletion of charges may remove an obstacle to accessing dental services but on the other their existence may create an incentive for individuals to improve their oral health.

5.4 Simplifying Charges

Patients are unaware of the real complexity of the statement of dental remuneration. However, patients would appreciate the transparency of a simplified charging system to the total removal of charges. There are split views on this latter point. On the one hand does abolition of charges remove an obstacle to accessing dental services or on the other does retention create an incentive to improve oral health.

5.5 If patient charges are to continue to be levied, the opportunity exists to consider detaching the link between these patient charges and dentists' remuneration. This would facilitate the introduction of a revised and simplified patient charges system without a necessarily co-incidental radical change in the payment system for dentists.

5.6 The introduction of a simplified patient charges system would not necessarily disrupt the dentists' remuneration system which could be changed independently i.e. income generation could continue unchanged pending successful completion of negotiations.

5.7 Future Range of NHS Dental Treatments

The Board considers that a more limited range of treatments should be provided on the NHS coupled with a change of emphasis towards rewarding prevention.

5.8 In future patients should not be required to pay for dental examinations or oral health promotion activities. They should, however, be required to contribute towards the cost of their treatment. Eligibility for subsidised/free dental treatment should be limited to those who maintain regular attendance with a reducing scale of subsidy for those who do not maintain contact with the GDS. It is important that individuals should recognise their own responsibility to maintain oral health. The continuation of patient charges would be one way of reflecting the significance of this responsibility.

5.9 NHS treatment should not necessarily encompass purely aesthetic treatment such as tooth whitening, tooth coloured posterior restorations unless proven to be more effective than traditional materials. However aesthetic considerations are important when anterior teeth are restored and these should be undertaken within the remit of the NHS. All gold restorations should be subject to prior approval and orthodontic treatment should be restricted to the severest malocclusions.

Further detail is provided in Annex 1.

5.10 Payment

We also would encourage the Scottish Executive to reconsider the current method of service delivery whereby dentists are required to render a patient

dentally fit within each course of treatment before submitting a claim for payment. This is an unrealistic goal, especially in those areas where dental health is poorest. We question whether this provides greatest value for money. There is no incentive to either the patient or the practitioner to improve or maintain oral health between courses of treatment. In effect, the payment system has become more important than the treatment or the attainment of sustained oral health gain.

5.11 Quality

A fairer remuneration system should recognise both quality of clinical treatments and quality of practice infrastructure as well as quantity of care and oral health outcomes. This would need to be balanced with throughput and indicates that a hybrid remuneration system should be developed. Practitioners should be required to achieve at least minimal standards in practice infrastructure and these should be financed independently of treatment provision. This could possibly be achieved through a practice allowance that would be payable monthly irrespective of output beyond an agreed threshold. Essentially remuneration should reward evidence-based best practice.

5.12 Clinical Pathways

Patients should be confident that they receive the most appropriate treatment for their needs within NHS resources and that their capacity to maintain their own oral health would be considered when treatment is provided. The development of clinical pathways would support dentists in their treatment planning.

6 Opportunities for Integrated Working

6.1 The consultation paper understates the importance of integrated working in a modern dental service. This applies not only to working with the secondary care sector but also to multi disciplinary working with other non-NHS services. In particular it would be helpful to see the oral health role and input of dental professionals in the planned community health partnerships promoted and enabled by the Executive.

7. Investment

7.1 The consultation paper makes no commitment to additional funding in either the medium or longer term. Without this it is difficult to see how many of the aspirations expressed in the paper can be realised. The Board recognises that even with support such changes may take up to 10 years to fully implement.

ANNEX 1

The following specific issues should be considered:

- Remove the direct link between patient charges and dentists' income generation.
- Introduce scheme of banded patient charges and modify exemption criteria.
- Retain but simplify Item of Service payments pending more radical change.
- Remove direct link between patient registration (child and adult) and dentists' payments.
- Specify explicit conditions that attach to registration e.g. minimum frequency of attendance, minimum requirements for delivery of preventive care appropriate to age group especially for children.
- Remove subsidy from cosmetic treatments but retain a limited range of cosmetic treatments within the NHS.
- Restrict the provision of orthodontic treatment on the NHS to most severe malocclusions (IOTN 4 & 5 or equivalent).
- Seek change in legislation relating to the dental supervision of children under the age of 4 yrs to allow PCDs, with the delegated authority of the dentist, to undertake preventive treatment e.g. fluoride varnishes, without the need for a dentist's prescription.
- Enable suitably trained PCDs to undertake school dental inspections and epidemiological surveys.
- Recognise the role of other professionals like school nurses in the promotion oral health amongst children.
- Introduce practice infrastructure payments based on maintenance of minimum standards and reflective of commitment to provision of NHS dental care possibly linked to a cap on income derived from NHS treatments relative to time commitment to NHS dental care.
- There could be a progressive move towards NHS-owned and managed dental centres with salaried staff and with the appropriate skill-mix.