

## **MODERNISING NHS DENTAL SERVICES IN SCOTLAND**

### **RESPONSE FROM FIFE AREA DENTAL COMMITTEE and FIFE GENERAL DENTAL PRACTITIONER SUBCOMMITTEE**

#### **INTRODUCTION**

- 1.1 We welcome the Consultation Document and its recognition of the need for fundamental change in the way that NHS dental services are delivered.
- 1.2 Fife has seen some significant improvements in the dental health of 5 year old children since detailed surveys started in 1987. However, considerable challenges remain, with the latest survey (NDIP 2002/03) demonstrating that many children still have severe and untreated decay.
- 1.3 The issue of untreated disease is compounded by a widespread and longstanding problem with access to NHS dentistry in Fife. Although initially confined to the Dunfermline and West Fife area this access problem now exists throughout Fife – with virtually no dental practices currently able to offer treatment for unregistered patients.
- 1.4 Fife has therefore had to seek approval from Scottish Ministers for an increasing number of salaried dental posts. However, it has long been recognised by NHS Fife, the Area Dental Committee and the General Dental Practitioner SubCommittee that salaried dental posts are only a short term solution to much more fundamental problems within the current NHS dental system.
- 1.5 Fife's difficulties are compounded by its position in the Central Belt with no access to remote area or other designated allowances. Despite Fife's central location, Fife dental practitioners seem to have almost as many problems in the recruitment of Associates as experienced by colleagues in much more remote and rural locations.
- 1.6 We believe that any change to the way that NHS dental services are delivered will fail if the fundamental dental workforce shortages are not resolved.
- 1.7 These workforce problems are compounded by the lack of attractiveness of the current NHS dental system to young practitioners. Any new system for providing NHS dentistry in Scotland must ensure that it is attractive to

young practitioners who are at the stage of making long term career choices.

## **GENERAL COMMENTS**

- 2.1 We note the proposal to shift towards more local responsibility and accountability for NHS dental services and the proposed devolution of funding to NHS Boards. NHS Board areas have long needed more flexibility to plan local dental services in response to need. However, we have concerns that wholesale devolution of dental funding and administration to 15 NHS areas would be counter-productive. There should be a considered review to decide what elements should continue to be provided centrally.
- 2.2 Any local shift would require significant local planning and administrative capability in addition to strong professional leadership. The co-operation and close involvement of GPs would be key to this process. Working relationships would need to be forged with forthcoming Community Health Partnerships, Primary Care Divisions and other health and community care professionals.
- 2.2 A shift to more local responsibility could bring significant changes in the role of the Common Services Agency with respect to dentistry. The costs thus released should be available to NHS Boards to support the increased local administrative functions which would be required by a shift towards more local responsibility. This is important since we believe that no additional administration costs should be taken out of current expenditure on clinical dental services.

## **CHANGES TO THE SYSTEM**

### **The extent and nature of NHS dental services**

*What services should come within the NHS for the future?*

- 3.1 We believe that a core NHS dental system should continue to be provided in the future to ensure a minimum level of service for all. We do not believe however that this should include all the treatments currently available on the NHS Fee Scale. Complex and expensive treatments (particularly where these have a large cosmetic component) should be excluded – with the balance shifting towards the addition of more evidence based preventive interventions.
- 3.2 For example, we do not believe that some complex or expensive prosthodontic procedures (including bridges and veneers), molar root

treatments, adult orthodontics and children's orthodontics for the lesser categories of need should fall into a core NHS dental system.

- 3.3 Once the extent of a core NHS dental system has been agreed, NHS Boards require the flexibility to contract with a variety of providers (including individual dental practitioners, dental practices and corporate bodies) to ensure that the core service is widely accessible and meets population needs.

*Should they be prescribed and limited or unlimited?*

- 3.4 The core NHS dental system outlined above should include a limited range of prescribed treatments.
- 3.5 It is clear from the Consultation Document and from many discussions with local dental colleagues that the existing 'treadmill' system of remunerating dentists for items of work completed needs to be replaced.
- 3.6 We believe that a system based upon remuneration for contracted sessions of core NHS dental service could offer a much better alternative if properly funded.
- 3.7 There have been many suggestions that productivity would fall in such a system. This may well be so but must be balanced by increased quality. We therefore suggest that a system of linking contracted sessions to target patient populations be considered.
- 3.8 A core NHS dental service would free up resources which could allow a properly funded sessional payment system. GDPs would contract to carry out an agreed number of sessions to provide care to an agreed number of patients. Dentists who contracted for a lesser number of sessions would be expected to maintain a service to a proportionally smaller population. Practice populations would receive all necessary care within the agreed core NHS dental service and would be given access within agreed time periods depending on the degree of urgency. These time periods have already been set out in the Scottish Dental Action Plan monitoring framework within the PAF.
- 3.9 We also suggest that any sessional payments could be enhanced - with practitioners eligible to be remunerated at a higher band for a variety of reasons. These could include deprivation, rural and remote location, enhanced range of local services and higher qualifications. This could offer a degree of incentivisation for dentists.

*What system should there be for reviewing and updating?*

- 3.10 The list of agreed treatments available within the core NHS dental service would require to be regularly reviewed in the light of usage and evidence of effectiveness. Preventive treatments should be fully supported.

*What is the right balance between preventative and repair services and what, in particular, should be included in the former?*

- 3.11 Entry to a core NHS dental service should be on the basis of an oral health examination which could place the patient in one of several bands depending on an assessment of dental risk factors. This could affect payment for those patient groups who were not exempt from dental charges (this is further developed in section 3.20 onwards) and could reinforce positive oral health messages.
- 3.12 This gives an opportunity to slant the core NHS dental service towards prevention since the patient will have a vested interest in improving their oral health. As already outlined, the inclusion of treatments in the core NHS dental service should be on the basis of evidence of effectiveness.
- 3.13 It is important that any new way of working does not de-stabilise current services. It is likely that a move towards a system based on sessional remuneration for a core NHS dental service delivered to an agreed practice population would be largely built around the existing registered patient base and would initially deliver a similar (although restricted) range of services.
- 3.14 However, NHS Boards need to consider the needs of their entire population. Currently only about one half of the adult population is registered with a general dental practitioner – with half attending on a more irregular basis. NHS Boards will also therefore need to put a range of services in place to meet the needs of those people who chose to attend more intermittently. We suggest that this falls into the remit of an expanded salaried primary care dental service. Indeed this is already developing in many parts of Fife as reduced access to NHS dentistry has resulted in an expansion in the salaried service.

### **The delivery of NHS dental services**

*What are the views on the range of delivery and funding options?*

- 3.15 Suggested principles for delivery have been outlined in paragraphs 3.1 to 3.14. On this basis there would remain a role for independent contractor dentists but a different contracting arrangement would apply.

*Are there specific issues about future funding of infrastructure e.g. premises?*

- 3.16 In the long term, the principle of practitioners or groups of practices joining together to share staff, premises or equipment is strongly supported and would be facilitated by the existence of a stronger, more predictable financial framework in the form of agreed sessions for core NHS dental services.
- 3.17 However, any move towards new or shared NHS premises would need to address the important issue of compensation for GPs who have current investment in their own premises.
- 3.18 In the shorter term, the management, collection and disposal of clinical waste and special waste; the inspection and testing of autoclaves and pressure vessels and provision of some staff training could become the responsibility of local NHS systems. This would help to ensure consistency and to release dentists to provide more clinical care. The level and costs of such arrangements would be proportional to the number of sessions of NHS dental service provided.

*Should the dental public health role of CDS be kept separate from the family health role of dentistry in the community?*

- 3.19 A range of services are required for patients who chose not to attend on a regular basis and who are not routinely in receipt of a core NHS dental service. In the past, the role of the Community Dental Service (CDS) and the Salaried Dental Service (SDS) in providing services has overlapped and has been made more complex by the fact that two different funding streams are involved.
- 3.20 We therefore believe that the distinction between the CDS and the SDS should be removed – creating a new and expanded primary care salaried dental service. This should have a single funding stream and include the following priority groups within its remit:
- Patients with special needs;
  - Patients who require emergency access (including out of hours access);
  - Dental public health duties (including epidemiology);

- Patients who require specialist primary care dental services (including surgical dentistry).

3.21 Each category is important in its own right and should have ringfenced funding in order that an appropriate balance is maintained.

### **Patient charges**

*What principles should be pursued in determining a system for patient charges?*

3.22 We understand that there is a commitment to introduce free dental inspections by 2007. We believe that a review of patient charges should go further and re-consider the categories of exempt patients.

3.23 We suggest that there is a case for removing patient charges from the elderly in residential care settings – partly because they are a key priority group with poor oral health. There is often also a positive disincentive to treat because of the difficulties in recovering charges from them or their legal representatives.

3.24 Exemption on the basis of age (children) and income support should remain but we question the cost benefits of free dental care for pregnant and nursing mothers.

*What are the views on the options listed?*

3.25 There is no doubt that the current complex system of patient charges is both confusing and cumbersome. Any new system should be easy to understand for patients and their representatives and should be easy and quick to administer by practice staff.

3.26 A system which relies on patient charges for individual items of treatment (albeit, simplified) runs the risk of becoming as complex as the present system over time. It also requires practice staff to calculate charges for each patient and requires cost estimates when giving patients initial treatment plans.

3.27 If a sessional based payment system for dentists is used there would be no need for a detailed dental fee scale and this could allow a great deal of simplification of patient charging arrangements. The principle of monthly payments in private dental insurance schemes is now well established and could be adapted for the NHS. Further consideration needs to be given to the re-imburement of laboratory charges under a sessional pay system.

- 3.28 We therefore propose that patients are placed in one of several bands based on an assessment of dental risk from their initial oral health assessment. This would result in an insurance type system where patients paid a regular NHS payment in return for access to a core NHS dental service to agreed quality standards.
- 3.29 The payment bands could reflect oral hygiene as a component of dental health status – thus giving the patient some incentive to achieve a higher level of oral cleanliness.
- 3.30 This leaves the issue of payment for non core items of care where we envisage that dentists will want to make their own arrangements for treatment under private contract. There is strong case here for individual published fee scales to provide some assurance for patients that their dentist's charges are reasonable and comparable.
- 3.31 We think that a core funded NHS dental service with improved quality and access will bring significant patient benefits. A range of features to make such a system attractive to dentists (particularly young dentists who have yet to make long term career choices) is also important. We have outlined some of these though other factors (eg continued access to NHS superannuation scheme) will also influence the decisions that dentists make.

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