

LOTHIAN PRIMARY CARE NHS TRUST  
DUNCAN STREET DENTAL CENTRE  
EDINBURGH EH9 1SR

## **Modernising NHS Dental Services in Scotland**

### **Response from NHS Lothian Salaried Primary Care Dental Service**

#### **Introduction**

NHS Lothian Salaried Primary Care Dental Service (SPCDS) welcome the opportunity to respond to the Scottish Executive Consultation.

## **1 THE EXTENT AND NATURE OF NHS DENTAL SERVICES**

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

There should be a consistent approach to this throughout Scotland, and this should be applied consistently both in the SPCDS and the General Dental Service (GDS).

#### **Children**

All treatment and prevention necessary to secure oral health should be provided to all children. The age definition for this should be revised slightly: up to 18 years, and those in full time education.

Orthodontic treatment should be provided under the NHS only to more severe cases, e.g. IOTN 4, 5 and some aesthetic components of IOTN 3. All other orthodontic treatment would be provided privately.

Some have expressed the view that children's dental services should be provided through a family dentist. However we know that the majority of adults in some parts of Lothian have no family dentist. This is particularly true in areas of deprivation. There would therefore be merit in considering whether there is a role for a children's dental service. This would protect children living in areas of deprivation who are less likely to be taken to a "family dentist".

#### **Adults**

All treatment and prevention necessary to secure oral health should be provided to adults with special needs. However there should be an agreed definition of what is meant by the term "special needs" in this context.

If funding for NHS dentistry remains at its current level a core NHS service should be provided for all adults. Whatever this core service is, it must encourage a greater emphasis on prevention.

**1.2 What system should there be for reviewing and updating the services available under the NHS?**

It is pleasing that the NHS recognises the importance of research and development in primary dental care. The establishment of the Scottish Dental Practice Based Research Network is welcomed. Nevertheless it can still be difficult to access resource – both funding and expert support – to turn an idea into a research project. The funding system is still designed with academics in mind. While it is important that any research carried out in primary care is done to a high quality, it must be recognised that the great majority of primary care practitioners are not trained academics.

There should be a system in place which will examine SIGN Guidelines, and any newly published Guidelines to see whether they provide sufficient evidence to alter the treatment/prevention offered under the NHS.

Consideration should be given to adding a “fee for research” into whatever system is devised for the GDS.

**1.3 What is the right balance between preventative and repair services?**

The SPCDS has always had an emphasis on preventative services and would wish that to continue. This same emphasis must be consistent throughout primary care dental practice.

There is a need to help patients understand their own personal responsibility for their oral health. Similarly parents and carers need to act on the knowledge they already have so that dental disease in children can be minimised.

Dentists alone cannot take responsibility for the oral health of children, particularly the under fives, where the majority still do not attend any dentist.

**1.4 Should the ‘public health’ role of the Community Dental Service be kept separate from the ‘family health’ role of dentistry in the community?**

These are two distinct services. However there is great advantage within a salaried service that staff can be used in both roles, e.g. a dental nurse with oral health promotion qualifications can do chairside duties and public health duties.

We do not support the removal of the responsibility for oral health education from SPCDS into NHS Health Promotion departments. We do agree that there must be good working relationships between all health professionals, and others, who can influence oral health. There should be no barriers which would prevent oral health promoters employed by SPCDS carrying out duties within independent NHS GDS where this is appropriate.

PCDs, probably dental hygienists or dental therapists, should be trained and permitted to carry out both detailed and basic inspections in schools as part of the National Dental Inspection Programme – in addition to the duties they are already trained to perform. This will free valuable dentist time to provide direct patient care.

## **2 THE DELIVERY OF NHS DENTAL SERVICES**

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

The legislation which bars SPCDS staff working in NHS general dental practices should be removed.

There must be an improved career structure both for dentists and PCDs within the SPCDS. We anticipate that this will be addressed by the Review of Salaried Primary Care Dental Services being undertaken by Margie Taylor.

Further thought should be given to the place of dentistry in CHPs. Locally the workload of CHPs is such that they do not have time available to devote to dental issues. If it is felt that CHPs have a role to play in improving oral health they need to be resourced to deal with this.

Registration is poorly understood both by patients and health professionals. As a minimum registration for children should be automatic and continuous.

The current fee scale contained in the SDR must be simplified.

We support the idea of rewards for meeting quality targets and the provision of incentives to provide services in deprived or sparsely populated areas. The option to provide a service using salaried staff must remain.

If as a result of this consultation, funding for primary care dentistry is devolved locally, there must be a floor below which it cannot fall. There should be equitable access to grants for premises upgrading to both SPCDS and GDS. It is increasingly difficult to access NHS capital to replace worn out dental equipment.

There should be an independent Dental Reference Officer type of service for the SPCDS. However it would be essential that the dentists employed in this service had extensive SPCDS experience, to take account of the particular patient groups cared for by SPCDS. Ideally these individuals would continue with a part time commitment within SPCDS.

We support the suggestion that there should be better peer support for isolated and single handed practices. This support is equally needed in SPCDS in remote areas.

We are interested in the Dutch system of dental provision, which links patient payment to the commitment and responsibility shown by the patient.

## **2.2 Do you think there should be changes to the way that the NHS funds dental service infrastructure?**

We agree that local NHS boards should become involved in the provision of dental premises for independent NHS GDS practitioners. In certain locations it will make sense to co-locate GDS and SPCDS dentists in premises also used by other health professionals.

## **2.3 Are there other approaches or incentives that merit consideration? –**

SPCDS based salaried specialists are beginning to prove valuable. Further specialist posts should be established. The ability to locate these specialists in independent GDS premises will improve access for patients.

## **2.4 If changes to the current system were to be made, how best should they be managed?**

Possibly best managed locally to a locally agreed timetable rather than everyone reacting to a centrally agreed programme. There will be some changes which will require to be implemented nationally all at the same time.

## **3 PATIENT CHARGES**

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

Patient charges should be applied consistently across primary care – patients who would have paid for treatment in the GDS should not be able to receive the same care from SPCDS free of charge. Consideration should be given to exempting from payment, patients whose oral health will have an impact on their overall health.

The charges must be simpler than current SDR and easy for patients to understand.

There should be incentives to encourage regular attendance and preventive care.

Ideally the need to collect payments from patients by dental practices should be removed. Some interesting alternatives have been suggested – vouchers, smart cards.

### **3.2 What are the views on the options listed?**

(Page 20)

- Agree with the "simple approach option".
- This option seems too complicated to pursue.
- Too complex.
- This seems to be more linked to private dentistry.

(Page 21)

- May be useful.
- May be useful.

### **3.3 Are there other approaches that merit consideration?**

A view expressed a number of times during the consultation is that in general, patients do not value dentistry. If charges were to be reduced or eliminated it is felt that this would have an adverse effect on perception of dentistry and dental services by the public.

#### **Training**

This doesn't fit easily into the answers to the above questions but it is important that the training role of SPCDS is recognised, and properly funded. It is entirely appropriate that SPCDS plays a key role in training and we welcome the increasing involvement there has been in recent years. We acknowledge the part played by NHS Education in this change. The training role of the SPCDS now incorporates; undergraduate dental students, General Professional Training, Specialist Registrar training, pre and post qualification Professionals Complementary to Dentistry.

This increasing demand brings with it pressure on existing premises, and local NHS Boards must be made aware of the need to include this need in its capital planning programmes.