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Glasgow Homelessness Network is the voluntary sector organisation which acts as the umbrella body for organisations and individuals working to tackle homelessness in Glasgow

### Modernising NHS Dental Services in Scotland

## A Consultation Response from GHN

(April 2<sup>nd</sup> 2004)

*"Glasgow Homelessness Network strives to prevent, alleviate and ultimately eradicate homelessness by raising awareness of the issue, facilitating a joint working approach, influencing policy and provision at all levels and empowering homeless people to contribute to this process."*

Glasgow Homeless Network (GHN) welcomes this consultation as a contribution to the debate on the future development of dental services in Scotland and would hope that the debate be quickly completed, and consensus achieved. This will allow for the development of practical measures that will improve dentistry and dental health for all residents of Scotland including people affected by homelessness.

NHS Dental Services have always had limited resources and potential demand for services has always outstripped supply. Currently services are rationed on two bases. Firstly, there is an inadequate supply of service so that many people cannot access any NHS dental service. Secondly the range of services available free on the NHS is limited. The first of these bases is unacceptable whereas the latter can be justified only as a measure to address the first. The present situation is unjustifiable. It is on this premise that we make this response to the consultation.

The current range of treatments should be made available to all residents of Scotland. Although these are limited, this is justified because such provision would promote reasonable dental health for the whole population. Any review or updating of the list of services available from the NHS should focus on a cost/benefit analysis and the effect on the availability of dental services to the population. The prime measures should be the dental health of the population and the access the population has to services. Once these have reached acceptable levels, the expansion of the range of services available can be addressed.

Investment should be made in preventative services. The present concentration on children can be justified. However as adults are enjoying longer life and can reasonably expect to retain their teeth for the duration of their lives preventative services will have a role in promoting this positive outcome. Prevention work, not necessarily performed by qualified dentists, can relieve future demand for 'care and repair' services. **The extent and status of this PCD work should be enhanced as it contributes to the dental health of the population.**

It is worth considering whether people who keep six-monthly appointments are actually the people on whom limited resources should be spent. There are diminishing returns in concentrating services on these people and resources could be better spent on targeting groups with poor dental health.

Many people affected by homelessness have no access to dental services. The automatic de-registration of patients who do not regularly make and keep appointments with their dentists has a drastic impact on the number of people who can maintain access to services. This form of rationing is unacceptable. The population of people who are made homeless and subsequently have to move from their communities or to live in temporary accommodation suffer disproportionately in this regard. It should be emphasised that these people do not necessarily have 'chaotic' lifestyles and are not necessarily 'difficult to engage' – they simply have temporary housing issues that make it difficult for them to prioritise routine dental check-ups. Capitation funding only re-enforces this regime. **More flexibility as regards this de-registration or, preferably, the elimination of this unnecessary 'hurdle', should be considered.**

**The children of families affected by homelessness should have at least, the same access to services as other children.** Indeed research should be commissioned, if necessary, to ascertain whether they are more likely to form part of the population who have poor dental health due to poor diet, being less responsive to health education, having poorer dental hygiene regimes and being less likely access to services. **If this is proved the children of families affected by homelessness should receive priority treatment.**

**People affected by homelessness should be kept within mainstream dental services as far as is possible.** However, it may be necessary to develop specialist services and / or develop outreach services to services that engage with people affected by homelessness. This work should include in its priorities regular checks on and advice regarding oral hygiene and oral cancers. **Such services should not be premised on crisis intervention for people who are experiencing pain.**

Access to what other people may regard as basic items – toothbrushes, fluoride toothpaste and dental floss can be limited for people affected by homelessness and particularly those who are rough sleeping. There is an obvious financial issue with purchasing such items but also an issue with prioritising dental health when there are more immediate issues. **Provision of these basics should be regarded as a fundamental part of homelessness services and should be adequately funded.**

The Homelessness Taskforce recommended that substance misuse should not bar people from accessing health services. This includes dentistry. **Incentives should be paid to dentists who work with people from priority groups and this should include people affected by substance misuse and people affected by homelessness. These incentives should not be merely made up of capitation funding but be funded on the basis of a quality service including preventative work.**

People on methadone continue to receive poor advice as regards the direct and indirect impact of methadone on their dental health. Without an adequate dental hygiene regime and access to treatment, this can be severe and permanent. Such people should be maintaining better dental hygiene than the rest of the population. Access to advice is simply insufficient and access to dental services should be prioritised for this group. **Access to a dentist should be made available to all people commencing methadone treatment. If necessary incentives should be paid to dentists to provide a quality service to these patients.**

**All NHS services to people who are affected by homelessness and their children should be free.**

It is regrettable that this consultation ignores the recommendations of the British Dental Association's Expert Reference Group as laid down in their policy discussion paper *Dental Care for Homeless People* (BDA December 2003). This would form the basis for services for various excluded and community care groups and for the population more generally. While it should be considered as a whole, three of its recommendations are worth outlining here.

- **All sectors of dentistry have a part to play in providing services for homeless people – provided that training and funding issues are properly addressed**
- **More needs to be done to alert homeless people, and people working with them, to dental health issues and to inform them about ways they can access dental healthcare services.**
- **The curricula for dentists, dental hygienists and dental therapists (and the occupational standards for dental nurses) should make explicit reference to gaining experience of working with socially excluded groups, including homeless people.**

This response has made reference to issues around the first and second of these recommendations. As regards the third recommendation, there is a consistent issue with the culture of health services. Most particularly there seems to be a lack of appreciation of issues facing patients in their everyday lives. While there are examples of good practice, these seem to be dependent on the level of interest, life and educational experiences of individual clinicians. A more comprehensive and structured education on issues including homelessness would enhance services and give more professional satisfaction to clinicians. It is distressing to hear that clinicians continue to talk to deaf patients who rely on lip-reading with their masks in place or to hear that clinicians have a dismissive attitude, or worse, to the concerns of people who have chaotic lifestyles or are phobic about dentistry. Survivors of abuse, for example, can experience difficulty with invasive examination and treatment and may need reassurance and to be accompanied by a friend or companion. A more informed response from dentists would improve the experience of all parties. **Likewise a funding regime that was not dependent on 'piece work' would help develop a better, more inclusive, culture.**

GHN would hope that this response will contribute to and help expand the range of the debate around the development of dental services in Scotland. The current consultation needs to take account of people who are currently excluded from services. GHN believes that financial, administrative, clinical and practical improvements which address the needs of people affected by homelessness will contribute to an improvement in services for the whole of Scotland's population.