MODERNISING NHS DENTAL SERVICES IN SCOTLAND

Response to the Scottish Executive's Consultation Paper, 2003

by

Dr W M M Jenkins, Dr V Bissell, Mrs S M Winning

Consultants in Restorative Dentistry

Department of Periodontology

Glasgow Dental Hospital and School

378 Sauchiehall Street

Glasgow G2 3JZ

We wish to contribute to the debate on modernising NHS Dental Services by focusing on the prevention and control of periodontal disease in the GDS. Although we ourselves have limited first hand experience of primary dental care, we have considerable experience in history-taking and examination of a large number of patients (~1200 – 1500 /year), referred to our department by a large number of GDPs, and we believe this has given us considerable insight into the current approach to the management of periodontal disease by a substantial number of dentists within the primary care sector.

We welcome the statement on page 17 of the consultation document that there is 'a wish to focus more on prevention (where evidence-based)' and also the query which is raised at the bottom of that page as to the nature of appropriate preventive services. We wish to make our observations under three headings: Prevention and early detection of periodontal disease: Management of established disease; and Manpower considerations.

1 Prevention and early detection of periodontal disease

1.1 Prevention of periodontal disease will, inevitably, always be *secondary* prevention and, in its widest sense, will embrace the following principles:

- Screening for early signs of disease
- Case presentation and discussion
- Smoking cessation advice
- Removal of plaque-retentive features such as restoration overhangs and supragingival calculus.
- Oral hygiene instruction.
- Appropriate follow-up

1.1.1 Screening for early signs of disease.

Whatever system of remuneration is put in place, whether it be item-of-service or a salaried service, screening of all patients, say once a year, should be mandatory and, unless the patient refuses to accept treatment, there must be an obligation to address all the problems detected by this screening

procedure. All patients with signs of periodontal disease will require oral hygiene instruction. The CPITN (BPE) is a widely accepted tool for recording the findings of a screening procedure.

1.1.2 Case presentation and discussion

This is a crucial element in the delivery of periodontal care which is given scant recognition in the current fee scale narrative. It is the means by which dentists explain the implications of their clinical examination, convey to the patient his or her responsibility for appropriate preventive dental health behaviour and make sure that the aims of the clinician and expectations of the patient are correlated as closely as possible before treatment begins. Without a case presentation and discussion, most subsequent clinical intervention for patients with signs of periodontal disease is doomed to failure.

1.1.3 Smoking cessation advice

It is now well established that smokers, on the whole, are more severely affected by periodontal disease (relative risk = 2 to 6 times that of non-smokers) and their tissues respond to periodontal treatment less readily. Brief advice from a health professional can lead to 2% of smokers quitting. Quit rates of up to 12% can be obtained when motivated patients are given nicotine replacement therapy. There is good evidence that dentists and dental hygienists, trained in smoking cessation techniques, can achieve quit rates comparable to other health professionals. Smoking cessation interventions are highly cost effective for the NHS.

1.1.4 Removal of plaque-retentive features

In some patients, this will mean replacing restorations or removing overhangs recognising, of course, that there are situations where the benefits of replacing a restoration are insufficient to justify the risks or costs associated with the procedure. Supragingival calculus has little direct effect on the adjacent tissues but plaque grows on its surface and has to be removed to create optimal conditions for self-performed plaque control. There is, of course, little value in scaling teeth unless the patient leaves the surgery willing and able to clean them properly on a daily basis. After all, the plaque attached to a tooth surface, 24 hours after that tooth has been cleaned, is just as harmful as the plaque which was attached to the removed calculus.

1.1.5 Oral hygiene instruction

Oral hygiene instruction should be given only after a record of plaque accumulation has been obtained, and should be continued at subsequent visits until patients achieve their peak level of plaque control or signs of periodontal disease disappear, whichever occurs sooner. It is important to get the balance right between scaling and oral hygiene instruction and, in our view, there is far too little oral hygiene instruction currently given in relation to the amount of scaling which is carried out. Part of the problem stems from the fee-scale narrative: there is no separate item for oral hygiene instruction for adults. Instead, it is included with procedures such as scaling, polishing and 'periodontal treatment' in items 10a, 10b and 10c. Dentists can claim fees for these items of treatment without having to declare how much (or how little) oral hygiene instruction was given. Oral hygiene instruction should, therefore, be a separately accountable item of treatment. There is little value and no health gain in scaling teeth in patients with unremittingly poor oral hygiene, a point made in the Report of the Audit Commission into Primary Dental Care Services in England and Wales (2002), and one with which we agree. For the year ending March 2003 there were 1,420,519 claims under item 10a (widely regarded as a '1-visit scaling'). Each claim was worth only £10.45, but the total cost to the NHS in Scotland was almost £15 million.

1.1.6 Appropriate follow-up

In patients with incipient disease with a positive attitude to oral health, the measures described above should be sufficient to restore good periodontal conditions but there must be recognition of the need to follow-up patients once oral hygiene instruction and smoking cessation advice has been given to determine whether recommendations have been followed and whether further advice is needed. It is not desirable to leave this until the next check-up 6 or 12 months later. Furthermore if the screening procedure identified 'established' rather than 'incipient' disease, more treatment will be required, as described below.

2 Management of established disease

There is wide agreement on the proper procedures for treating established periodontal disease. Following diagnosis and case presentation, a *sustained* course of treatment is required incorporating: smoking cessation, if possible, and the establishment of good supragingival plaque control, as described above; and the removal of subgingival tooth surface irritants by non-surgical or, where appropriate, by surgical means. It is essential to establish a suitable programme of recalls to

maintain whatever improvements have been achieved, and for the most susceptible patients, repeat courses of sustained treatment may be required. This is what we have been teaching for a great many years. It is apparent, however, that many patients, referred to our department by their dentists, are unaware of the cause of periodontal disease, have poor oral hygiene and give a long history of '3-month scalings' to remove calculus from behind their lower front teeth, but cannot recall having had a sustained course of treatment. It is for general dental practitioners to explain why so much inappropriate treatment is delivered, but it is worth pointing out that the current financial provision for basic periodontal treatment is woefully inadequate. Anecdotal evidence would suggest that much of the periodontal 'treatment' effort in NHS general dental practice consists of short visits to a dental hygienist every 3 months, in perpetuity. There is abundant scientific evidence that such maintenance programmes, provided they are based on oral hygiene re-instruction, are essential for the maintenance of periodontal health in *previously treated patients*. However, there is absolutely no evidence that short visits to a dental hygienist every 3 months can prevent deterioration in patients who start a programme of 3-month visits with existing periodontal disease. We feel that the unrealistically low fees available for proper periodontal treatment are to blame for this inappropriate and ultimately futile approach to the management of periodontal disease. Scottish Dental Practice Board statistics for 2002-3 support this view. There were only 2330 claims for Item 10c, 'Non-surgical treatment of chronic periodontal disease ...... over a minimum of three visits.' This amounts to the provision of 1 intensive course of periodontal treatment per general dental practitioner per year! While there were 2,131,423 claims for an 'Examination and Report' for adult patients, only 0.1% (1 in 1000) gave rise to an Item 10c treatment. This is an astonishingly low figure and might suggest that periodontal disease is not a problem in Scotland!

3 Workforce considerations

Currently, and most likely also in the future, dental hygienists will be the members of the dental team principally responsible for the prevention and control of periodontal disease in the primary care setting. We, therefore, view with some alarm the steps which have been taken already to convert two of our three Schools of Dental Hygiene into Schools of Dental Hygiene and Therapy where PCDs emerge with dual qualifications. We have nothing against the dual qualification itself, but take the view that additional training placements should have been found. Instead, the output of PCDs from these two Schools will remain the same but, if these PCDs subsequently devote, say, 50% of their

time to dental therapy work, then the dental hygienist output will effectively have been cut by 50%. There is also a risk that these therapists/hygienists will obtain more job satisfaction from carrying out fillings and extractions than from dental health education, oral hygiene instruction and scaling, and will seek out as much therapy work as possible at the expense of preventive periodontal procedures. After all, isn't this one of the reasons why the uptake of periodontal treatment by dentists is less than one would expect from the amount of periodontal disease within the population? There is, therefore, a significant conflict between this action to convert dental hygienist training places and the oft stated aim of the Scottish Executive that NHS services should focus more on prevention in order to reduce the demand for 'care and repair'.

4 Summary

- Dentists should be required to record periodontal conditions on an annual basis for all the patients attending their practices and should demonstrate that they are addressing the problems which each screening procedure identifies.
- Case presentation and discussion and smoking cessation advice are important elements of preventive periodontal care.
- Oral hygiene instruction is the key to establishing periodontal health and may have to be delivered in a sequence of visits at short intervals.
- Scaling is of little value unless the patient leaves the practice knowing how to clean more effectively and willing to do so.
- There is strong circumstantial evidence that proper periodontal treatment in general dental practice is being neglected and replaced by '1-visit scalings', the benefits of which are unproven.
- Most periodontal treatment in the primary care sector could be undertaken by dental hygienists, provided that it is properly remunerated.
- We view with very great concern the conversion of dental hygienist training into hygienist/therapist training and would urge the Scottish Executive to review this decision as a matter of urgency.