

Scottish Dental Practice Board

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Your Ref
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Dear Dr Wilson *19/3*

Modernising NHS Dental Services in Scotland: Consultation

I refer to your letter of 3 February 2004 and have pleasure in enclosing the response to the consultation document by the Scottish Dental Practice Board.

Yours sincerely

Glenys Graves
Chairman
Scottish Dental Practice Board

Enc.



Chairman Glenys Graves
Secretary Hilary Forbes

SCOTTISH DENTAL PRACTICE BOARD

Response to the Consultation Document

Modernisation of NHS Dentistry in Scotland

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**The response of the Scottish Dental Practice Board to the
consultation document regarding the Modernisation of NHS
Dentistry in Scotland.**

The Scottish Dental Practice Board welcomes the opportunity to respond to the Scottish Executive consultation document that relates to the Modernisation of NHS Dental Services in Scotland. This response represents the collective views of the Board, not those of individual members.

The Scottish Dental Practice Board has the unique composition of three lay members who may be seen as representing the patient perspective, four dental members who understand the general dental practitioner view and a chairman who is a dentist. Whilst discussing the subject of the modernisation of NHS dentistry in Scotland the Scottish Dental Practice Board has attempted to approach the subject from the patient and practitioner perspective and that of its own statutory functions, role and remit. This would also include comment on the impact that any changes may have.

As this response cannot express individual views it will report the discussions that have taken place regarding the three main points of the consultation process:

- The type of dental services that should be provided under the NHS
- Contractual arrangements for such services
- Patient charging systems

It lists the risks and benefits that were perceived to exist with each suggestion.

The type of dental services that should be provided in the future

The general view of SDPB is that whilst in an ideal society there should be infinite resources to dental health care and as such the range of treatments available should be unlimited, the realistic view is that where finite resources are available, there should be a core service concentrating on providing good quality, clinically necessary dental care with a system that is heavily weighted towards oral health assessment and prevention, acknowledging that a repair service must be adequately funded to allow time for such initiatives to have impact. Any preventative package should relate to caries and periodontal disease and issues such as smoking cessation that would have an impact on oral cancer.

The SDPB are of the opinion that there would be merit in evaluating the models of dental service provision operating in other countries.

The benefits of such an approach would be;

A 'core' NHS service would allow resources to be targeted at clinically necessary items of treatment. These items of treatment would be better funded allowing the dentist to spend more time in their provision. This would hopefully result in increased quality of treatment and a better patient experience.

With a 'core service' heavily weighted towards oral health assessment and a preventative approach patients would have the advantage of more time with their dentist discussing and planning future dental care.

Resources could be directed away from areas of potential over treatment to the educational and preventative role of Dentists and Professionals Complementary to Dentistry.

The risks;

There could be a risk of under treatment.

An under funded 'core' service linked to an SDR could still be perceived as having the potential for a 'treadmill' effect.

A 'core' service would have to be defined. It would be a most difficult task to justify the omission of treatments that are available at present on the NHS.

Regardless of whether or not a modified core service is adopted, there would still be a need for the monitoring of NHS dental services. The change of emphasis from a repair service to a health assessment and preventative approach would require a different form of monitoring. The SDPB are of the opinion that monitoring is best undertaken centrally to ensure consistency. A new minimum data set would be required to address the monitoring of oral health. This could perhaps include periodontal, caries and orthodontic indices.

Whilst monitoring is essential to identify poor standards, demonstrably high standards should be rewarded.

Although this response relates to the Modernisation of NHS Dental Services in Scotland the SDPB is of the view that there should also be monitoring of the Private Sector.

Contractual Arrangements

The SDPB were of the view that there were two broad types of contractual arrangements worth considering.

1. A modified system based on the present Statement of Dental Remuneration
2. A practice based system

1. A modified system based on the present Statement of Dental Remuneration

This could be based on the core service as discussed above and could be heavily weighted towards both an oral health assessment and a preventative approach. There should under this system be simplified approach to the numbers of items of treatment.

Benefits

No change at all could lead to stagnation and dental practitioners possibly moving to the private sector or migrating away from Scotland.

This payment system is a known quantity to dentists requiring only modification. There would be no major disruption.

A centrally based monitoring system is in place, which would require minimal extra cost to, or input from NHS organisations.

A core service would enable good quality clinically necessary dental care for all.

A modified Statement of Remuneration would allow a simplified banding of charges, which could be more readily understood by patients.

Similarly dentists would also benefit from a less time-consuming system of assessing fees and patient charges.

Risks

The Statement of Remuneration as a means of payment does not necessarily address patient need.

The constraint of an SDR does not allow the discretion of dentists or NHS organisations to provide a range of treatment according to local population or individual patient needs.

This system may not be as easily adapted to one based on oral health assessment and prevention

This system may still be perceived as linking dentist's pay to items of treatment. This could perpetuate the status quo encouraging further migration of dentists from the NHS sector in Scotland

2. Practice based system

A practice-based system allowing practices to negotiate with their local NHS organisation, incorporating an annual income paid on a monthly basis and reviewed at planned intervals.

Benefits

Practices would be able to negotiate their own requirements that would reflect the needs of patients within the practice.

This system should allow for a broader base of treatments being available at the dentists discretion based upon the needs of the patient.

This type of contract would not be linked to a Statement of Dental Remuneration, with payment for individual items of treatment, and as such it would lend itself more easily to an oral health assessment and preventative approach.

Practice based system would allow for validation of the whole practice team as opposed to monitoring the individual practitioner.

Assured annual income paid monthly would allow practices to achieve better business and financial planning.

Risks

At present this is unknown territory

Lack of clarity and forward planning regarding changes to the payment system could lead to disillusionment amongst general dental practitioners with a potential drift to the private sector.

A practice-based system with monthly payments would still require the monitoring of clinical aspects.

This would require that a new minimum data set of information be collected centrally. Some form of base line oral health assessment would be required in order to monitor activity of dentists and outcomes of treatment within a practice and its health region.

Improved IT systems would have to be developed and funded. These would link practices to NHS Health Boards and they in their turn to a central organisation so that standardised information would be available for monitoring

If NHS Boards were to undertake both the payment and monitoring responsibilities, which are at present undertaken centrally, further additional expense and duplication of the training of suitably skilled staff would have to be considered.

There is the potential for under treatment in such a system.

Issues that would have to be addressed

Questions regarding where the responsibility of care would lie

Potential problems with the determination of superannuation

Self employed status of dentists

Would this have any real impact on access issues in rural areas?

Would incentives still have to be paid?

Would this system enable NHS Boards to offer future incentives, which would relate to local needs?

Patients' charges

Those suggestions mentioned in the consultation document were discussed

- Single charges for specific procedures

It relates specifically to the work carried out
Can be seen as being fair to both patient and dentist

However there is no real difference to the present system that is considered cumbersome and difficult for patients to understand

- Change to a variable percentage charge

This system has the merit of encouraging preventative dentistry, however a very delicate balance would have to be achieved so that patients requiring crowns and bridges were not seen to be disadvantaged.

- A change to the percentage charged depending on patients' characteristics.

This requires greater clarity before comment could be made.

- Fixed charge related to time in the practice.

This was considered to be anomalous, being overly dependent on individual practising characteristics.

- Separate payment arrangements for dental appliances

This system may benefit laboratories, which at present feel disadvantaged by the SDR.

It may however discourage patients from having essential appliance treatment.

- Insurance type system.

Similar systems abroad should be researched before considering this.

Whilst the SDPB feels that the consultation document has addressed the issues relating to the actual provision of NHS dental services we would like to take the opportunity to also address the issue of the monitoring of NHS dental services.

The SDPB is of the view that in fairness to both patients and dentists, the monitoring of the provision of dentistry within Scotland should continue to be undertaken centrally. The size and infrastructure of Scotland is such that central monitoring is far easier than in England.

To allow individual NHS organisations to undertake such responsibilities would result in duplication of roles, extra cost, and the possibility of different standards being adopted across the country. This would be unfair to both patients and dentists.

As stated at the beginning of this response, these are the collective views of the Scottish Dental Practice Board and are not attributed to any particular individual.

The Scottish Dental Practice Board would be happy to expand any of these views if requested.