

Lomond & Argyll Division

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Eric Gray
Primary Care Division
SEHD
St. Andrew's House
Regent Road
Edinburgh
EH1 3DG

Community Dental Service
Bank St Clinic
46-48 Bank St
Alexandria
G83 OLS

Tel: 01389 604309
Fax: 01389 604310



Dear Mr Gray

Modernising NHS Dental Services in Scotland

Lomond & Argyll Division of NHS Argyll & Clyde supports the view that in future there should be one salaried primary dental care service. The artificial divide between the community dental service and salaried general dental service should be removed. Although joint and split posts have been useful, a single salaried service would be much simpler and should lead to more straightforward management and administration.

It is acknowledged that different parts of Scotland have their own distinct needs. The system that is devised for primary care dentistry will need to be flexible enough to allow slightly different services to develop in different parts of Scotland.

The Extent and Nature of NHS Dental Services

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 Salaried Primary Care Dental Service (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 ideally up to at least 18 years and include 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 should be provided privately.

The view has been expressed that children's dental services should be provided through a family dentist. However we know that the majority of adults in many parts of Scotland have no family dentist. This is particularly true in rural and

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 these areas 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.

Underpinning these treatment services will be the QIS Clinical Standards for primary care dentistry. Unfortunately these are as yet unseen but it is anticipated that they will be applied across both the GDS and SPCDS.

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 academia 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 that will examine SIGN Guidelines, and any newly published Guidelines, to see whether they provide sufficient evidence to alter the treatments offered under the NHS.

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

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. For children SIGN 43 has been very useful and the anticipated issue of the SIGN Guideline on prevention in pre-school children is still awaited. Although there is a SIGN Guideline on third molars, further guidelines on other aspects of dentistry would be useful.

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. Regrettably, in some areas, the majority still do not attend any dentist.

It is disappointing that there has been no response from the Executive to the consultation on "Towards Better Oral Health in Children". It is hoped that there will be a positive outcome, particularly legislation that will match that enacted in England, giving responsibility for water fluoridation to local NHS Boards.

It is encouraging to see the interest shown by the Executive to all aspects of healthy eating. Further national initiatives in this area will be welcomed as a contribution to improving oral health.

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 where staff can be used in both roles, e.g. a dental nurse with oral health education qualifications providing chair side assistance or in a public health function.

Responsibility for oral health education should be retained within SPCDS. At the same time it is essential that there is excellent working relationships between all health professionals, and others, who can influence oral health. There should be no barriers to preventing oral health educators employed by SPCDS carrying out duties within independent NHS GDS where this is appropriate.

PCDs, dental hygienists and 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. This would free valuable dentist time to provide direct patient care.

The Delivery of NHS Dental Services

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.

Ideally there should be some control over the location of NHS GDS practices. However unless funding arrangements are radically changed this may be difficult to achieve.

There must be an improved career structure both for dentists and PCDs within the SPCDS. It is hoped that this will be addressed by the current Review of Salaried Primary Care Dental Services,

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 should be resourced to provide it.

Registration is poorly understood both by patients and health professionals. Registration for children should be automatic and continuous. Similarly, registration should be linked to specific "life periods" e.g. 75 plus.

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

The idea of “rewards” for meeting quality targets and the provision of incentives to provide services in deprived or sparsely populated areas would be welcome. 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 property and surgery upgrading to both SPCDS and GDS. It is increasingly difficult to access NHS Boards’ capital funding to replace dental equipment and improve facilities to meet increasingly stringent standards.

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.

The suggestion that there should be better peer support for isolated and single-handed practices is endorsed. This support is needed also for the SPCDS in remote areas.

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

It is agreed 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. There should be a flexible approach to premises in both urban and rural areas.

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.

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

They would be best managed locally within NHS Boards to a locally agreed timetable rather than reacting to a centrally agreed programme. However there may be some changes that will require to be implemented nationally.

Patient Charges

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

Patient charges should be applied consistently across primary dental care, those who require to pay 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, use of CHP administrative staff.

Are there other approaches that merit consideration?

A view expressed 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.

Patients who have high caries rates should not be penalised financially, provided that they attend regularly to secure and maintain oral health.

There would be merit in investigating using a “grant in aid” or voucher scheme to help patients pay for their dental care.

Training

Training does not fit easily into the questions posed in the consultation document. 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 the increasing involvement there has been in recent years is welcomed. It is acknowledged that NES has played a large part in this change. The training role of the SPCDS now incorporates; undergraduate dental students, General Professional Training, Specialist Registrar training and 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 adequate facilities in their capital planning programmes.

I trust you find this response helpful and look forward to the SEHD reaction to the consultation in due course,

Yours sincerely,



John F. Herrick
Director of Dental Services