BDA
British Dental Association

Introduction

At the March 2018 Scottish Council meeting, there was an action to seek the views from the BDA craft committees on what impact the Oral Health Improvement Plan (OHIP) will have on the profession. Members were specifically asked for what they considered to be the ”top five” issues in the OHIP.

Members were asked to consider all the actions listed in the OHIP and reflect on their potential impact to provide a basis for future negotiations, and potential trade-offs, with Scottish Government.
Members were concerned that the overall lack of detail and clarity in the OHIP made it difficult for them to provide informed feedback on the plan.
BDA Scotland has collated feedback from members and summarised the following top five concerns:

1. Changes in funding to GDPs
2. Domiciliary care in care homes and people in their own homes
3. Director of Dentistry role
4. Oral Health Risk Assessment (OHRA) / periodontal care / general health checks
5. Simplifying Items of Service.

Members’ Top Concerns regarding OHIP

1. Changes in funding to GDPs

GDPs are rightly asking questions on how the changes outlined in the Plan can be delivered with no extra Government funding. It has been difficult to convince Scottish Government that GDP earnings have fallen by 30 per cent in real terms in the last 10 years, although there is evidence for this reduction in a report by the NHS Education for Scotland Dental Workforce Report 2016 http://www.nes.scot.nhs.uk/dental-workforce1.html (2.10 Earnings) Practice owners and experienced GDPs are retiring from the NHS in large numbers and the lack of detail in the OHIP may accelerate this exodus. The family GDP is under significant pressure from the GDC, rising patient expectations, lack of funding, reduced earnings and poor morale. BDA Scotland is concerned about the sustainability of dentistry as a profession in Scotland.

Although not a specific action point in the OHIP, the following statements in the Plan will fundamentally change the economics of general dental practice.

Payments to General Dental Practitioners/Dental Practices (OHIP, page 29)
‘The strength of the existing payments regime for GDS is that there is a mixed economy of item of service, capitation and continuing care payments, and individual and practice allowances. We will continue to retain a mix of payments going forward, but the balance of payments will change accordingly.
In summary there will be:

• a new system of capitation payments to support preventive care and treatment in children and young adults, supported by monitoring;

• a new system of enhanced continuing care payments to support the introduction of Oral Health Risk Assessments for adult patients;

• a simplified set of item of service payments for restorative care and treatment;

• changes to the General Dental Practice Allowance to incentivise general dental practices with patients from more deprived communities;

• changes to the reimbursement of rental costs to ensure that payments are based on an appropriate size of practice and taking into consideration its location;

• a new NHS commitment criteria; and

• a single quality-based practice allowance which reflects the unique circumstances faced in both remote and rural areas and deprived communities.'

There is no further detail provided in the Plan, and – with no additional funding – the potential for disruption of the GDS is considerable. There is understandable uncertainty and concern about the future viability of practices. Such major changes would merit a pilot project to mitigate unintended consequences of practice closures and lack of access for patients to a NHS dentist.

Current guidelines for treatment planning assume patient engagement with little or no advice for what to do for patients that do not engage. OHIP states it will change payments to encourage better compliance by dentists in giving advice. Scottish Government can only do this if patients engage and comply. BDA Scotland is concerned this will translate into more regulation by holding dentists accountable for individual patients' lifestyle choices.

Although the Plan states that the Scottish Government aims to maintain the financial viability of the GDS, Scottish Dental Practice Committee (SDPC) members are concerned about redistribution of practice allowances to follow deprivation, which has the potential to destabilise practices. Reducing the frequency of dental checks, and decreasing the numbers of scale and polish treatments, also have the potential to financially penalise dental practices.

Action 36 – '*Scottish Government will work with NHS Boards and NSS to ensure any Payment Verification issues are dealt with*'

BDA Scotland agrees a stronger partnership between the NHS Boards and NSS is necessary and would suggest there should be greater communication between the NHS Boards, PSD and GDPs. BDA Scotland recognises that the payment system is complicated and there needs to be a way in which GDPs can gain a better understanding of the information PSD provides. If changes are to be made to the SDR, then potentially the payment system must be addressed. Roadshows would be a good way of communicating changes about the SDR to the profession.

2. Domiciliary care in care homes and people in their own homes

BDA Scotland has highlighted the following concerns regarding domiciliary care for the elderly:

Patient safety

Treating an elderly patient in a care home in a non-dental chair in a non-clinical settling with poor lighting, no aspiration, and with limited materials and instruments could be regarded as negligent. Members are concerned that it is not safe to carry out invasive treatment in a care home or the patient's own home. The OHIP should not be encouraging this approach to treating patients. The elderly will have multiple medical issues, polypharmacy, capacity issues that make consent and compliance difficult if not impossible. In addition, being treated in a standard house chair with no head rest will involve bending their heads backwards, and can only be unsupported for a limited time before tiredness begins. Elderly patients can have a reduced gag reflex or swallowing pattern which makes aspiration of small items more likely

and swallowing of impression material a real possibility. Aspiration is a medical emergency and swallowed impression material can result in surgical intervention. These patients will be a high risk for a general anaesthetic.

BDA Scotland is concerned that dentists treating patients in a care home setting or their own homes are carrying the risk that something could potentially go wrong during treatment. BDA Scotland suggests that dentists could be putting their GDC registration at risk. BDA Scotland would refer to the GDC Standards which have nine principles dental professionals must follow:

BDA Scotland would also suggest that patients should be seen by a dentist before entering a care home.

Action 11 - *'The Scottish Government will introduce arrangements to enable accredited GDPs to provide care in homes. These practitioners will also work with care home staff and the PDS to ensure the maintenance of good oral health and hygiene'.*

At the Conference of Scottish LDCs in April 2018, the Cabinet Secretary for Health and Sport announced that by the end of this financial year, Scottish Government plans to implement a joint working group for GDPs and the PDS to address the shared care arrangements. These will initially focus on care in care homes and will eventually move to address the needs of those living in their own homes.

The activity of a dentist or dental therapist is governed primarily by the Focus on Standards, a GDC document. The promotion of domiciliary dental care, including dental care provided in elderly patients' homes, as proposed in the OHIP is contrary to a number of the standards (listed above) laid out in the Focus on Standards document. These standards may easily be contravened by treating patients in a care home or their own home. Patient safety must come first and the dentist should not be forced to put their registration at risk. Elderly patients require the best quality dental care available in a safe, clean and suitable environment. The most appropriate place to deliver safe dental care for some forms of treatment for the elderly is in a modern equipped dental practice where all the facilities and staff are located to deal with any emergency that may arise.

Action 13 – *'Once we have sufficient numbers of accredited GDPs in place, the Scottish Government will introduce new domiciliary arrangements for people who are cared for in their own home'*

BDA Scotland refers to the statements made in the OHIP in relation to the development of an accreditation scheme for GDPs:

'*These practitioners and their teams would work with care home staff to ensure adequate preventive care is in place for residents, complementing the PDS, which will continue to provide those procedures that cannot be readily done by a GDP. With the increasing numbers of people in care homes it will be necessary to ensure the PDS are only used for patients requiring their advance skills'.*

From a Public Dental Service (PDS) point of view, BDA Scotland is concerned about the potential impact that an 'enhanced service' for elderly patients and domiciliary care might have on the PDS since the service already offers special care dentistry. There are concerns that funding for these services might be reduced, and that the PDS would lose its current skill base.

Scottish Public Dental Service Committee members questioned how many accredited GDPs might be trained in an area or for each care home, the timescale for implementation, and if remuneration would differ once a GDP became accredited. Members also questioned whether remuneration would be sufficient to make this option attractive to GDPs. BDA Scotland would highlight that patient care is of the greatest importance.

There is also the potential that any subsequent treatment pathways could be 'patchy' from area to area depending on service uptake, skills availability, and interest from practitioners. BDA Scotland is concerned that funding may be diverted from the PDS to incentivise enhanced contracts and that this could lead to underfunding and fragmentation of the PDS.

BDA Scotland is concerned that this may be a step towards commissioning and questions who would be responsible for quality and governance. There could also be a danger of 'cherry picking' a few easy cases while leaving the PDS to pick up 'unprofitable' cases.

Limited scope of dental care
Given the problems outlined with patient safety, the scope of dentistry available in the domiciliary setting will be limited to the treatment of lower anterior teeth, hand excavation of root caries and the application of glass ionomer cement.

Extractions in a care home are contra-indicated because of the danger of it turning into a surgical removal. The provision of new dentures will require at least impressions and a hot burner to soften wax. Treatment of upper teeth will cause problems in a non-dental chair with an aspiration risk. Routine restorations may require to be amalgam due to deep cavities and moisture control, creating disposal risk, aspiration risk of amalgam, wedges and bands.

Quality issues, stress and infection control
With poor light, a non-clinical setting, no head rest, anxious and confused patients, poor moisture control and poor oral hygiene, there is a significant risk that the quality of dentistry delivered will be poor. This will lead to high stress levels for both the patient and the clinician attempting to provide the care. Providing dental care in a homely setting is not conducive to modern infection control.

Time, funding and training
A single visit to a care home to restore a number of lower anteriors with glass ionomer could take 2 hours and require a dentist/dental therapist with a dental nurse to act as assistant and chaperone. This will have to be reflected in the fee per item. It is imperative that GDPs receive specialised training if they wish to assume this role and BDA Scotland questions who will provide this training.

Transportation
The Scottish Ambulance Service provide support to the Public Dental Service by facilitating access to dental clinics through the use of the Patient Transport System (PTS) for those treatments which are not appropriate to be carried out at home. However, PTS will only deliver patients to hospital sites and not to GDP dental practices.

Health and Social Care Partnerships
Action 14 – '*The Scottish Government will work with Chief Officers within HSCPs to establish how we can work together to improve the oral health of people who are cared for in domiciliary settings.*

BDA Scotland suggests that awareness of the 'Caring for Smiles', the national oral health promotion, training and support programme for older people, should be raised.

3. Director of Dentistry role

Action 20 – *'The Scottish Government will work with NHS Boards to introduce a Director of Dentistry in each Board area'*

OHIP states that the Director of Dentistry (DoD) is expected to be an existing senior dental staff within each NHS Board. It is generally thought that Consultants in Dental Public Health (CDPH), Chief Administrative Dental Officers (CADO), the Clinical Dental Director (CDD) for the PDS and Dental Practice Advisers (DPA) as the current senior staff within each NHS

Board would be considered. In the past, Dental Lead Officers were established after the publication of Dental Action Plan in 2005. The post of Dental Lead Officer no longer exists and the DoD may be considered to be a 'replacement' for the Dental Lead Officer. This was a CDPH, and was 'honorary' with no remuneration. Not every NHS Board has a dedicated CDPH. In the past, PDS Clinical Directors of Borders, Highland, Lothian, Tayside and Island Boards came to Dental Lead Officers meetings. BDA Scotland considers that there may not be one solution which will suit every NHS Board.

There is concern that NHS Boards will not fund CDD roles if they have to fund DPA and DoD positions, and even before the creation of the new roles there is an increasing number of NHS Boards choosing not to appoint a CDD.

BDA Scotland has reservations about a CDPH being appointed DoD as they do not have a clinical role and in many cases, have not treated patients in a long time. SDPC members believe that the DoD should come from the GDS as most dental treatment is carried out in primary care.

BDA Scotland is concerned that the creation of a DoD within each NHS Board may be a way of bringing GDPs under the closer control of the HSCPs and NHS Boards, and risks the independent contractor status of dentists within the NHS. BDA Scotland questions what the oral health gain the proposed DoDs will provide for the Scottish population, and whether their introduction will lead to increased bureaucracy and cost for the NHS Boards and dentists alike.

Specific queries around the planned introduction of DoDs include:

- Will the new posts be responsible for local implementation of OHIP actions, and monitoring subsequent progress?
- Will the DoDs have any experience of running a business such as a dental practice, or have a clinical background?
- Who will the DoDs be accountable to?
- What is the grievance procedure?
- What will happen to the Area Dental Committees as these will in future be under the control of the same PDS managers?
- Will the DoDs be responsible for commissioning dental services as outlined in the OHIP?
- What experience will the DoDs have in commissioning?
- How can the public be assured that commissioning will not simply result in a race to the cheapest supplier with loss of quality?

This will be the first time that commissioning will be used in the NHS in Scotland and risks opening the door to Dental Bodies Corporate.

BDA Scotland is concerned that current NHS managerial staff do not have the skills to become managers of primary dental care. NHS managers have no professional standards to uphold, are unaccountable and are regarded by the profession as uncommunicative, unhelpful and overbearing to achieve their aims which are short-term, target-driven and not patient-focussed. Furthermore, NHS managers have no experience of running and owning a business. Bringing GDPs under the direct control of HSCPs will further reduce morale within the profession. The overall effect will be to push experienced dental practice owners to sell practices and retire. BDA Scotland is concerned that the family dental practitioner and the independent contractor model is at risk in Scotland and dentistry will no longer become a desirable profession.

BDA Scotland believes there is the potential impact for the PDS where NHS Boards without a dedicated CDPH and the CDD takes on the additional role of DoD. NHS Boards most likely to be affected are: NHS Borders, NHS Highland, NHS Lothian, NHS Tayside and Island Boards.

4. Oral Health Risk Assessment (OHRA) / periodontal care / general health checks

Action 4 – '*The Scottish Government will introduce an Oral Health Risk Assessment'.*

BDA Scotland agrees with the introduction of an OHRA which is important for dental professionals to care for patients' oral health. However, the proposed Oral Health Risk Assessment is aspirational and lacks detail. SDCEP produced a document several years ago on OHRA, but to complete a full assessment for each patient will take a significant amount of time and cost much more than a current examination fee. No additional funds have been announced for the OHRA.

BDA Scotland is also concerned that the proposal to extend the recall time to 24 months will leading to less frequent oral screening and symptom-free conditions left untreated for a longer period of time. GDPs would be less able to identify oral health diseases such as oral cancer. Over this extended period there may be considerable change in a patient's lifestyle, and therefore result in a change with the assessment score being increased or decreased. Even if the score decreased, it is important to see the patient routinely at six monthly intervals to provide positive reinforcement for making lifestyle changes. Additionally, some oral diseases may not be directly caused by points on the risk assessment.

Action 5 – *'The Scottish Government will introduce a clinically-proven programme of periodontal care for patients with periodontal disease and those with high risk of developing it'*

The OHIP mentions the broader risks of diet, smoking and alcohol to good oral health but there is little mention of personal oral hygiene. Maintaining good oral health is primarily the responsibility of individuals, not dentists.

Action 6 – '*The Scottish Government will explore the potential for introducing general health checks for adult patients whilst attending for routine dental checks'*

Currently GDPs do not have a remit to carry out general health checks. Within the dental profession there has been the introduction of Dental Therapists and Hygienists who are able to carry out certain aspects of dentistry to allow the dentist to work on different treatments. If GDPs are to undertake yearly assessments on patients to monitor for general health issues (such as monitoring blood pressure, glucose levels and heart rate) more time and remuneration is needed for the check-up appointment. It is essential that additional training be given to GDPs to carry out this role.

BDA Scotland is disappointed that there is no provision in the OHIP to account of prisoners' oral health within the Scottish Prison Service.

5. Simplifying Items of Service

Action 19 – **'***The Scottish Government will streamline items of service payments to GDPs'*.

BDA Scotland agrees this is an important issue and is applicable to all dental sectors. As this is such a significant change, a lot more information is needed. With over 400 treatments available to use, currently only around 100 are commonly used, BDA Scotland suggests that a table showing what is commonly used and what changes are to be made would be helpful. BDA Scotland also questions whether the costs of treatments will change.

Other areas of concern

In addition to the 'top five' concerns, committee members also commented on the following aspects of the OHIP:

- **Community Challenge Fund**

Action 7 – '*The Scottish Government will introduce a new three-year Community Challenge Fund for Oral Health Improvement. We will host an event with our partners to help develop the key components of the fund'*

In April 2018, the Cabinet Secretary for Health and Sport announced that this initiative would be launched later this year.

Scotland's Oral Health Inequalities are as entrenched as ever, and whilst BDA Scotland believes this proposal is well intentioned it is difficult to envisage how it will work within a restricted budget.

- **Water Fluoridation**

OHIP cites that alternative solutions to water fluoridation are more achievable and BDA Scotland is disappointed that it not to be implemented, particularly when Scottish Government has tackled the considerable challenge of minimum pricing for alcohol and has implemented this initiative. It is BDA policy that the government should let communities choose whether they have their water fluoridated. The oral benefit of fluoridated water is well established; for example, data comparing socially similar areas in the UK suggest children in fluoridated areas enjoy significantly fewer decayed, missing and filled teeth.

- **Priority Groups**

Action 10 - '*The Scottish Government will ensure the PDS actively pursue shared care arrangements with local 'high street' dental practices'.*

BDA members are concerned that there is an implied threat that funding will be cut unless the PDS can show 'active pursuit of funding'. More detail is needed as to how shared care would be developed.

BDA Scotland
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