NHS SCOTLAND

MODERNISING NHS

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MODERNISING NHS DENTAL SERVICES IN SCOTLAND

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1. INTRODUCTION

This consultation paper has been prepared to support the delivery of the undertaking in the White Paper *Partnership for Care*[1] that we would "take forward proposals for changes to the system for rewarding primary care dentistry in order to promote prevention, improve access to services and improve recruitment and retention". It also addresses the commitments in the *Partnership Agreement*[2] relating to dentistry.

The paper

- sets out the background to oral health and dental services in Scotland
- provides a summary of what has already been put in place to support NHS dental services
- describes the pressures and need for further change, and
- puts forward options for changing the current system, including patient charges

It also sets the context within which legislative provision may be needed to underpin agreed changes for the future.

It seeks the views of the public, professionals, NHS bodies and others concerned with the sustainable delivery of NHS dental services in the community.

[1] Scottish Executive, *Scotland's Health White Paper: Partnership for Care (2003)* http://www.scotland.gov.uk/library5/health/pfcs-00.asp

[2] Scottish Executive, *A Partnership for a Better Scotland: Partnership Agreement (2003)* http://www.scotland.gov.uk/library5/government/pfbs-00.asp

2. BACKGROUND

2.1 Oral Health in Scotland

Oral health in Scotland is poorer than in many other European countries and people in Scotland have substantially higher levels of tooth decay than people in England and Wales.

There have been considerable improvements in some aspects of dental health over the last twenty years, notably for adults, with many more Scottish adults retaining some natural teeth than was the case thirty years ago. However, the picture is inconsistent, with significant inequalities in oral health evident in some areas of Scotland and between specific groups within the community.

The national target of 60% of 5 year old school entrants to have neither cavities nor fillings/extractions by the year 2010 is unlikely to be met without a significant shift in emphasis to preventative care and effective and consistent advice on dental care for children and their parents.

Adults

- By middle age, the average Scottish adult has lost 8 adult teeth and has 10 teeth filled, and over half of 65 year olds have lost all their teeth.
- 41% of dentate adults in Scotland reported having some dental pain in the previous 12 months.
- Over 500 cases of oral cancer are diagnosed in Scotland annually, half of which will be fatal.

Children

- By the age of 3, over 60% of children from areas of deprivation have dental disease.
- By the age of 5, over 56% of all children have dental disease.
- By the age of 14, over 67% of children already have decay in their adult teeth.

It is important to note that many of the factors leading to poor oral health are the same as those which underpin the poor general health of the population – poverty, diet, tobacco use etc. Tackling oral health, therefore, forms a key plank in the overall strategy of health improvement in Scotland.

2.2 Changing Demography

It is important that any review should be considered in the context of the changing demography of Scotland.

The proportion of the population which is elderly is predicted to rise, with increasing numbers of people keeping teeth into older age. Good oral health is also important in the prevention and management of oral cancer. It is necessary to consider the impact that these changing population characteristics will have on the approach we take to dental and oral care. Key population groups such as the elderly, children and those with special needs may need services to be more focused in future if we are to achieve our aim of oral health for all people in Scotland.

2.3 Current Provision of Dental Services in Scotland

2.3.1 General Dental Services (GDS)

The majority of the approximately 1900 General Dental Practitioners (GDPs) in Scotland are independent contractors who treat children and adults under a hybrid system: a partial capitation and continuing care arrangement is supported by an item of service fee structure. This means that the dentist is paid for each patient that they have on their list to treat under NHS arrangements, and is also paid per item of NHS treatment that they carry out. In addition there are payments for 'occasional' and emergency treatment and a number of specific allowances (e.g. for continuing professional development). GDS constitute the main provision for family dental services for people in Scotland, delivered from some 900 locations. The nature of the service has changed over the years from extractions to restorations and, more recently, to aspects of prevention, but is still seen largely as 'care and repair'.

An estimated 10-20 practitioners undertake only private work whilst the majority undertake a mixture of private and NHS treatment. There has been an increasing move towards private provision during recent years.

2.3.2 Salaried General Dental Practitioners

Scottish Ministers have the power to authorise Boards/Trusts to appoint salaried dental practitioners in areas of unmet need or where there is difficulty accessing NHS dental services. Over 50 salaried dentists are currently working in Scotland. These dentists provide the full range of NHS dental services and work from premises owned, supported and staffed by NHSScotland.

2.3.3 Community Dental Services (CDS)

There are approximately 300 Community Dental Service staff in Scotland who are employees of NHS Boards/Primary Care Trusts. Their main target populations are disadvantaged groups and those with special needs (including children, people with learning difficulties and the elderly in residential care). In addition they provide a 'safety net' for those who are unable to access GDS. Salaried GDPs and the CDS play a significant part in service delivery in remote areas. Their services are provided at some 300 locations across Scotland, in fixed or mobile clinics.

2.3.4 Specialist Dental Services

Hospital dental services (HDS) accept patient referrals from both dental and medical practitioners and from other hospital services. The main specialist areas are oral and maxillofacial surgery, oral medicine, orthodontics, restorative dentistry and paediatric dentistry.

2.3.5 Professionals Complementary to Dentistry (PCDs)

Professions Complementary to Dentistry are dental nurses, dental hygienists, dental therapists and dental technicians. The range of work that suitably trained dental therapists and hygienists are permitted to carry out was extended on 1 July 2002. This was intended to

allow hygienists and therapists to take on more of the dentist's routine work and allow dentists to take responsibility for more patients as a result.

2.3.6 Expenditure

Current (2002/03) expenditure on GDS is around £194m, including £53m of income from patient charges. Capitation and continuing care fees account for around 20% of expenditure. Some areas of activity have increased more than others over recent years e.g. the cost of orthodontic treatment has gone up from £4.4m in 1995 to £7.25m in 2002.

3. POLICY CONTEXT: DENTAL SERVICES IN NHSSCOTLAND

3.1 *Action Plan for Dental Services in Scotland*

An Action Plan for Dental Services in Scotland[3], published in August 2000, set out the Executive's strategy for improving oral health and dental services in the context of both changing Scottish demography and a dynamic dental workforce. Significant progress has already been made against many of the key targets in the *Action Plan*; many of these are unique to Scotland.

3.1.1 Health Improvement

A range of measures has been introduced to improve children's oral health:

- a caries prevention scheme for 6 and 7 year old children.
- efforts towards closer integration with the health improvement agenda, especially in health eating campaigns and the promotion of water as a healthy drink.
- free toothbrushes and toothpaste alongside nursery tooth-brushing programmes and health education for pre-school children.

[3] Scottish Executive, *An Action Plan for Dental Services in Scotland (2000)* http://www.scotland.gov.uk/library3/health/apds-00.asp

- a consultation on children's oral health in Scotland: *Towards Better Oral Health in Children*[4].

3.1.2 Supporting NHS Dentistry

A range of measures have been introduced in recognition of the need to support quality improvements in dental practice, and to encourage young dentists who have trained in Scotland to remain here following qualification:

- £9.8m made available for dental practice improvements in the last 3 years.
- a 'Golden Hello' allowance for newly qualified practitioners which is enhanced in areas designated in special need of dental practitioners
- an additional allowance for dentists who take up their vocational training in a designated area.
- grants for established practitioners setting up or expanding approved vocational training practices.

Other measures recognise commitment to the provision of NHS dental services and also the particular difficulties faced by dentists working in rural and remote areas of Scotland, where the viability of practices may be threatened by low population density:

- a new general dental service practice allowance and a new sedation practice allowance.
- commitment payments for assistant practitioners.
- an increased ceiling for seniority payments.
- an enhanced return to work scheme.
- a remote areas allowance.
- enhanced continuing professional development funding for practitioners in remote areas.

[4] Scottish Executive, *Towards Better Oral Health in Children (2002)* http://www.scotland.gov.uk/consultations/health/ccoh-00.asp

3.2 Workforce Planning in Scotland

The Scottish Advisory Committee on Dental Workforce (SACDW) and NHS Education Scotland (NES) have published extensive reviews of dental workforce in Scotland. These reviews show that:

- There has been an increase in the number of dentists in the NHSScotland dental workforce. However, over the past decade, a significant number of new Scottish graduates and established dentists have not contributed as much of their time to the NHS dental workforce in Scotland. This is due to an increase in career breaks, changes in working patterns, early retirements, drift to other countries and a move towards private provision of care (preventative and treatment).
- There has been a sustained increase in the number of older dentists and in the proportion of women in the Scottish dental workforce. There has been more part-time working and earlier retirements.

Building on these analyses, SACDW has made several key recommendations, which are being implemented:

- an annual output of 120 dental graduates per annum in Scotland (currently under review).
- planned and centrally funded education and training for dental hygienists and therapists.
- the beginning of training for dually qualified hygienists and therapists suitable to take on wider aspects of dental work such as fillings.

The present workforce plans will deliver additional graduates and more professionals complementary to dentistry by 2006. It is essential that we have stable and attractive dental services and premises if we are to recruit these personnel to NHSScotland.

3.3 Further Measures: *Partnership for Care* and *A Partnership for a Better Scotland: Partnership Agreement*

The White Paper *Partnership for Care* and the *Partnership Agreement* made a series of pledges to support NHS dentistry and to improve oral health:

- to systematically introduce free dental check ups for all by 2007.
- to further pursue mechanisms which encourage preventive dentistry and design appropriate reward measures to support that objective.
- to undertake an assessment of the reasons for the shortfall in the number of dentists in some areas of Scotland and the options for addressing that.
- to expand the capacity of dental training facilities in Scotland by establishing an outreach training centre in Aberdeen and to consult further on the need for its development to a full dental school.

These commitments will be relevant to any future system for the delivery of dental services in Scotland.

4. THE NEED FOR CHANGE

4.1 Previous Reviews

A number of key expert reports, notably the Royal Commission on the NHS (1979), *The Schanschieff Report* (1986) and the *Fundamental Review of Dental Remuneration* (1992) highlight issues that are still of relevance to dentistry in Scotland today, despite subsequent modifications to the dental contract. In particular, the 'Treadmill Effect' (whereby dentists feel that to be adequately remunerated under the current payment system, they must concentrate on providing a high number of treatments rather than preventive advice) has been a perceived problem throughout the time span of all these reports.

In 2002, the Department of Health published its framework for reform of dental services in England: *Options for Change*.

Key features include:

- local commissioning and funding
- prevention and an oral health assessment for patients
- clinical pathways to treatment
- information and Communication Technology
- changes to practice structure
- development of the dental team

4.2 Pressures for Change

A number of factors have led to a growing momentum for change in the way dental services are delivered to meet the needs of a modern Scotland:

- continued and growing problems of service availability and access leading to major public and patient concerns.
- the changing demography of Scotland with the consequent impact on healthcare services.
- growing dissatisfaction within the dental profession with the current framework.
- the changing nature of the dental profession – more women, more career breaks, more dentists retiring early.
- a lack of incentive in the GDS contract for promoting dental health.
- concerns about aspects of private dental services (e.g. lack of information; regulation of standards) as outlined in the recent Office of Fair Trading report.

There is a growing consensus that the status quo is not an option. But equally, there is a recognition that there should be a measured transition to any changed future arrangements.

4.3 Guiding Principles for an Appropriate Framework

Patient and professional groups have indicated what they would like to see in a modern Scottish dental service:

Patients

- access to a good quality dental service when required for treatment and advice, and for timeous onward referral to specialist care when needed.
- access to good quality dental treatment in an emergency.
- to be free from worry about charges for necessary dental treatment and to have a more transparent charging system.
- an effective system for dealing with concerns and complaints.

Professionals

- job satisfaction and career progression.
- support to deliver high quality preventive and treatment services.
- access to relevant information and well trained staff.
- reasonable reward for providing high quality services.
- good quality, fit for purpose premises.

4.4 The following principles are seen as underpinning future arrangements:

- an emphasis on quality as well as quantity of treatment.
- a focus on longer term improvement of oral health
- equitable access and service provision.
- evidence based services and standards.

- integrated team working with best use of skills.

5. SUPPORT AND INFRASTRUCTURE FOR FUTURE CHANGES

5.1 This paper is focused very much on the system for providing and rewarding NHS dental services in the community, as stated in *Partnership for Care*. However, whatever the nature and scope of the system in the future, there are aspects of the delivery of services which, while not the main subject of this consultation, are essential for the future of NHS dentistry.

5.2 These include:

Human Resources

- the need to have the right number of professionals (dentists, PCDs and support staff) in place, working in partnership with the higher and further education sectors.
- a focus on the whole practice team, appropriately educated, trained, supported, and developed.

Quality and Standards

- high quality practices fit for purpose, including modern premises, equipment, information technology, decontamination systems.
- an emphasis on evidence based care, with quality assured and patient focused standards.
- clinical networks with, and support from, specialist services.

5.3 Planning, Provision and Monitoring of Services

While, at present, local NHS bodies have some responsibilities in relation to the planning and provision of NHS dental services, much of the focus of activity has been on a national (largely UK-wide) approach, although with increasing numbers of Scottish-specific initiatives implemented over the last 2/3 years. In common with other health and healthcare issues, the

focus needs to shift towards more local responsibility and accountability, so that NHS Boards determine, in partnership with the public and professions, what the local needs are and how they can best be met. This also means giving Boards increased powers to deliver services, through a range of contractual arrangements, salaried services or direct provision. However, this needs to be done within an overall Scottish-wide framework which recognises the value of a consistency of approach which can then be tailored to local circumstances. This increased responsibility and accountability at local level needs to be accompanied by devolution of funding to NHS Boards, thus ensuring that dental services are seen as an integral and essential part of local planning and provision. This will not only address local dental service provision but will also develop better community level support for prevention of dental disease and better contact with other health and community care professionals.

At present, the Common Services Agency provides a range of support services to NHS dentistry – payments, information, quality monitoring etc. In doing so, it supports the formal responsibilities of the Scottish Dental Practice Board as set out in legislation. It will be for further discussion, once views have been secured about the nature of any changes to the current system, how the best balance can continue to be achieved between local responsibility and national support. Whatever the detailed arrangements, robust IT systems are required to support clinical care, audit and communications.

6. CHANGES TO THE SYSTEM

6.1 Introduction

Any effort to reform dental services must inevitably consider the balance between the requirement for change and the extent to which existing systems have been effective in meeting the needs of the public and dental health professionals. No change is possible without some degree of risk to the stability created within the existing framework.

For the profession, there is a need to ensure that future services evolve in a way which continues to protect stability and investment whilst building on a culture of quality within the NHS. It is important that new arrangements incentivise and support dental professionals in the delivery of services at all stages of professional life.

For the public, there is a need to have a clear understanding about what the options are for a modernised dental service, what these would look like, how they would gain ready access to these services and how dental charges would fit within any new arrangements.

There needs to be clarity about the scope and extent of a modernised NHS dental service, the arrangements for delivering a service, and the consequent system for patient charges.

This section briefly considers each of the following issues in turn and raises questions about them. It must be stressed that there is an inevitable inter-relationship between the three elements. The issues presented, particularly about delivery, are not mutually exclusive and should not, therefore, be seen as separate options. There is unlikely to be a single solution which fits the circumstances in all parts of Scotland. However, decisions will have to be taken about –

- what sort of dental services should be provided under the NHS.
- how dentists' contractual arrangements will look if they are to support the delivery of these services.
- how patients should contribute to the cost of the service.

6.2 The Extent and Nature of NHS Dental Services

Dental services provided under the NHS in the community are currently defined in the 1978 NHS Scotland Act. The detail for general dental services is contained in the GDS Regulations and Statement of Dental Remuneration (SDR), and for community dental services in guidance and circulars. CDS could largely be described as GDS for special needs groups or for those who cannot access GDS through normal routes. The exception is the 'dental public health' service set out in Section 39 of the 1978 Act which provides for the dental screening of school pupils by the CDS. If we are to make the best use of workforce in the future, we should look at the full range of professionals working in the community and target the whole service to meet local needs in the most effective way. This implies a more cohesive and integrated approach to primary care dental service provision.

The current service is intended to promote oral health and 'dental fitness'. It now includes a range of prevention and treatment approaches, with a mixture of general and specialist services. Specialist services in the community are primarily orthodontics, with an increasing number of other specialist practitioners in e.g. surgical dentistry. Patients can be referred from other practitioners or services.

There are already restrictions on the range of services which can be provided under GDS; examples of excluded items include certain types of white fillings, tooth coloured crowns on molar (back) teeth, and dental implants. Technological change affects dentistry as much as any other aspect of clinical care, and the current system is not adept at responding to these changes. However, any extension to the current service, through treatments new to the NHS, will have an inevitable cost impact, whether met directly by the NHS or by patients.

Equally, it could be argued that what is already available under the NHS is more than is essential to deliver oral health and dental fitness. For example, it has been suggested that aspects of orthodontic care and some crown restorations are cosmetic, and that treatments such as crowns and bridges go beyond what is absolutely necessary in this regard.

There is, therefore, a need to define what the NHS is there to provide and at what cost (directly or indirectly). There is also, as with other NHS services, a wish to focus more on prevention (where evidence based) in order to reduce the demand for 'care and repair' services. This is not just an issue for children (although that has been the main focus to date) but increasingly for adults and particularly for older people.

The issues in this section are:-

- What services should come within the NHS for the future?
- Should they be prescribed and limited or unlimited?
- What system should there be for reviewing and updating?
- What is the right balance between preventative and repair services and what, in particular, should be included in the former?

- Should the 'dental public health' role of CDS be kept separate from the 'family health' role of dentistry in the community?

6.3 The Delivery of NHS Dental Services

As described earlier, there are two main systems currently in operation for the delivery of NHS Dental Services – independent contractor dentists and salaried arrangements. For independent contractors, there is a complex system of fees and allowances as set out in the SDR with over 400 items described and priced. It is largely a piece work system, with some elements of capitation and allowances. There is no minimum NHS commitment required of independent contractor dentists, although remuneration reflects what they actually provide. They do not have to provide NHS treatment at all. If they do wish to be on an NHS list then they must provide NHS treatment to at least one patient every six months.

There has been an increasing emphasis in recent years on the wider dental team, including the PCDs (hygienists, therapists, nurses etc) and managerial and support staff. It is suggested that, as with other aspects of primary care services, the focus for the future should be more on the whole practice – with the right skills and good quality infrastructure (premises, equipment etc). And, indeed, there might also be a greater drive to support practices working or joining together and also more closely with other parts of the NHS. As with other primary care services, the emphasis would increasingly be on the local NHS Board having the responsibility to secure dental services either through contractual arrangements with practices or by direct provision through salaried staff.

Independent contractor dentists are responsible for providing the staff, premises and equipment needed to deliver services and this past investment has to be recognised in any future changes. These facilities are directly provided by the NHS for salaried GDS and CDS practitioners and staff. While there has been some movement towards financial support to independent dentists through certain types of reimbursements and allowances, it has been suggested that there might be greater support from the NHS in return for defined NHS commitment.

For services delivered through contract, therefore, there may be a range of possible changes. These are not mutually exclusive, and could be seen as a possible 'menu' from which to meet specific local needs:

- funding focused on the practice rather than the individual practitioner
- widening the range of dental contract holders to encompass corporate bodies or practice groups
- a simplification of the existing feescale reducing the number of items of service (i.e. treatments)
- greater support for staff and infrastructure (e.g. premises) costs in return for specified NHS commitment
- funding solely by capitation (i.e. monthly payments) for registered patients
- sessional or block contract payments rather than item of service payments
- rewards for meeting quality targets
- incentives to provide services in deprived or sparsely populated areas
- better peer support for isolated and single practitioner practices
- move from a 'family' approach to the development of separate contracts/arrangements for specified groups/services (eg children, adults, elderly, specialist services, emergency services).

For salaried staff, it is assumed that they will continue to be employed under national terms and conditions but with the same types of flexibility which will apply to other staff covered by *Agenda for Change*. It is also suggested that the 'public health' dental service should be provided by clinical staff (dentists and PCDs) separately from the providers of practice based preventative and treatment services.

The issues in this section are:

- What are the views on the range of delivery and funding options?

- Are there specific issues about future funding of infrastructure, e.g. premises?
- Are there other approaches or incentives that merit consideration?
- How best should any new arrangements be put in place?

6.4 Patient Charges

The current system of patient charges for NHS dentistry requires individuals (who are not exempt or qualify for help) to pay 80% of the treatment costs, subject to a current maximum of £372. Because a course of treatment may comprise a number of individual items, each with a different fee, the system is extremely difficult for patients to understand (and complex for dental practices to manage). There is also some limited charging for services provided through CDS (and the hospital dental service).

Changes to the remuneration system for contractor dentists and greater integration of GDS and CDS into primary care dental services would mean changes to the patient charging system. Successive administrations since the early 1950s have taken the view that patients – unless exempt for specific age, condition or income reasons – should contribute to the cost of dental treatment. Income from dental charges is currently over £50m in Scotland.

Consumer groups and professionals have pressed for simpler charging arrangements which are also seen to be as fair and equitable as possible. Suggestions for change have included:-

- single (simple) charges for specific procedures (examinations, fillings, extractions etc)
- change to the percentage (or amount) charged depending on the nature of the service e.g. less for essential preventative care and more for bridges and crowns
- change to the percentage (or amount) charged depending on the patient's characteristics e.g. age, dental status
- fixed charge for each visit to the dentist, which could be related to time in the practice

- separate payment arrangements for dental appliances (dentures, bridges, crowns) rather than through the fee related system
- insurance type system (similar to some private dental plans), with or without assessment of dental health and status.

The current system for exemption from and help with charges would continue (with the addition of the Partnership Agreement commitment on free dental checks).
The issues in this section are:-

- What principles should be pursued in determining a system for patient charges?
- What are the views on the options listed?
- Are there other approaches that merit consideration?

6.5 Financial Implications

It is important to recognise that changes to the current scope of NHS dental services may have an effect on the funding required, from the Executive and/or from patients. Any additional expenditure from the Executive (beyond that already planned) would need to be considered against other Health Department priorities.

6.6 Legislation

Changes to the nature of NHS dental services, to the responsibility of NHS Boards, to funding arrangements, and to patient charge arrangements, may require primary legislation. The results of the consultation will help to inform and shape any legislative changes needed.

7. CONSULTATION

7.1 This paper is being issued as a key element in the consultation on the future of primary care dentistry in Scotland. It is intended also to engage actively with representatives

of those who plan, provide and use these services, through discussion, including specific meetings which are being arranged across Scotland.

7.2 Comments on this paper may be sent by Friday 5 March 2004 to:

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