Survey 1 – List of Treatment Items – Report

1. Background

The profession was asked to complete a survey giving us their views on a draft list of treatment items that we think should form the basis of a revised system going forward (a full copy of the list can be accessed here). The survey was intended to focus on the principles of what treatment items should be available on the NHS and not on the payments dentists would receive for each item. The survey was available from 28 June 2022 until 23:45 on 31 July 2022 and was open to the whole profession, including dentists, members of the wider dental team (both clinical and administrative), Health Boards and professional organisations.

This document reports on the responses provided to the survey and will be used to help shape the development of a final list of general dental treatment items to be included in a revised Determination I.[1]

2. Methodology

The survey asked respondents an initial question about whether they would prefer to retain the existing Determination I, develop a simplified version, or extend the existing version. This was followed by a series of questions about each of the six sections contained in the list of treatment items – Oral Health Examination & Diagnosis, Urgent Dental Care, Preventive Care, Routine Treatments, Advanced Treatments, and Advanced Aesthetic Care.

For each treatment section respondents were asked 3 questions:

- a general question on whether they agreed or disagreed that the list contained all of the treatments that they would normally provide to their NHS patients;
- a free text question asking if there was any other treatments that should be included in the section; and
- a free text question asking if there were any treatments on that section they thought should be excluded or altered.

All of the questions in the survey were optional and as a result some people have answered the agree/disagree questions but provided no comments and some have provided comments but not answered the initial question. In addition, in every section of the survey even where respondents said that they agreed that the proposed list was complete a number of them still provided comments, some of which were additional treatment items whilst others were questions or commentary. Regardless of whether respondents agreed or disagreed with the statement or answered every question in a section, their comments have been considered in the reporting in the relevant section.

Initial statistical data was automatically generated by the survey platform and then further analysis work was undertaken. For the free text questions a qualitative

[1] Please note that orthodontic treatment items will be considered at a later stage in the reform process and therefore have not been included in this list of treatment items.

analysis of the responses was required. A framework was developed to support the analysis and ensure that all of the responses were treated consistently.

In undertaking the qualitative analysis a number of assumptions about the information provided had to be made in order to ensure consistency and that respondents' views were reflected as accurately as possible. The assumptions that have been made as part of the qualitative analysis are:

- where respondents have provided a comment for 'exclude/alter' question and not specified whether they want the item excluded or altered it has been assumed to mean that the item should be excluded;
- where respondents have explicitly written that an item should be included but have done so in an 'exclude/alter' question the information has been categorised as if it had been written in the 'include' question and vice versa;
- where respondents have provided the exact same comment for every question their response has been removed from the general analysis and considered in the 'comments not included elsewhere' section;
- where respondents have provided comments such as 'see above'/'see previous answer' they have been considered within the section that the full answer originally appeared.

It should be noted that the qualitative analysis provided in this report is based solely on the comments provided, the number of which varied widely per question, and therefore the views expressed are not necessarily representative of the wider population. Where possible, an indication of the number of responses which stated a given view has been provided. All of the comments provided by respondents will be taken into consideration in developing any further changes to the list of treatment items. However, for the purposes of this document only those topics that received comments from 10 or more respondents within a section have been summarised.

3. Overview of Responses

The survey received a total of 557 responses from a range of dental professionals situated across Scotland. Demographic information gathered shows that whilst there were respondents from all Health Board areas, the most commonly selected Board area was Greater Glasgow and Clyde (28.7%), followed by Lothian (11.8%) and Lanarkshire (10.1%). This is broadly similar to the spread of dentists across Health Board areas, with a difference of 5% or less, plus or minus, in some Board areas.[2]

The most commonly held job role amongst respondents was Associate Dentist (49.4%), followed by Principal Dentists (31.6%) and PDS Dentists (9%). The other job roles counted for around 10% of respondents combined. Of those respondents who were able to provide their NHS/private split, the majority had NHS earnings of 80% or more: 33.8% was 90%+ and 23% said their split was between 80% and 90%.

In terms of gender, 48.7% of respondents identified as female, 39.5% as male, and the remaining 11.8% as other, preferred not to say, or did not respond to the

[2] NHSScotland workforce statistics, as at 31 March 2022, Data tables | Turas Data Intelligence (nhs.scot)

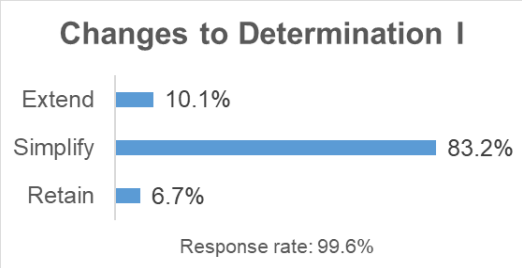
question. This is broadly similar to the male/female gender split in the general dental workforce data.[3]

4. Changes to Determination I

Before considering the proposed list of treatment items, respondents were asked to choose whether they would prefer to:

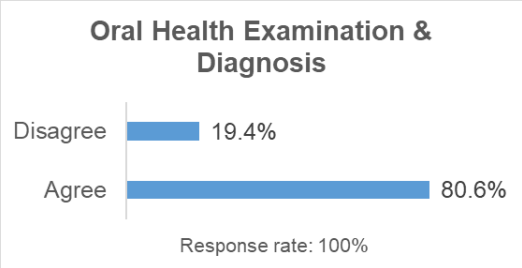
- retain the existing Determination I,
- develop a simplified version, or
- extend the existing version.

A total of 555 people answered this question and of those, 83% stated that they would prefer to develop a simplified Determination I.



5. Oral Health Examination & Diagnosis

All 557 respondents answered the question, of which 449 selected that they agree that the proposed list of treatment items included all the examination and diagnostic tools that are required to assess a patient's oral health and make a treatment plan.



In this section written comments were provided by 180 respondents. The table below shows the main treatment types that were suggested for inclusion, exclusion and alteration. Where further comments have been provided by 10 or more respondents these have been summarised.

[3] NHSScotland workforce statistics, as at 31 March 2022, Data tables | Turas Data Intelligence (nhs.scot)

Table 1 – Oral Health Examination & Diagnosis			
Treatment Type	**No. of Responses**		
	Include	**Exclude**	**Alter**
Advanced Treatments	-	1	-
Aesthetic/Cosmetic treatments	-	1	-
Change Terminology	-	-	1
Dental Implants	-	1	-
Domiciliary care	1	-	-
Endodontics	-	3	-
Exams/appointments	35	20	4
Management of TMD/TMJ	2	-	-
Management of tooth surface loss/tooth wear cases	9	-	-
Periodontal	29	1	-
Prescriptions	1	-	-
Preventive care/screening	20	1	-
Sensibility/vitality testing	10	-	-
Treatment planning	29	31	11
Veneers	-	1	-
Wax up diagnostics	4	-	-

5.1 Include Comments

Exams/Appointments (35)

A wide range of suggestions were made for types of exams/appointments that respondents felt should be added to the list. These included: appointments for complex patients/patients with anxiety/for de-sensitisation visit (9 comments); a review/support appointment (4); emergency appointments for treatment, review, and/or advice (2); medical history appointment (2), trauma appointment (2); full case assessment (2); one-off pre-op assessments required by doctors/hospitals (2); extra oral assessment (2); appointment for assessment and advice (1); domiciliary care exam (1); risk assessment (1); phone triage (1); exam of specific tooth where existing restorations need removed (1); and a specific new patient exam (1).

Treatment Planning (29)

A number of suggestions were made for elements of treatment planning that should be recognised, such as time for discussion with patient and/or their family beyond the initial appointment (5); time for discussion with other colleagues, such as GPs about medications (5); time for treatment planning after seeing patients (3); reporting on, and assessment, of radiographs (3); time to do referrals/prior approvals (2); CBCT (2). Models were also suggested for inclusion by 10 respondents, specifically facebow (7) and articulated study casts/intraoral STL/mounting study models (6).

Periodontal (29)

Of those comments that suggested the inclusion of periodontal, 25 specifically mentioned a perio assessment, with various elements mentioned such as BPE (8), plaque and bleeding indices (3), pocket charting (13), plaque charts (2), recession charting (2), mobility charting (3); double perio charts (1), risk assessment (1). A further two suggested a detailed perio exam, which could be triggered by a BPE of 3/4 and includes a set range of checks (1) or could be claimable at set intervals (1). Two comments mentioned that scale and polishes should be included, with one stating that they can sometimes be required before a basic exam can be done.

Preventive Care/Screening (20)

A range of preventive care/screening measures were suggested for inclusion, such as oral health instruction advice and education (4); diet diaries (7), oral cancer prevention/risk (5); caries risk (2); application of Fluoride varnish/Silver Diamine Fluoride Liquid Treatment for over 12s (1); prescription of fluoride products (1); risk assessments (1); dental anxiety scores (1).

Sensibility/Vitality Testing (10)

Where comments were provided it was suggested that it should be per tooth (1); pulp vitality testing for endodontics (1); and for trauma (1).

5.2 Exclude Comments

Treatment Planning (31)

Comments suggested that a range of diagnostic methods be excluded, including: digital scans (15), models (6), clinical photos (5), and CBCT (1). Where further explanation was provided it was that these items can be expensive and not necessary to secure and maintain oral health.

In addition 14 responses wanted prior approval to be excluded. Comments suggested it was because the system was difficult/inefficient (3), outdated (1), time consuming (1); adds admin time better spent on patient care (2), and shows a distrust of dentists (1).

Exams/Appointments (20)

All 20 responses that mention exams/appointments wanted to exclude virtual consultations. Reasons given included: difficult to make an accurate diagnosis this way (1); exams should always be patient facing to make a diagnosis and get a sense of the needs and condition of a patient (4); it is not safe/valid unless in lockdown (2); and that it's impossible in dental care (1).

5.3 Alter Comments

Treatment Planning (11)

Four responses suggested changes to radiographs, with individual comments suggesting that they should be coded according to type (1); that the list should provide more detail about sizes and types (1); and that medium films should be used as they expose patients to less radiation and give more information (1).

Two comments suggested prior approval should be a separate item and one suggested that prior approval/referrals should include external checks with other services such as GPs and social services. It was also suggested that virtual consultation be broadened to encompass reviews in certain circumstances, such as a post-treatment review (1).

5.4 Fees/Remuneration

Respondents felt that fees should be included for the following range of items: referrals (6); prior approvals (3); advice where no treatment is provided (2); admin time for writing up notes etc. (4); where a translator or interpreter is required (5); reviews (1); perio exams (1); perio charting (1); where a patient fails to attend (1); and for models to support lab costs (1).

Some responses suggested general changes to fees, including that they should be increased: in line with inflation (1); for non-regular attenders (1); or depending on patient recall frequency (1). One respondent also suggested that the fees for photos and models should be available for a wider range of items (1) and that items such as radiographs, photos, and models be paid per item (1).

Comments suggested a range of individual fees that should be increased, including: domiciliary care (1); patients with special needs as they require more time (1); exam fee for advanced treatment planning (1); radiograph fee to reflect time for reporting (1); scale and polish fee (1); continuing care fees to cover virtual consultations (1); and oral health assessments.

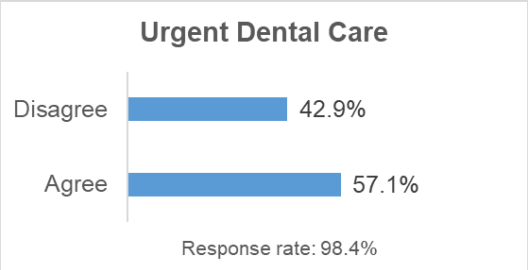
5.5 Other comments

Some respondents noted that more information was required, specifically in relation to: where perio charting and mobility and plaque indices would sit within the list (1); how many photos are in a set (1); referral and prior approval and whether there will be a fee which reflects the time taken for these; and whether the items comply with current regulations regarding for example, radiation exposure (1).

Other comments made included: suggesting that realistic medicine is included to take into account what matters to the patient and shared decision making/person centred care(1); noting that digital scans are usually for private dentistry (1); and suggesting that time limits be based on disease risk (1).

6. Urgent Dental Care

Of the 548 respondents who answered this question, 313 agreed that the proposed list of treatment items includes all of the items that would generally be provided when someone presents with an urgent dental complaint.



In this section written comments were provided by 299 respondents. The table below shows the main treatment types that were suggested for inclusion, exclusion and alteration. Where further comments have been provided by 10 or more respondents these have been summarised.

Table 2 – Urgent Dental Care

Treatment Type	No. of Responses		
	Include	Exclude	Alter
Aesthetic / Cosmetic treatments	-	1	-
Bridges	5	1	-
Change category	-	-	2
Crowns	7	28	5
Dental pain	12	-	-
Dentures	21	2	-
Domiciliary care	1	-	-
Endodontics	4	4	3
Exams/appointments	8	-	-
Extractions	105	-	-
Fillings/Direct restorations	13	3	1
Management of oral medicine conditions	12	-	2
Management of TMD/TMJ	10	-	-
Management of tooth surface loss / tooth wear cases	1	-	-
Oral Surgery	54	-	-
Orthodontics	1	1	-
Periodontal	27	-	-
Prescriptions	47	-	-
Preventive care/screening	1	-	-
Recement	5	42	6
Socket Cleaning / dressing / debridement	18	-	-
Splints / Splinting	5	-	-
Stone / Smooth sharp or rough surface	13	-	-
Trauma	10	-	-
Treatment planning	14	-	-

6.1 Include Comments

Extractions (105)

Respondents noted that extractions should be included in this section and specifically highlighted: surgical extractions (7); extractions where a patient is in pain (2); the removal of fragments or broken tooth/fractures cusp (7). It was also noted that emergency extractions tend to differ in nature from routine ones and should not be considered the same (1).

Oral Surgery (54)

The most frequently mentioned oral surgery procedures that respondents felt should be included were: incision and draining (48); suturing (7) and the removal of bony tissue (1).

Periodontal (27)

Perio care and treatment that respondents considered should be included were: management or perio abscess/periodontium (8); management of pericoronitis (7); scaling (6) in relation to acute conditions/infections (5); treatment of ANUG (5); treatment of acute perio infection/conditions (4); acute gum problems (3).

Dentures (21)

Treatments in relation to dentures that were discussed inclusion were: repair of dentures/removable prosthesis (8); denture ease (4); addition to dentures (3); alteration/adjustment of dentures (3); provision of a temporary denture (1); and management of implant supported dentures (1).

Socket cleaning/dressing/debridement (18)

Comments suggested that the treatment of infected sockets (7); management/treatment of dry sockets (5); debridement of infected pockets (2); and irrigation and medicament (1) should be included.

Treatment Planning (14)

The requirement for radiographs (10) when treating urgent conditions was noted in the comments, along with clinical photos in connection to trauma (2); discussion with colleagues, such as GP, (1); discussion with patient and/or their family (1); and patient management/enhanced behaviour management (1).

Fillings/Direct Restoration (13)

In relation to fillings respondents noted a requirement for: temporary fillings (7); dressings (1); restoration (1); fractured incisor (1); filling adjustment (1); and some permanent fillings such as those in a front tooth (1).

Management of Oral Medicine Conditions (12)

Respondents suggested including: the treatment of acute mucosa infections (6); monitoring of soft tissue lesions/conditions (4); biopsies (1); and further investigation of conditions (1).

Dental Pain (12)

Responses noted a need to be able to treat dental pain as an urgent condition and specifically mentioned: hypersensitivity/sensitivity (4); treatment of sensitive dentine/cementum (3); emergency pain assessment (1); and other assorted undefined types of pain (3).

Management of TMD/TMJ (10)

Where comments were provided the provision of an emergency appliance for TMJ (2); management of pain (1); as an acute issue (1); and extracapular/intracapular urgent care (1) were noted for inclusion.

Trauma (10)

Some respondents mentioned trauma in relation to facial swelling (1); sealing exposed dentine from trauma (1); the inclusion of all trauma injuries and not just avulsions/luxations (1); reattaching fragment of tooth after trauma (1); lacerations (1); and an additional code to reflect the upheaval of the day due to the trauma patient (1).

6.2 Exclude Comments

Recement (42)

Respondents felt that recements were not necessarily always urgent and specifically mentioned recements of: crowns (37); bridges (35); indirect restoration (2); and all recements (2).

Crowns (28)

All 28 respondents felt that the provision of temporary crowns should be excluded.

6.3 Fees/Remuneration

Respondents suggested a range of fees that they felt should be added, including fees: for advice in an urgent situation (10); for arrest of haemorrhage (8); for referrals (7); for a pulpotomy/extirpation of pulp (3), separate from the remaining treatment required and for registered patients too, as patients often don't return to complete the treatment; for when an urgent dental patient attends but is not urgent on exam to reflect surgery time taken (3); for lab costs (3) specifically noting for sandblasting (1), for dentures (1) and for re-etching (1); for dressings (2) that can be claimed before the restoration is placed (1); for multiple visits (3); for when translators/interpreters

are required (1); for pulp removal (1); for dressing above/inside pulp chamber rather than extirpation (1); and for urgent care (1).

It was suggested that certain individual fees need to be increased/appropriately remunerated, including: dressings (1); temporary crowns (1) and that the urgent part should be paid for even if a full restoration is subsequently completed; for emergency appointments as they take a long time (1); and repair of dentures (1) so that it supports the lab costs.

In addition, some alterations to fees were noted, including: changing the dressing fee so that there is an item for acute temporary fillings which are separate from the final restoration (1); urgent dental fees should be payable for registered and unregistered patients (1); extirpation fees should vary depending on number of teeth/number of canals (1); and extraction fees should be per tooth (1).

A few respondents also suggested: increasing fees in line with inflation (2); there should be a fee for everything (1); and that the items in the list could be provided if appropriately remunerated (1).

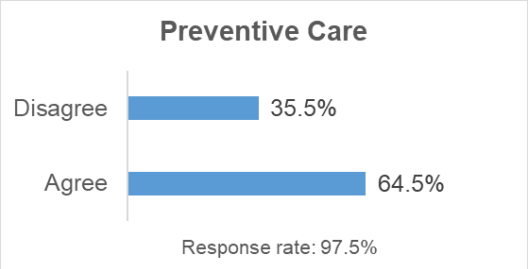
6.4 Other Comments

Some respondents noted that more information was required and raised questions, including if: the management of soft tissue conditions includes infected sockets (1); a natural tooth bridge would come under splinting or another item (1); the items listed included the necessary diagnostic tests or if they will be separate items (1); irrigation refers to stage 1 RCT as it is more complex than just irrigation (1); it includes desensitisation treatment and drainage of abscess (1); domiciliary care will be included/incentivised (1); and what assessment and management of urgent conditions actually includes (2).

Other comments made suggested: that a comprehensive dental trauma service cannot be included and that the emphasis in this section should be on symptom management (1); that the urgent dental care list should be available to both registered and un-registered patients (1); that urgent dental care/dental emergencies should only be for pain, infection and bleeding (3); urgent should be pain not responsive to OTC painkillers, arrest of haemorrhage; management of facial swelling and reimplanting avulsed teeth (1); sometimes a definitive restoration is the appropriate solution even in an urgent situation (1); trauma is urgent (1);

7. Preventive Care

Of the 543 respondents who answered this question, 350 agreed that the proposed list of treatment items includes all of the preventive care items that would generally be provided to NHS patients.



In this section written comments were provided by 224 respondents. The table below shows the main treatment types that were suggested for inclusion, exclusion and alteration. Where further comments have been provided by 10 or more respondents these have been summarised.

Table 3 – Preventive Care			
Treatment Type	**No. of Responses**		
	Include	**Exclude**	**Alter**
Change terminology	-	-	1
Crowns	1	-	-
Dental pain	3	-	-
Dentures	6	-	-
Exams/appointments	5	-	-
Management of oral medicine conditions	4	-	-
Management of TMD/TMJ	10	-	-
Management of tooth surface loss / tooth wear cases	2	2	2
Orthodontics	2	-	-
Periodontal	102	-	-
Preventive care/screening	131	2	8
Sedation	1	-	-
Splints / Splinting	3	-	-
Treatment planning	2	-	-

7.1 Include Comments

Preventive Care/Screening (131)

Respondents felt that this section should include OHI advice/discussion/instruction (74) and comments specifically noted that it should include: a demonstration (6), particularly a flossing demonstration (1); OHI for adults (5); specific advice relation to perio (4); OHI for carers/parents (2); OHI for domiciliary care/in a domiciliary setting (2); soft tissue care/thrush prevention (1); an appropriate fee (1); enhanced advice for patients with certain medical conditions (1). Comments also noted that education on prevention should be included (3) and one respondent noted that this should be for all categories of patients (1).

Respondents also felt that this section should include the provision of: diet diary/advice (29), with comments specifically mentioning diet advice (23), diet diary (5), weight management (2) and advice for adults (2); smoking cessation advice (24); fluoride varnish/silver diamine fluoride liquid (22), specifically for adults (4), outwith

Childmile parameters (1) and for vulnerable adults (1); toothbrushing instruction (10); prescription of fluoride products (9); dry mouth screening/management (6); fissure sealant (5); diabetes screening/assessment (2); alcohol cessation advice (5); oral cancer prevention/advice (2); brief intervention (1); drug cessation advice (1); adult preventive care with reviews and support (1); oral health education visit/talk (1).

Respondents also thought there should be advice provided on bone reabsorption (2); general health/mental health (1); and in relation to other health conditions/parafunctions (1). It was also suggested that Caring for Smiles be included in this section (2).

Periodontal (102)

Comments suggested that perio assessment/discussion/education/preventive advice (93) should be included in this section, with a specific mention of the inclusion of an 'adultsmile' (9). In addition perio treatment (3); scale and polish (3); and management of perio abcess/periodontium (1) were suggested for inclusion.

Management of TMD/TMJ (10)

Comments specifically suggested including: provision of TMJ advice (4); management of general issues (2); prevention of and advice for bruxism (2); management of headaches caused by TMJ (1); and an exam for TMJ (1).

7.2 Fees/Remuneration

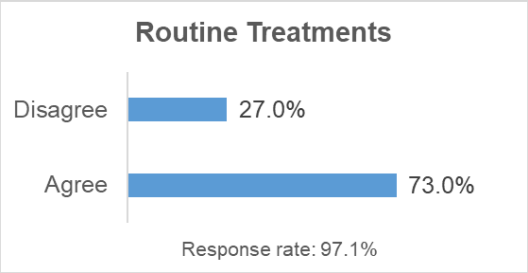
Respondents noted that OHI and prevention needs to be adequately remunerated/enhanced (3); individual preventive care elements each need to be recognised and financed separately (2); there should be no reduction in capitation and continuing care (1); a referral fee should be introduced (1); and core information that needs to be provided should have a fee to reflect the time it takes to provide it (1).

7.3 Other Comments

Other comments included: that dentists should not have to carry out prescriptive tasks, for example demo toothbrushing (1); the focus should be on interventions the clinician deems appropriate for each patients (1); that the scientific evidence on water fluoridation should be acknowledged (1); oral health advice should not be time barred (1); information/advice provided to patients should be tailored (1); general health interventions should be included/funded (1); holistic healthcare should be considered as dentists give a wide range of advice (2); the items need to be able to accommodate variations (2); and that a common risk factor approach should be considered (1).

8. Routine Treatments

Of the 541 respondents who answered this question, 395 agreed that the proposed list of treatment items includes all of the routine treatments that would generally be provided to NHS patients.



In this section written comments were provided by 284 respondents. The table below shows the main treatment types that were suggested for inclusion, exclusion and alteration. Where further comments have been provided by 10 or more respondents these have been summarised.

Table 4 – Routine Treatments			
Treatment Type	**No. of Responses**		
	Include	**Exclude**	**Alter**
Biomimetic techniques for restoration	1	-	-
Bridges	15	6	2
Change category	-	-	37
Change terminology	-	-	13
Crowns	32	44	8
Dental pain	1	-	-
Dentures	18	30	3
Domiciliary care	5	-	-
Endodontics	8	80	13
Exams/appointments	5	3	1
Exclude everything	-	3	-
Extractions	4	-	2
Fillings/Direct restorations	4	2	5
Lab work	-	2	1
Management of oral medicine conditions	1	-	-
Management of tooth surface loss / tooth wear cases	4	3	-
Non-vital bleaching / Internal bleaching	1	-	-
Oral Surgery	2	-	-
Periodontal	1	14	14
Preventive care/screening	8	1	-
Recement	-	2	-
Sedation	4	12	3
Socket Cleaning / dressing / debridement	1	-	-
Splints / Splinting	5	23	3
Treatment planning	1	1	3
Veneers	5	1	-

8.1 Include Comments

Crowns (32)

Respondents suggested the inclusion of pre-formed metal crowns/stainless steel hall crowns (23), with comments noting that this should be: for deciduous teeth (4); for children (6); for primary molars (2); to stabilise 6s (1); on primary teeth (2); on hypomin 6s (1); and on permanent teeth (1).

The inclusion of onlays (2), including with cuspal coverage restoration (1); inlays (2); post crowns (2); zirconia crowns (1), and the provision of more than 2 crowns where required (3) was also noted by respondents.

Dentures (18)

Respondents who noted that dentures should be included specifically mentioned cobalt chrome dentures (18), stating that: this should be for patients who have always had chromes (1); patients will expect it (1); and that they might be required in cases where there is a powerful bite/bruxism (3).

Bridges (15)

Respondents noted that bridge work generally (9); resin retained bridges (3); Maryland bridges (2), instead of dentures (1); removing bridges prior to extraction (1); and adhesive bridges should be included.

8.2 Exclude Comments

Endodontics (80)

Of the 80 responses which mentioned endodontics 14 said to exclude endodontics and did not provide any further comments. A further 49 responses said to exclude molar endodontics, with some respondents stating a preference to: exclude 1st molar endo (6); exclude 2nd molar endo (5); exclude 3rd molar endo (4); take the shortened dental arch approach (6). Five respondents only wanted molar endo excluded if fees for it were not increased. Where reasons were provided for excluding molar endo they included that: it is a difficult treatment (2); it's time consuming (2); a lot is done poorly (1); it should be a specialist service therefore only private (1); and it is not financially viable.

Other endodontic treatments which respondents suggested should be excluded were: pulpotomies (5); complex endodontics (2), i.e. those with more than one root (1), anatomy molars (1); posterior endodontics (4), specifically anything beyond anterior teeth (1) or anything beyond 2nd premolar (1); anterior endodontics; and re-endodontic treatment (1).

Crowns (44)

The types of crowns that respondents suggested be excluded from the list included: crowns (24) without providing any further information; molar crowns (9), specifically

2nd molars (1) and 3rd molars (1); posterior crowns (6); certain crowns (1); aesthetic crowns (1); crowns for maintenance (1); white crowns on premolars (1); and gold inlays (1).

Of those who provided further comments the reasons for excluding crowns included: onlays should be used instead (1); crowns are destructive and no longer evidence based (2); they are not financially viable (1); a lot of work is done poorly (1); treatment should be specialised therefore private (1); should take the shortened dental arch approach (2); and that crowns should not be routine on the NHS (1).

Dentures (30)

Elements of denture provision that were suggested for exclusion were: dentures generally (8), with a suggestion that Maryland bridges be used instead (1); denture repairs/relines (8), as the lab costs are too high (2) or unless fees are increased (1); acrylic dentures (2); cobalt chrome dentures; and partial dentures (1).

Splints (23)

Some respondents suggested that splints generally (11) should be excluded, whilst some specified: lab made splints (9), except soft vacuum splints (1), as it's generally cheaper to pay privately (1), the lab costs (2) and prior approval (1) are prohibitive; and bite splints for TMJ (1).

Periodontal (14)

Where respondents suggested specific elements of perio care that they felt should be excluded, this included: unstable perio (6), as multiple pocket charting is time consuming (2), charting is pointless and BPE is sufficient (2); stable perio (2); perio treatments (1); and uncompliant perio patients (1).

Sedation (12)

Some respondents felt that sedation should be excluded completely (6), whilst others specifically mentioned oral sedation (5). Reasons given for excluding oral sedation included that: it requires cannulation therefore similar to IV sedation (1); they are worried about potential issues that could develop (1); it requires specialist skills and equipment (1); very few practices provide it (1); and they don't agree with it being provided in practice (1).

8.3 Alter Comments

Change category (37)

Respondents felt that a number of treatment items should be moved from the routine category to another section. In relation to endodontics, it was suggested that: 1st molar endodontics should be in the advanced treatments (15); all endodontics should move to advanced (3); all molar endodontics should move to advanced (4); Re-root canal treatments should not be routine (1); pulpotomy should not be routine (1). In terms of crowns, changes suggested were: that crowns should be in

advanced treatment (3); posterior crowns should be in advanced (1); that it should be crowns under 4 instead of 2 (1); and that any number of crowns is basic treatment (1). For sedation, some felt that oral sedation is not routine (3); and that sedation should be in advanced treatments (2). In relation to dentures, some felt cobalt chromes should be routine (3); that cobalt chromes are not advanced aesthetics (1). Other suggested changes were: that unstable perio should be in advanced treatments (1); de-sensitisation is not routine (1); surgical extractions are not routine (1); and splints should be in advanced (1).

Periodontal (14)

Respondents suggested the following changes in relation to the perio items listed: perio needs to be in line with BSP/current guidance (4); perio should be preventive first (2), and if patients cannot show compliance with oral hygiene then they are not suitable for perio treatment (1); perio treatment should only be for those with BPE of 3 or higher who are compliant (1); unstable perio should be referred (1); perio care should be limited and dependent on oral hygiene (1); stable perio (up to 2 BPE) should only be maintainece (1); should only be maintenance of stable perio through private hygienist (1); perio therapy is fluid so should be classed as such (1); it needs to be evidence based and patient centred (1); there needs to be more explanation in the perio section (1).

Endodontics (13)

A variety of changes were suggested including: changing endodontics to 5 to 5 only (3), unless the fee for molar endo is increased (2); make it up to and including premolars (2); change to only up to premolars (2); allow pulpotomy in adults (2); molar endo should include 1st molar (1); advanced endo should be 6/7/8 (1); endodontics should have enhanced training (1); molar endo should only be on strategic teeth and require prior approval (1).

Change terminology (13)

In some instances respondents felt that the terminology used in the list of treatments should be changed. It was suggested that oral sedation be changed to oral premedication (6); perio classifications should be changed (2), as it is more complicated that stable/unstable (1) and the current list doesn't allow for provision of non-surgical perio therapy (1); change 'periodontal – stable' to periodontal supportive therapy (1); crowns should be per crown (1); fillings should be changed to direct restorations (1); and it was noted that it is difficult to say that <2 crowns is routine and > 2 crowns is advanced (1).

8.4 Fees/Remuneration

The majority of respondents that commented on fees/remuneration in this section noted that the fees for existing items made them not financially viable to provide, needed to be increased and should be adequate to cover NHS provision. The fee items specified were for: dentures (8); extractions (6); perio (4); sedation (2); crowns (2); fillings (2); endodontics (2); splints (1) specifically lab made splints; cores (1);

and bridges (1). Concerns were raised about lab fees (5) as the costs are prohibitive and increasing.

Two items were noted as requiring a fee: de-sensitisation visits (2) and patient management (1) as these are currently done for free.

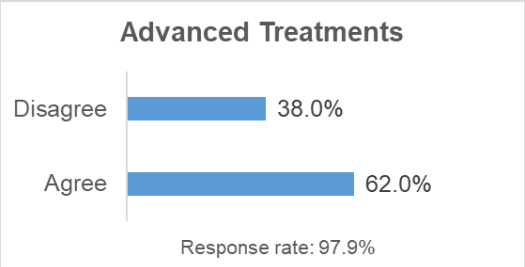
8.5 Other Comments

Some respondents noted that more information was required: on fillings in terms of what materials would be included (7); on crowns – specifically on what crown <2 teeth really means (3), what happens if more than 2 crowns are required, why a particular number is specified (3), whether crowns will be paid per crown, and what types of crowns are allowed (2); on whether pulpotomy in children is on primary dentition, secondary or both; on endodontics, including on which teeth; on perio – both generally and in relation to how often perio pocket charting would be required; on whether skill mix will be used effectively under new system and if there be direct access for DCPs.

Other comments made noted: that the perio options were good (2); that the current perio system is outdated (1); that the perio section makes no sense (2); that as caries and perio issues are preventable only prevention and trauma should be routinely provided and that patients need to accept more responsibility for their oral health (1); all types of fillings and endodontics should not be grouped together as different materials and time need to be considered; crowns and dentures should be separated from items with no lab charges; and that possibly a section specific to treatment on children is required.

9. Advanced Treatments

Of the 540 respondents who answered this question, 335 respondents agreed that the proposed list of treatment items includes all of the advanced treatments that would generally be provided to NHS patients.



In this section written comments were provided by 339 respondents. The table below shows the main treatment types that were suggested for inclusion, exclusion and alteration. Where further comments have been provided by 10 or more respondents these have been summarised.

Table 5 – Advanced Treatments			
Treatment Type	No. of Responses		
	Include	Exclude	Alter
Advanced treatments	-	3	-
Aesthetic / Cosmetic treatments	-	1	-
Biomimetic techniques for restoration	1	-	-
Bridges	18	3	2
Change category	-	-	19
Change terminology	-	-	8
Crowns	18	77	9
Dentures	9	4	-
Domiciliary care	1	1	-
Endodontics	9	135	18
Exams/appointments	1	-	-
Exclude everything	-	21	-
Extractions	5	5	-
Fillings/Direct restorations	2	-	-
Lab work	1	2	-
Management of oral medicine conditions	5	-	-
Management of TMD/TMJ	1	-	-
Management of tooth surface loss / tooth wear cases	16	-	-
Oral Surgery	10	10	1
Orthodontics	3	-	-
PDS codes	2	-	-
Periodontal	5	-	-
Sedation	9	30	5
Splints / Splinting	2	-	-
Treatment planning	2	-	-
Veneers	-	123	10
Wax up diagnostics	1	-	-

9.1 Include Comments

Bridges (18)

Where further comments were provided respondents suggested including: sectioning bridges prior to extractions (2); resin retained bridges (1); conventional bridges (1); adhesive bridges (1); Maryland bridges (1); fixed/permanent bridges (1); anterior bridges in specific circumstances (1); and posterior bridgework (1).

Crowns (18)

Respondents suggested a range of elements related to crown provision that should be included, such as: onlays (8); post crowns (3); complex crown provision (2); multiple crowns (2); molar crowns (1); and removing crowns (1).

Management of tooth surface loss/tooth wear cases (16)

Respondents suggested that: composite build up/building core/posterior composites for wear (7); occlusal adjustment/stabilisation/rehabilitation/assessments (5); and anterior tooth wear (1) be included in this section.

Oral surgery (10)

A range of oral surgery procedures were suggested, including: apicetomy (6); raising a flap and bone remodelling (1); suturing following surgical treatment (1); soft tissue surgery (1); and minor oral surgery, such as mucocele removal (1).

9.2 Exclude Comments

Endodontics (135)

Of the 135 responses which mentioned excluding endodontics, 129 specifically mentioned molar endodontics; 19 of which stated 2nd/3rd molar endodontics; 1 specified 3rd molar endodontics; and 1 multiple molars. Where reasons why these should be excluded were provided they included: unless the fee was increased (6); as they aren't feasible on the NHS (2); they should be a specialist/advanced treatment (3); as 5 to 5 is the minimum required for function (1); unless there is a health reason to do so (1); unless dentition is otherwise perfect (1). In addition, three comments suggested removing re-root canal treatment.

Veneers (123)

Of the 123 responses that mentioned excluding veneers, 92 of those provided no further comment or explanation. Where comments were provided it was suggested that veneers should be excluded: as they are an aesthetic/cosmetic treatment (9); they are not needed to maintain oral health (5); as they shouldn't be an NHS treatment/publically funded (5); as materials and lab costs mean it is not financially viable (5); unless the fee is increased (4); as they are an advanced/specialist treatment (4); unless there is a health reason for providing them (1); unless they are replacing existing veneers (1); and as they should be prior approval only (1).

Crowns (77)

A sizeable number of the respondents who provided comments suggested that inlays (71) be excluded. Reasons given included: that they should not be available on the NHS (5); that they should be excluded unless the fee is increased (4); lab fees make it no longer viable (3); they are an advanced treatment (2); only function restoring crowns should be provided (1); simpler treatments can be used to secure oral health (2); and that they are often for cosmetic reasons (2). In addition there were some suggestions that molar crowns (2) and post core crowns, especially where oral health is poor (1) should be excluded.

Sedation (30)

The most common type of sedation that respondents suggested excluding was intravenous sedation (10), followed by inhalation sedation (4). In addition, some respondents stated that sedation should not be carried out in primary care at all (4), as it should be provided by a specialist, in secondary care or privately.

Exclude everything (21)

About half of respondents who said everything should be excluded (11) provided no further information. Of those who did provide comments, reasons were varied and included: that the treatments listed should only be available outwith general dental practice (3); they should not be available on the NHS (1); the treatments listed are not needed to maintain oral health so should only be available privately (1); they should be enhanced cosmetic treatments (1); the treatments are not financially viable (1); and some of the treatments are luxuries (1). In addition, one respondent who said to exclude everything stated that alternatively if they are kept they could be prior approval only or up to a maximum limit.

Oral surgery (10)

Nine respondents suggested that minor oral surgery be excluded as it should be provided privately or secondary care (2); it's not financially viable (1); unless the fee is increased (1); and it is beyond the scope of the BDS (1). One respondent suggested 3rd molar surgery be excluded.

9.3 Alter Comments

Change category (19)

Respondents thought that a range of treatment items should move to a different section of the list. In relation to endodontics this included: all molar endodontics should be in advanced treatment (8); re-treatment endo is not routine (1); re-root canal should be separate from other endo (1); molar endo should include 1st molars (1); and molar endo should be routine (1).

In terms of other types of treatment the following was suggested: that veneers are not advanced/should be routine x 2; inlays should be routine (2); perio splinting is not routine and should be in advanced (1); multiple metal crowns should be advanced (1); management of tooth wear should be routine (1); sedation should be advanced (1); minor oral surgery should be advanced (1) as it requires more training than basic undergrad (1); minor oral surgery roots should be advanced (1); all items in this section are routine (1); and the advanced treatments and advanced aesthetic care sections should be combined (1).

Endodontics (18)

Respondents suggested a range of ways in which endodontics should be altered. This included: molar endodontics should be all molars (7); molar should only be treated when it is a strategic/functional tooth or it is the only/last standing molar (4);

molar endo should only go to 1st molar (2); endo only on incisors/premolars (1); molar endo should only be offered in certain cases (1); molar endo due to caries should be reconsidered (1); equipment for molar endo (i.e. files) should be provided (1); and that the endodontics section should be re-treatment and all endo rather than just molars (1).

Veneers (10)

Respondents suggested that veneers be altered as follows: allow on more than 2 teeth if required (3); limited to replacements only (2); should not be provided for aesthetics (1); should need a consultant opinion (1); and that they should only be provided if remuneration is suitable (1).

9.4 Fees/Remuneration

Respondents suggested a range of fees that they felt should be added, including a fee: for sedation dentistry (1); for failed extractions (1); and for multiple endodontic visits (1). Some respondents also specified individual fees that they felt should be increased, including: fees for endodontics (5); extraction fee (1); sedation fees (3), specifically noting intravenous (2) and inhalation (1); and minor oral surgery with roots (1).

In addition, it was noted: that fees should be increased generally (2) in line with inflation (1); that the use of rotary instruments over hand instruments should attract a higher fee (1); and for wear cases there should be differentiation of fees for localised and generalised wear (1). Concerns were raised about lab fees (4), as they are thought to make treatments not financially viable and that it is difficult to get labs to do NHS work for below the fee paid. It was also noted that the current fees do not encourage dentists to spend time providing the treatments (1) but that everything in the list could be made available if it is funded properly (1).

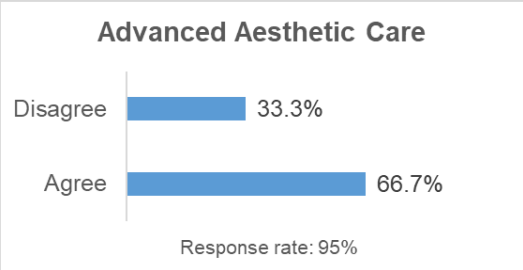
9.5 Other Comments

Some respondents noted that more information was required on: what materials and associated fees will be; why 1st molars are in a different section to molar endodontics; whether advanced oral surgery techniques not listed will become prior approval only; perio classifications; why it is only 2 teeth for inlays and veneers; types of veneers.

Other comments made suggested: that guidance on management/repair of dental treatment carried out abroad may be required; that more than 2 units is often required; that advanced treatments need appropriate expertise so should only be provided where there is appropriate expertise and equipment; that items in this list should only be carried out by dentists with enhanced training.

10. Advanced Aesthetic Care

Of the 529 who answered this question, 353 respondents agreed that the proposed list of treatment items includes all advanced aesthetic care treatments that would generally be provided to NHS patients.



In this section written comments were provided by 338 respondents. The table below shows the main treatment types that were suggested for inclusion, exclusion and alteration. Where further comments have been provided by 10 or more respondents these have been summarised.

Table 6 – Advanced Aesthetic Care			
Treatment Type	**No. of Responses**		
	Include	**Exclude**	**Alter**
Aesthetic / Cosmetic treatments	-	34	1
Bridges	1	76	9
Change category	-	-	24
Change terminology	-	-	6
Crowns	4	47	5
Dental Implants	1	-	-
Dentures	4	176	1
Endodontics	-	1	-
Exclude everything	-	52	-
Fillings/Direct restorations	-	1	-
Lab work	-	1	-
Management of tooth surface loss / tooth wear cases	4	-	-
Microabrasion	4	-	-
Non-vital bleaching / Internal bleaching	8	-	-
Splints / Splinting	1	-	-
Treatment planning	-	-	1
Veneers	-	89	3

10.1 Exclude Comments

Dentures (176)

All 176 respondents that suggested excluding dentures specifically stated cobalt chrome dentures. Reasons provided for why they felt they should be excluded were: that they are financially unviable (30); unless funding is increased (14); there is no functional requirement for chromes over acrylic dentures/chromes not needed to secure oral health (8); there is a lack of labs willing to provide them (3); and that they should be a private option (2).

Veneers (89)

Where comments were provided, reasons given for the exclusion of veneers included: that they shouldn't be available on the NHS (4); they aren't required to obtain/maintain oral health (4); unless there are exceptional circumstances to provide them (3); they are often only for aesthetic/cosmetic purposes (3); unless fees are increased (2); not financially viable on NHS (1); unless they are replacement of existing veneers (2); and that it is difficult to get labs to do the work (1).

Bridges (76)

More than half of those who provided comments suggested excluding bridges (49) as: they should not be provided on the NHS (2); they should only be provided in exceptional circumstances (2); they should be a private treatment (1); as the lab fees are too high (1); the NHS should be about function rather than aesthetics (1); unless fees are increased (1).

Some respondents also specified types of bridges that should be excluded. This included: acid etched bridges (11); permanent bridges (10); fixed bridges (4); posterior bridges (4); resin retained bridges (1); Maryland bridges (1); conventional bridges (1); and pre-molar/molar bridges (1).

Exclude everything (52)

Where comments provided more information on why respondents thought everything on this list should be excluded the reasons given were: unless fees increased (8); the treatment items don't improve dental fitness/not required to maintain oral health (3); it is too advanced for the NHS (1); they should be private options (1); or have as prior approval/maximum budget per patient (1); and that these treatments are only needed when people do not look after their teeth so the taxpayer should not have to pay for it (1).

Crowns (47)

Inlays (34) were the most commonly suggested item to be excluded. Also suggested for exclusion were: onlays (4); multiple crowns (4); posterior crowns (2); molar crowns (1); aesthetic crowns (1); and advanced crowns (1).

Aesthetic/Cosmetic Treatments (34)

Of those who suggested that aesthetic/cosmetic treatments should be excluded, 31 stated that advanced aesthetic and/or aesthetic/cosmetic treatments should not be available on the NHS. Reasons for why included: that the NHS should provide functional solutions to maintain/secure oral health and not aesthetics (8); the NHS should be for health and not cosmetics (3); it is not financially viable (2); aesthetic care should be provided privately (2); and that no other area of healthcare provides aesthetics (1).

10.2 Alter Comments

Change category (24)

It was suggested that a number of treatment items should be moved to a different section of the list. In relation to dentures, it was generally thought that chrome dentures (12) did not belong in advanced aesthetic care, with some suggesting it should be moved to routine treatments (6) and a few suggesting it should be in advanced treatments (2). For other treatment items, it was noted that bridges are not advanced aesthetic (8); multiple crowns are not an aesthetic option (1); and veneers are not advanced care (1). On the other hand, one respondent suggested that anterior composite fillings should be considered aesthetic.

It was also suggested that the advanced treatments and advanced aesthetic lists be combined (2). One respondent also suggested that nothing on the list should be considered advanced as it is all part of the undergraduate training.

10.3 Fees/Remuneration

Suggestions were made for a range of fees that respondents think are required, including: fees for lab costs (3), with a suggestion that it could be incorporated into the individual item fees (1); scanning fee (1); wax up diagnosis fee (1) that covers lab fee and time; lab made splint fee (1), that also covers lab fees and time; and a fee for temporisation of the preps (1).

Additionally, respondents also noted that: the fee for chrome dentures needs to be increased (6) so that it reflects the lab fees (5) and so practices do not work at a loss (1); fees should generally be increased (2); and that fees should be appropriate for the time spent, skill required and expense of quality materials (2). Suggestions were also made that lab costs should be reviewed (1) and that there should be a differentiation between costs for individual restorations rather than one fee for all '>2' (1).

10.4 Other Comments

Some respondents noted that more information was required on: materials and fees (3); and on what the limits on veneers, crowns, and inlays really means in practical terms. Other comments made suggested: that the proposed list of treatments could result in practices operating at a loss; and that it should be simplified.

11. Comments not covered elsewhere

Where possible comments that do not fit easily into the treatment type categories used in the preceding sections, have still been considered at the end of each relevant section. However, there was also a range of comments that it has not been possible to include in individual sections and these will instead be considered here.

A small selection of respondents (<10) chose to provide the same comment in answer to every question. These responses have been noted but have also been removed from the analysis above, to prevent the views being counted more than

once. In general these respondents wanted to highlight their view that: there should be a core service; the required changes to the SDR are unaffordable; and that everything should be excluded from the lists if Scottish Government cannot afford to pay for it or the fees are not aligned with other developed countries and increased in line with inflation.

The other comments that have not been included in the previous sections are those that were not specifically about treatment items and therefore were less relevant to the analysis of each section. However, these have still been considered and are summarised below by the main themes.

Categorisation of treatments

A small number of comments (<10) expressed a view that the distinction between different categories of treatment, for example routine and advanced treatments was pointless and queried why the distinction was being made at all. They suggested that it was very difficult to distinguish between degrees of difficulty/complexity and what may be routine for one dentist may very well be advanced to another. It was also noted that calling certain treatments advanced aesthetic could be misleading and result in patients having unrealistic expectations about what is available, such as expecting aesthetic shape and shade matching.

Principle of NHS offer

A small number of comments (<10) suggested changing the nature of the NHS offer, with some suggesting a core service, focusing on health, children and the elderly or a capitation based model. It was also noted that the focus should be on prevention and tackling the backlog of patients and oral disease and that remedial treatment required for dental work done outwith the UK should not be provided on the NHS.

Lack of Detail

A small number of comments (<10) stated that it was difficult/impossible to comment on the treatments that should or should not be included going forward without information on the level of remuneration and whether this will support practices. It was also noted that it was difficult to comment with the general lack of detail and without any description of complexity at either tooth or patient level.

Survey design

A few comments (<10) focused on the design of the survey itself, suggesting that it was poorly designed, lacked academic rigour, seemed vague, lacked meaningful plans and questions, and was aimed at providing a poorer service. It was also noted that a general comments box should have been included and that honest consultation requires an open forum.

Miscellaneous

A range of miscellaneous comments (<15) were also provided that have not been included in any other section. The focus of these comments varied and included:

that the push to simplify the SDR comes from those who are unwilling to engage with the document; the proposed system seems like it will be open to gaming; that it is ridiculous that dentists get no fee for treating patients in an emergency even when they have not attended for years; patient expectations are high; that lots of treatments are carried out daily that currently attract no fee; dentists owe a duty of care for social emergencies and dental urgencies but that seems to have been forgotten by most people; NHS dentistry needs to modernise and allow newer techniques; and what the impact on equalities will be for those with heavily restored dentition if treatment items are limited by number.

12. Next Steps

The survey results show that respondents are strongly in favour of a reduced Determination I and that, in general, the list of treatment items captures the majority of treatments required in any new Determination I. However, the wide-ranging and varied comments highlighted some other items of treatment that respondents felt should be considered for inclusion and/or exclusion. The main areas suggested for inclusion were periodontal care, preventive screening and urgent extractions; whilst the main areas suggested for exclusion were: endodontics, veneers, dentures and crowns.

The information provided in the survey will now be used to help inform the development of a revised Determination I. As this work progresses it will be shared and discussed with the CDO Advisory Group. The agenda and meeting notes from this group will be published on ScottishDental.org following each meeting, as we are keen for the reform process to be as open and inclusive as possible. Following the conclusion of the series of Advisory Group meetings, a fully revised Determination I will be shared with the profession.