Recd 30/3/04.

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Your Ref
Our Ref WH/AM/001/ND

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Dear Dr Wilson

Modernising NHS Dental Services in Scotland Consultation Document November 2003 – Ayrshire & Arran NHS Board Response

Thank you for inviting Ayrshire and Arran NHS Board to contribute to this consultation process and for hosting the consultation events which were helpful in stimulating, informing and structuring the views of those who have contributed to this response.

As the Scottish Executive disseminated the consultation document to all local stakeholders for direct response, Ayrshire and Arran NHS Board have sought to promote and encourage direct response to the Scottish Executive rather than seeking to collate all contributions into one response. This approach was adopted as it was felt that the process of group discussion and empowerment amongst stakeholders on the modernisation of NHS dental services in Scotland was as important as the range of views that would ultimately be expressed.

The contents of this response are based on the comments contributed by the NHS Board's Departmental Directors, the NHS Board's Oral Health Strategy Implementation Group and the responses made to the Scottish Executive by the Ayrshire and Arran Primary Care Dental Executive Group and the Area Dental Committee.

One of the fundamental problems encountered in all group discussions that took place about options and suggestions for primary dental care service design, was lack of clarity about what the aim of the service was or would be. As discussions proceeded it was clear that the public, the profession and government all have differing perceptions and understanding of what the aim of primary dental care services is. To enable constructive, objective, specific discussion on the development of a modernised dental service design there needs to be greater clarity, agreement and definition about what this aim is for the future. This in turn requires development of a working definition of oral health that underpins a stated long term target for oral health. This would enable shorter term, transitional targets to be identified for key age groups. If this framework was established it would facilitate and focus future discussion on dental service design and evaluation of options proposed and piloted.

We were pleased to note that the consultation document continued to identify, acknowledge and raise awareness that the prevention of oral diseases is not the sole remit of the dental profession. The Board looks forward to receiving the Scottish Executive's response to the

consultation document "Towards Better Oral Health in Children" which will set out a national multidisciplinary strategy seeking to improve child dental health in Scotland. Local stakeholders felt that had this strategic plan also been available it would have assisted a more structured debate on modernisation of dental service design.

The consultation document mentions the development of dental clinical networks and support from specialist services. In our Board area there has been informal discussion about the development of local specialist networks. These have identified that to enable the free flow of patients in all directions around a network there needs to be simplification of referral of patients for care from acute care specialist services to primary care services. Also, that if patients are referred in this direction to maximise capacity in specialist services, the choice of specialist practitioner by the referring practitioner is taken into consideration.

In section 5.3 the development of information, monitoring and IT systems and support are discussed. We strongly recommend that all systems developed are linked and compatible with the GMS/primary care systems including GPASS and the child health surveillance system.

Another general comment expressed was that it was fundamental that any new service design introduced should promote integration and joint working among primary dental care practitioners and also between them and the other members of the primary care team.

There was comprehensive support that any changes to the current system would be approached through an evolutionary process to protect stability. It was also felt that any changes should be introduced following piloting which would promote professional and public co-operation, confidence and assist long term culture change/understanding of what is being undertaken.

When considering **what sort of dental services should be provided under the NHS** the general view was that, given the financial parameters stated in the document, there should be an adequately funded comprehensive dental service available for children but a core service for adults could be considered. A core service should include oral examination, diagnosis, discussion of treatment options, preventive advice and care, a list of specified treatments and emergency care (although this latter item could be excluded and provided by a separate emergency dental service).

There was concern about what items could be included in a core service without developing a 2 tier system excluding those on lower incomes from obtaining some treatments. However, it was acknowledged that until the dental manpower shortage in Scotland is alleviated, a strategy will be required, such as the introduction of a core service, to try to spread the existing capacity in NHS dental services. Ayrshire and Arran NHS Board would like to see the development of an integrated primary dental care service, especially in low socio-economic areas where oral health is worst. This would require the development of a primary dental care service were the structure, functions and remuneration of all primary dental care practitioners is comparable. To encourage the long term development of this approach would also require a change in the ethos of undergraduate selection and training with more emphasis on the public health function of primary care practitioners. It was felt that the integration and simplification of primary dental care services may promote the "family" approach and uptake

of dental care, particularly in deprived areas. It was acknowledged that, depending on which model for remuneration was implemented, the treatment of those who had special needs may require additional funding.

It was also suggested that if a sessional contract was adopted then sessions could be identified for providing care to institutions such as nursing or residential homes.

Another suggestion was that pilots of new innovations should be carried out under NHS conditions and be funded by the NHS, especially preventive ones for children. The introduction of successful pilots should be supported by any new service design implemented.

The suggestion that the funding pool for child dental services should be split into general care and orthodontic care produced a mixed response but there was general agreement that the provision of orthodontic care should be provided on the basis of need using the Index of Orthodontic Treatment Need.

When considering **the delivery of NHS dental services** the general view was that whatever system of delivery was put in place it should be funded at a level which allows dentists to provide quality care without being pressurised to produce a quantity of care which they feel compromises quality.

It was felt that all three possible models for remuneration of service delivery (i.e. item of service, salary or capitation) could be implemented in a way that could perpetuate this element of pressure felt by practitioners regarding quality verses quantity. It was acknowledged that there also needs to be a change in practitioners work culture in primary dental care that complements a change in service design and that this change needed to take place from undergraduate training onwards as well as in those already practising.
Many practitioners wanted to know what models of dental/medical care and incentive schemes had proved to be successful elsewhere internationally and how these had been implemented. They felt that it was very difficult to discuss or grasp the full implications of some of the points raised as they had always worked within or in parallel with the current system. There was comprehensive agreement that whatever changes were introduced, they should be piloted and incrementally introduced as it was felt younger practitioners and new graduates would be in a better position to plan and accept a change to the structure of the system within which they worked whereas older practitioners would not. The view was that there should be a prolonged introductory transitional phase where new systems worked along side existing ones providing an option for practitioners.

When funding was discussed views differed on whether funding based on the practice rather than the practitioner was preferable. It was acknowledged that in some areas practice based funding may meet local needs better and simplify payment. It was felt that younger practitioners may favour this option but not older ones.

The Area Dental Committee expressed the view that if dental contract holders were widened to encompass corporate bodies or practice groups this would allow for unlimited companies which would have tax benefits which would disadvantage other practitioners with a knock on effect for patient access e.g. in remote areas.

It was felt that once it was clearer what practitioners were going to be employed to provide then perhaps a simplified fee scale in their contract would be possible but there was not agreement on capping fees.

The suggestion that there could be greater support for staff and infrastructure was welcomed. There was debate around how this funding could take place and who would ultimately be responsible, own, manage, insure, pay for upkeep, training etc. for resources funded in this way. These issues need clarified before practitioners could assess the full potential and benefits of this suggestion. There was interest in how the GMS had shifted away from practitioner owned premises and what schemes had been implemented to facilitate this. It was felt that even without a change in service design practitioners needed support to ensure their service could comply with the introduction of the Disability Discrimination Act.

Views differed on whether funding solely by capitation for registered patients would work. It was thought that a capitation system for adults would need to be linked to initial disease levels in which patients were initially assessed to enter this system and thereafter reassessed to ascertain compliance with maintenance which would then determine the level of ongoing capitation payments. It was thought this could ensure inequalities in oral health were addressed. However, many felt that such a system had been tried with children and had not succeeded in delivering either disease control or prevention in high risk groups. The view was expressed that a capitation fee should reflect the true cost of providing quality care.

Practitioners felt that if NHS sessional or block contracts were introduced there would need to be agreement and flexibility about private sessions.

There was support for rewards for meeting quality targets supported by more funded audit and development of better systems to promote peer support for isolated and single handed practitioners.

When **patient charges** were considered it was felt that the system needed to be simplified for patients to understand and practices to administer. Also that the same patient charges should apply to all primary dental care dental services.

The option of a cashless system, such as an annual voucher scheme or swipe card system, was supported.

It was felt that patient charges should be constructed to avoid the development of a 2 tiered service that disadvantages those on low incomes. It was felt that a patient charging system solely based on percentages weighted in favour of preventive care would be advantageous to those with good oral health at the start of this system but not those who still required care and repair to enable them to achieve a level of good dental health whilst at the same time being encouraged to adopt a preventive approach to self care. It was felt that if this point was not taken into account a preventively weighted percentage system could be a disincentive to initial uptake of care by those with the greatest levels of untreated disease.

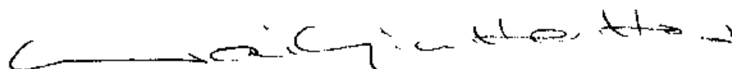
The suggestion of a fixed charge for a patient contribution related to the length of time for a visit was not generally favoured unless the variation and difference in costs for the types of treatment provided was met by the NHS contribution.

Practitioners felt that rather than separating payment for appliances etc. there should be an adequately funded core service with a simplified price list for patients.

Ayrshire and Arran NHS Board and all who contributed to this response welcomed the proposed introduction of free dental check-ups by 2007.

The Board and the Profession locally have welcomed the opportunity to contribute to this initial consultation discussion and felt that it was a positive first step in the long process of developing a modernised NHS dental service in Scotland. We look forward to contributing and participating further in the forthcoming stages of this process.

Yours sincerely



Wai-Yin Hatton
Chief Executive

Cc:
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