BDA SCOTLAND RESPONSE TO THE
SCOTTISH GOVERNMENT CONSULTATION EXERCISE
‘THE FUTURE OF ORAL HEALTH’

December 2016

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Final version for Scottish Council
Introduction

The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its 18,558-strong overall membership is engaged in all aspects of dentistry including general practice, salaried services, community dental services, the armed forces, hospitals, academia, research, and prison dentistry and has more than 2,500 student members.

BDA Scotland welcomed the Scottish Government Consultation Exercise, ‘The Future of Oral Health’ issued by Scottish Government on 15 September 2016 and has sought feedback from all of its standing committees, Scottish Dental Practice Committee, (SDPC), Scottish Salaried Dentists Committee, (SSDC), and Scottish Committee for Hospital Dental Services, (SCHDS).

An Extraordinary meeting of the SDPC was called in October to allow the committee to engage over the issues outlined in the consultation, and to be able to draft a briefing paper for BDA committee members, BDA members, BDA Branch and Section members and LDC members to aid them as they attended the various Scottish Government Roadshows which were held in a range of locations throughout the consultation period.

Comments have been received from all BDA Scotland committees and incorporated into this report.

This final response document was approved by the BDA’s Scottish Council at their meeting held on Thursday 8 December 2016.
Executive Summary

- Shona Robison, MSP refers in her introduction to the 4.8 million people registered with a NHS dentist, however the SDPC would highlight that approximately 1.4 million of the registered patients have not visited their dentist in over two years. The key issue is not the registration rates, these are only a function of the system of lifelong registration, the more important indicator is the “participation rate” i.e. patients actually attending their practice for a check-up or treatment. It is important to note that in areas of greatest deprivation only 63 percent of patients have seen their dentist in the previous 24 months.

- The view expressed by the BDA’s SDPC is that “Scotland’s Oral Health Plan” document is short on detail even though there are some 33 specific “proposals” listed. The proposals follow on from the publication of “A Plan for Scotland 2016-17” published by Scottish Government (SG) in September this year. This included a “Consultation on the future of oral health services in Scotland” with a focus on reducing oral health inequalities, shifting dental services to a more preventive focused approach for children and younger adults and meeting the challenge of an ageing population.” Many of the other initiatives outlined in the “Plan for Scotland” came with funding attached, but there was no mention of extra funding anywhere in the document for dentistry. This is very concerning to the profession.

- BDA Scotland urge SG to take action and work with local communities on the introduction of water fluoridation in Scotland.

- BDA Scotland calls for an oral health strategy in which patients, take responsibility for their oral health and that this view is promoted and supported by SG and the profession.

- BDA Scotland is in full agreement with the aspirations listed in the consultation document up to page 15, and specifically the proposals with regard to prevention and the principle of an Oral Health Risk Assessment. The introduction of a preventative pathway separate to a treatment pathway and the emphasis on prevention rather than treatment has been well received by the profession but, the detail behind these proposals is unclear at this stage. We are also concerned that there is already insufficient funding for NHS dental treatment currently, and that if an OHRA was to be implemented it is essential that it be properly resourced.

- BDA Scotland is pleased to note that SG has taken on-board a number of the key issues raised by the BDA in both their strategy document and BDA Scotland’s 2016 Manifesto, including the implementation of an oral health assessment.

- The overall tone of the document would appear to reflect the view that the principal challenges in terms of NHS dentistry are either currently “in process” or have already been achieved. As a result the document does not address a range of key issues which BDA Scotland defined in their recently published “Five Year Strategy for Dentistry in Scotland” and subsequently in the BDA Scotland 2016 Manifesto. These key challenges which the consultation fails to address include: the increasing incidence of oral cancer with the poorest survival rates at five years than any other country in Europe; the ongoing decline in dental incomes dropping 30 percent in the period 2008 - 2013 and which continue to decline making Scotland the lowest earning dental community in the UK; inequalities in oral health and the need to address the oral health needs of the growing elderly population in Scotland.

- SDPC condemns the proposed further unnecessary controls on the profession and additional bureaucracy to be applied to independent general dental practices (GDPs) as outlined in the

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BDA Scotland has grave concerns about what has been omitted from the consultation document, such as providing adequate funding in the NHS: periodontal care; care of the elderly in their own homes and in care homes and a properly thought out oral cancer strategy. In terms of funding, the consultation fails to address the inadequate item of service fees despite the fact that information published by the HSCIC demonstrates the increasing costs of providing NHS treatment. No account has been taken of the increasing laboratory costs, materials costs, labour costs including additional employers’ costs associated with the new government imposed pension requirements on staff. The consultation also fails to acknowledge the requirement for practitioners to comply with best clinical practice in the management and treatment of periodontal disease, specifically in addition to the requirements as outlined in the Scottish Dental Clinical Effectiveness Programme (SDCEP) Guidelines on Periodontal Disease in line with the standards for general dental practice as set out by the General Dental Council (GDC). In relation to the provision of dental services for elderly patients remaining in their own homes the consultation makes no recommendations on the management of these patients, despite the work of the BDA to highlight these issues. BDA Scotland has major concerns in relation to the lack of a “whole-system” robust strategy to address the disease incidence of oral cancer. This could be reduced through HPV vaccination of males with greater focus on tobacco and alcohol reduction and better health education of the whole population on the risk factors that lead to oral cancer. In addition, the consultation does nothing to address the need to diagnose patients at an earlier stage such as educating the public about suspicious signs to discuss with their dentist and the training of GPs/pharmacists to recognise signs and refer patients. Despite the published evidence which demonstrates the link between late presentation of symptoms and poorer outcomes, this gives Scotland significantly higher mortality rates than other health systems within Europe.

BDA Scotland is opposed to the proposal that Dental Care Professionals (DCPs) would operate independently out with the dental team. To date the position of SG is that DCPs should only be operating as part of a dentist led team, so this represents a significant change in position.

There are major implications and concerns about the proposal to introduce a commissioning model for a range of “enhanced services” which include orthodontics, complex oral surgery, complex restorative treatment and complex domiciliary care for the elderly both at home and those patients living in residential care. The implications relate to both GDPs and for Public Dental Service (PDS) dentists who currently provide domiciliary care for the elderly. It is the view of the profession that the current arrangements for the referral and treatment of orthodontic cases in Scotland work extremely well. BDA Scotland oppose any move to an enhanced service model for orthodontic services, with all the disadvantages and bureaucracy of contracting and commissioning. Several committees have raised concerns about the need for appropriate training and accreditation of specialist practitioners.

Feedback from BDA Scotland indicates strong opposition to the proposal that any dental services should be commissioned by H&SCPs, who currently have no dental representation at Board level nor have these organisations undertaken any needs assessments in the key areas outlined. BDA Scotland believes that it would be wholly inappropriate for H&SCPs to have any role in the commissioning or planning of those services designated as “enhanced services”.

BDA Scotland acknowledges that the proposal for the introduction of enhanced service models reflect the concerns of SG where many cases are referred inappropriately to the Hospital Dental Services (HDS) which could be treating primary care by “advanced practitioners” offering more specialist care. BDA Scotland seeks clarification on the definition of “inappropriate referrals” and the evidence which defines the scale of this issue.
SG believes that the relationship between the NHS Board and practice owner should be strengthened. BDA Scotland opposes the proposal to introduce a formal written contract between the NHS Boards and practice owners. It is important that associates maintain their own clinical accountability, and that the current contractual position is preserved giving the profession some degree of stability in the current circumstances.

SG has proposed that all GDC registered practice owners provide a minimum number of hours of clinical care in order to address issues in each practice. SDPC is opposed to a minimum number of hours of clinical care, and is concerned that this proposal is specifically aimed at addressing issues in relation to practices owned by Dental Bodies Corporate (DBCs).

BDA Scotland is disappointed that there is no mention of stress and anxiety and its impact on the dental profession within the consultation document, and that stress is not acknowledged as a recognised condition within the profession.

It was disappointing to note that the actual questionnaire section includes many questions in a closed format i.e. seeking an ‘agree’ or ‘disagree’ answer.
BDA Scotland’s Response to the Scottish Government Consultation Exercise ‘The Future of Oral Health’

BDA Overview
The overall view of BDA Scotland is that SG has two aims within its’ consultation document. The first aim which is commendable, is to improve the nation’s oral health through increased focus on prevention. The second aim is to gain more control over the ‘business of dentistry’ by creating additional and unnecessary bureaucracy, this is wholly rejected by the profession in Scotland.

BDA Scotland agrees that the current Statement of Dental Remuneration (SDR) is not ‘fit for purpose’, and requires to be updated to bring it into line with modern NHS dentistry. The oral health of the population for both adults and children has improved overall. There has been a reduction in caries with more adults retaining their natural teeth, however there are still major challenges to be addressed specifically the treatment of the elderly and how the SG will tackle oral health inequalities for those living in areas of deprivation.

Dentists need to be remunerated for the modern care they offer and for the provision of oral health advice and information on oral health improvement.

NHS fees still are a major funding source for most practices, with the majority still reliant on NHS funding and providing NHS services, however Item of Service (IOS) fees are so low they do not reflect the actual costs of NHS dentistry.

The over provision of dental graduates in Scotland over recent years has created a very aggressive market with practitioners competing for NHS patients.

There are concerns that SG is seeking to procure NHS dentistry at rates which do not adequately represent the costs of these services.

Introduction

Section 1.1 BDA Scotland acknowledges the excellent improvements that have already been made in the five years since Childsmile has been running and uses ‘observable caries experience’ as the main outcome. This is an examination using a light and a ball ended probe and is not conducted in a surgery with a dental light. Evidence suggests that 50 percent of caries is undetected by observation alone, this can be particularly true in fluoridated teeth. The children in the Childsmile Programme will have fluoridated teeth. It is likely that the true rate of caries in this population is much higher.

Whilst, welcoming the continued improvement in the oral health of P7 children in Scotland, the BDA has concerns that SG highlights isolated statistics from the National Dental Inspection Programme (NDIP) without context. Widely quoting that 75 percent of P7 children have no obvious caries experience in their permanent teeth, may mislead the public into thinking 75 percent are caries free or have never had decayed teeth, and worse still that the battle against caries is won. Widespread acceptance of the Childsmile Programme is based on the public perception that dental caries is still a current problem in Scotland.

BDA Scotland proposes that in order to maintain the excellent improvements already realised through the Childsmile nursery tooth-brushing programme, SG should now consult of a programme of targeted water fluoridation as part of the wider strategy to improve oral health and to continue the existing child dental health improvements and reduce dental health inequalities. It is important to note that every other country with fluoridation (e.g. England, Eire, USA and Australia), also uses fluoride toothpaste and fluoride varnish.
BDA Scotland suggests there should be a ban on all sugar related food and drinks advertising aimed at children. This would allow parents and carers the opportunity to influence what children consume. Younger children are unable to distinguish between television advertising and genuine programmes.

BDA Scotland support the extension of the sugar sweetened beverage levy to milk based drinks, proposed by Westminster, at the soonest possible opportunity, and that his is used to benefit oral health in Scotland. Proceeds of the levy in England have been earmarked for school physical education programmes. However, the Barnett formula applies, and SG has an opportunity to direct funding towards oral health improvement programmes, where a rapid impact can be made on an aspect of health that suffers directly as a result of sugary drinks consumption and has a substantial impact on well-being, quality of life and the national economy.

BDA Scotland supports the need for better food labelling. A simplified, front of pack, traffic light labelling system is required to enable consumers to make informed and healthier choices.

Section 1.2 Ninety percent of the population is registered with a dentist, however of that 90 percent 1.4 million of those registered patients have not visited their dentist in two years. An increase in registrants does not automatically mean the same in attendance levels. This figure is perceived to be largely a product of the system of lifetime registration which SG imposed on the profession in 2010. Figures published by NHS England and NHS Wales recently indicate that only 50 percent of adults and 60 percent of children attend the dentist on a regular basis. BDA Scotland suggests there is no reason to suspect that Scotland fares any better.

We believe the key issue is not the registration rates, these are only a function of the system of lifelong registration, the more important indicator is the “participation rate” i.e. patients actually attending their practice for a check-up or treatment. We would highlight that it is important to note that in areas of greatest deprivation only 63 percent of patients have seen their dentist in the previous 24 months.

BDA Scotland also suggests that courses of treatment and uptake of treatment would be a better measure. Once completed, data from the Scottish Adult Oral Health Survey (SAOS) would provide a good picture of oral health, rather than relying on National Dental Inspection Programme (NDIP) statistics. BDA Scotland questions whether changes should be delayed until the results of the SAOS are available.

Section 1.3 BDA Scotland agrees that many diseases of the mouth ‘are almost totally preventable’. BDA Scotland calls for an oral health strategy between the patients and the profession, to create an environment that favours healthy choices. Upstream interventions will be required from SG including polices addressing the causes of oral disease, such as sugar, tobacco and alcohol. Prevention must be at the forefront.

Preventative treatments in dentistry work, provided there is good patient compliance with the preventive advice given by the dental team. BDA Scotland is disappointed that water fluoridation is not mentioned in the document even though it represents the single preventive approach that would reach everyone, irrespective of their social status, level of deprivation or dental motivation. BDA Scotland believes that community water fluoridation should be targeted appropriately to local needs and feasibility however, there is a role for SG to educate the public on the benefits. A public oral health and well-being campaign is required to allow patients to take care of their own oral health and well-being.

The view of SDPC is that more scope for an integrated and more joined up approach and that dentists and their wider team are in a unique position to contribute to improving the overall health of the Scottish population, for example: funded blood pressure monitoring; provision of blood
glucose testing; smoking cessation; alcohol counselling and lifestyle and dietary advice. Appropriate funding and resources will be required for these additional activities.

**Section 1.4** BDA Scotland supports the need for prevention to be at the forefront of SG’s oral health plan. However, this must be combined with more SG policies to prevent oral diseases by addressing the fundamental causes of disease. Care needs to be taken to ensure that any reforms of the system and the family practitioner model is maintained in Scotland. There is concern within the profession that the growth of DBCs is based on the consumerist model, focused on customers rather than the patients. There is a risk that this model disadvantages those who cannot afford more complex or specialised treatments.

BDA Scotland has campaigned for measures which will deliver a reduction in the number of children admitted to hospital to undergo extractions under general anaesthetic (on average 7000 paediatric patients per annum). The incidence of caries in children and the higher numbers of extractions are more prevalent in areas of deprivation where children are living below the poverty line. The oral health strategy needs to be part of a joined-up approach by SG to address the factors which drive child poverty and the correlation between poverty, poor general health and poor oral health.

Whilst Childsmile has been effective in more affluent areas in Scotland. There remains a significant challenge for SG to improve the oral health status for children in poorer areas. Work must continue until we achieve levels similar to that reported for our Scandinavian and northern European neighbours. BDA Scotland believes that preventive dental care should be extended to all dental patients.

Legislation to implement water fluoridation in Scotland is already in existence Water (Fluoridation) Act 1985 now consolidated into the 1991 Water Industry Act. BDA Scotland would urge SG to take advantage of the benefits provided in this legislation and to consult on the introduction of water fluoridation in Scotland in areas where it might be appropriate and beneficial.

**Section 1.5** Dental care for the elderly requires needs to be properly addressed as the needs of this population are likely to increase as the elderly patient group continues to grow. Elderly patients often have a high caries diet and poor salivary flow with increased root caries. BDA Scotland suggests that the ‘Caring for Smiles’ programme should be implemented fully across all of Scotland, and that it be mandatory for older patients, specifically for those living in residential care, to be registered with a dentist. BDA Scotland seeks assurances from SG that ambulance transport will be able to arrange timely transport to a suitable location for elderly patients, especially those in their own home setting. This is currently an issue which will only become worse as the PDS treats more elderly and frail patients.

The increase in the use of dental implants in recent years means that the ongoing care of elderly patients will be complex with respect to dental disease, poly-pharmacy and complex restorations. The increase in Alzheimer’s disease and similar conditions means that the care of these patients will be challenging.

**Section 1.7** BDA Scotland would wish to draw SG’s attention to further oral health challenges facing Scotland. Periodontal disease and non-carious tooth erosion are huge problems in Scotland, erosion is caused by acidic drinks and foods and is very costly to repair. It can be prevented, but only if the public are properly educated and a supportive environment is created, for example, through food and drinks policy.

BDA Scotland also questions that the key oral health challenges facing Scotland are described in the document as being medium or long term in nature, however there is no indication of the time scale envisaged.
NHS Dental Services

Section 2.1 BDA Scotland believes that the profession should resist any proposals by SG to be unduly intrusive into the business aspects of running a dental practice. We would highlight that in this section it states that SG support the independent contractor status.

Section 2.3 BDA Scotland is content that SG recognise the special status of dental hospitals in providing primary care services in a secondary care setting, as this is important from the point of view of undergraduate education.

NHS Dental Workforce

Section 2.4 SG does not provide the opportunity for the advancements in the treatment of NHS dental patients because it does not fund more clinically advanced and complex treatments within the SDR. The GDS provided in Scotland takes no account of clinical advances in dentistry or more effective treatments for patients. As a result, it is a standard service which is only designed for functional dentistry. It is disappointing that in 2016 the system has not advanced beyond this.

The consultation document states ‘There has been a substantial increase in the NHS dental workforce in Scotland’, however, there is no mention of several important points and challenges which the NHS dental workforce has faced. The earnings for GDP’s have decreased by 32 percent in the last 8-9 years due largely to the current policy on public sector pay restraint, while costs have increased significantly, and workplace pension schemes have been introduced at a cost to practices. In addition dental incomes have been further eroded by costly dental decontamination units and the introduction of N3 computer networks. While some of the costs of these improvements have been met with ‘one off’ grants, the costs of upgrading of capital facilities, have largely had to be borne by the practitioner.

BDA Scotland is disappointed that there is no mention of stress and anxiety and its impact on the dental profession within the consultation document, and that stress is not acknowledged as a recognised condition within the profession. SDPC’s own working group has raised the issue of ‘Mindfulness Training’, and strongly believe that all GDPs should be made aware of this training in order to identify and assist with stress. It is important to note that the Northern Ireland Medical and Dental Training Agency has funded a stress management system, ‘Safe Talk’ which has been rolled out to all practitioners in Northern Ireland.

The lack of investment in NHS dental services by SG does not reflect the needs of modern innovative dentistry. NHS GDPs are working longer hours in order to maintain the viability of their businesses, this is also associated with lower morale and motivation and higher stress levels compared to colleagues in mixed NHS and private dental practices. SDPC members have reported that NHS GDPs feel “they must increase throughput and productivity in order to “keep up” and maintain practice income, difficulties arise for those practitioners who struggle to maintain incomes driven largely by IOS fees and as a result some practitioners cannot manage the stress which this situation generates. High stress levels in any profession leads to lower productivity and lower performance which might in part explain the higher referral rates to the GDC.

The behaviour of the dental regulator (the GDC) and the lack of mechanisms for local resolution of problems and the prolonged investigation process causes further stress and anxiety for the profession in Scotland.

Many GDPs in Scotland are non UK graduates recruited at a time when Scotland was experiencing a shortage of UK trained graduates to meet demand for NHS services. In Boards such as NHS Dumfries and Galloway 40 percent of GDPs are non-UK graduates. BDA Scotland is concerned that there is a degree of uncertainty on the potential impact of Brexit and a
lack of clarity on the likely effect on areas with a high percentage of non UK graduates, should these practitioners not remain in Scotland in the period after the UK exits from the European Union.

In 2016, the BDA conducted an Associates Survey and separately a Practice Owners Survey, in order to provide evidence on practitioner morale and motivation within the profession, to the DDRB (Doctors and Dentists Review Body). It was noted that in that survey a significant proportion of associates intend to leave the profession through retirement (13 percent) or working in a different sector (9 percent) or to reduce their hours (26 percent) in the next five years. The same was true of practice owners with nearly a third intending to retire in the next five years and a similar proportion looking to reduce their hours.

Within the current workforce, it is believed there is a lack of career advancement especially for young independent practitioners. There is more aggressive competition in the buying and selling of practices due in part to the growth of DBCs, and therefore fewer younger dentists buying into practice ownership.

Taken together all of the above factors caution against the belief that the NHS dental workforce is in a healthy state.

Over production of dentists and therapists is a major issue in the current workforce with many new graduates struggling to get sufficient experience in their Vocational Training year to prepare them to enter the workforce. Protected pathways should be designed to keep the workforce abreast of procedural practices and other changes, otherwise there is a danger of moving towards a system where secondary care will be overloaded with certain aspects of dentistry, e.g. oral surgery and sedation.

Health and Social Care Partnerships

Section 2.8 BDA Scotland condemns the proposal to involve H&SCPs in strategic planning and commissioning, a role the BDA committees disagree with, and do not believe that they are an appropriate organisation to undertake this work.

Identifying the Challenges

Section 3.3 ‘The current system in NHS dentistry is embedded in a restorative culture.’ BDA Scotland is concerned that it belies a prejudice from the writers of the report that dentists are content with ‘drilling and filling’ to make money. It is fact that caries is found in at least 25 percent of P7 pupils whose teeth need to be restored. BDA Scotland believes that the impact of the Childsmile Programme needs to be assessed over a longer period to time.

Section 3.4 BDA Scotland is concerned that using an indicator where more adults retain some of their natural teeth seems of little value since this could mean one or two teeth standing in diagonal quadrants which are non-functional.

Reducing Health Inequalities

Section 3.5 BDA Scotland would like to remind SG that whilst there is much talk of health inequalities and, although dentists can play a part in service delivery in this area, it is also a social issue related to poverty, poor lifestyle and unhealthy choices which manifest in deteriorating dentition in adults and high caries rates in children.

In relation to children, BDA Scotland supports the establishment of pathways to promote attendance and the follow-up of children who are identified at risk of dental disease, utilising the Childsmile Dental Health support Workers network and emphasising primary prevention. BDA Scotland suggests that this could be expanded to those who are not brought to dental
appointments. At present, there are different pathways for the PDS in each NHS Board, and GDPs have no clear pathways to follow for these children. Clearer, coherent, unified pathways would assist clinicians in safeguarding children identified as possibly suffering "dental neglect".

Health inequalities are raised as a significant challenge, with those from the most deprived areas having higher rates of decay. BDA Scotland calls on SG through interaction with the profession and the public to create a public health environment that favours health choices including policies with address diseased including sugar, tobacco and alcohol. The report does not mention that patients must bear some of the responsibility for their own health. BDA Scotland is concerned that there is no mention of a sugar tax, a ban on sugary drinks in schools, a ban on selling sweets to children before school, a publicity campaign to improve diet, fluoridated water schemes to target populations at risk. There is no mention that it is the responsibility of patients to attend the dentist for check-ups on a regular basis to address decay before restorative treatment is needed.

BDA Scotland believes that there are some patients who require PDS treatment because of their needs, however, some patients will move between the PDS and their GDP who will jointly provide shared care when necessary.

BDA Scotland is concerned that following the current negotiations on the implementation of the Minamata Convention on mercury within Europe which will affect the availability and cost of dental amalgam and the proposed ‘phase down’ of amalgam treatments. The SDR needs to clearly define what patients are offered and at what cost.

BDA Scotland urge SG to commit to delivering an immunisation programme for gender-neutral HPV vaccination for the prevention of oral cancer to create “herd immunity” and to realise overall improvements in general health.

Section 3.6 Adults from deprived areas and the most vulnerable may have poor oral hygiene and fail to attend the dentist unless they are in pain, in which case by the time they attend the tooth may be beyond restoration. BDA Scotland suggests there is a need for a campaign to encourage the public to attend for check-ups and take greater responsibility for their own oral health.

Section 3.7 BDA Scotland believes that with the extension of the Childsmile Nursery Programme, the profession should be fully involved in this process to ensure proper funding and effective delivery.

Section 3.8 BDA Scotland agrees that dental professionals already play an important role in delivering smoking cessation and alcohol advice specific to the patient. However, these interventions take time, and BDA Scotland calls on SG to properly fund the SDR for the provision of smoking cessation and alcohol advice for patients in a similar way in which funding is allocated to the pharmacists.

Oral Cancer Pathway

Summary of Proposals BDA Scotland supports the proposal from SG to review the approaches taken by NHS Boards regarding their oral cancer pathways and to streamline diagnosis and treatment. In addition, we would encourage SG to ensure a greater degree of consistency amongst NHS Boards on the implementation and the management of the pathways.

Modernising NHS Dental Services

Section 3.13 BDA Scotland agrees that a review of the SDR is long overdue, especially from the point of view of restorative dentistry. BDA Scotland asks how SG plan on changing the SDR to make it ‘fit for purpose’ and hopes that the provision of a proper level of periodontal care, aligned with current best practice guidelines in the NHS GDS, is something that can be facilitated.
However, more information is required about the proposed changes, and BDA Scotland would hope this would be an opportunity to remove the bar to mixing NHS and private treatment on the same tooth.

BDA Scotland suggests any review of the SDR would need to be properly piloted, as there is always the law of unintended consequences.

In the consultation document is states ‘the current system of remuneration for independent GDP’s is complex’ BDA Scotland agrees that it is complex, but the most problems are caused not by the complexity, but the continual lack of guidance from PSD, as to the interpretation of the SDR. Consistent, clear advice would go a long way to reducing problems. Some items are priced wrongly, with the full knowledge of the Scottish Dental Practice Board, which results in the fee being too small to cover laboratory costs.

The consultation document implies that a capitation system would be on offer with IOS payments from those with poor oral health.

Section 3.14 BDA Scotland proposed that the current NHS services could be extended to enable greater patient choice, for example, currently under the GDS in Scotland, a dentist cannot undertake NHS treatment and private treatment on the same tooth as is the case in England. In addition, patient choice could be extended by allowing the patient to pay a percentage of the cost of more expensive materials e.g. an all ceramic posterior crown.

Section 3.15 Refers to adults being accepted into a preventive care pathway whilst simultaneously trying to create a simplified payment structure (section 3.26). Does this imply there will be a form of adult capitation? Independent GDPs are wary of this suggestion in Scotland in relation to the inability of PSD systems to cope with such a payment process.

Sections 3.15 - 3.18 BDA Scotland questions whether preventative treatment pathway payments will be on a practice or contractor basis? Will they be paid as an allowance or per patient, such as with continuing care and capitation payments? How will individual dentist’s performance be measured? How will dentists be incentivised? Would the payments be graded according to the patient’s previous dental history?

Section 3.16 This section refers to ‘building on the continued success of the Childsmile Programme’. The year on year improvements are levelling off at about 75 percent. In the best case scenario this leaves 25 percent requiring restorative treatment. BDA Scotland suggest more data are needed on Childsmile outcomes over a longer period of time.

Oral Health Risk Assessment (OHRA)

Section 3.20 The Oral Health Plan could be an opportunity to shape the provision of dental care in a positive manner to help dentists as well as patients, however, BDA Scotland questions how comprehensive the OHRA will be e.g. will it include periodontal screening, oral mucosal screen, diet etc. In order to carry out an OHRA, a considerable amount of the dentist’s time will be required.

BDA Scotland questions how this will be funded, will it be paid as an allowance or per patient, such as with continuing care and capitation payments and by what payment system? How will individual dentist’s performance be measured? Adequate remuneration will be required to incentivise dentists to move to a more preventative approach. SDPC is concerned that there is no explanation as to how the two proposed pathways of item of service and preventive pathway will be funded, and it is thought it could be very confusing to have the pathways running simultaneously, and in addition would this mean separate payments for adults, and how would patients move between the pathways? There is a lack of detail on circumstances where patients were on a preventive pathway would be dealt with should there is a sudden change in oral health.
Whilst BDA Scotland endorses and commends SG on the proposal to introduce treatment and preventive pathways. Without a greater level of detail on how these pathways will work in practice, it is difficult to comment at this stage.

Some committee members have suggested that the patients assigned to the ‘Treatment Pathway’ are more in need of preventive treatment than those on the ‘Preventive Pathway’, and question how would their preventive needs be addressed and remunerated.

SDPC questions how a new system would be implemented without destabilising the current system, and how it would it operate given that some patients would transfer to a preventative pathway and some to a restorative pathway? SDPC is concerned about patient perceptions whereby patients currently expect to pay for operative treatment. How will GDPs explain to patients that there would be a charge during which they are receiving dietary advice and oral and general health counselling?

SDPC suggests the following ways to resolve some of the above issues includes: patients paying monthly planned payments; the need for any new system to be piloted and for SG to engage in a public health publicity campaign. SDPC highlights that in countries such as Germany patients carry a card which is dated and stamped when they visit the dentist for an examination in order to demonstrate to their dental plan provider that they are attending the dentist regularly. This in turn ensures that insurance plan costs are kept to a minimum. BDA Scotland suggests that SG may wish to consider what other countries use this type of system in respect of preventive pathways.

SG must give consideration as to the requirement for all software systems to be properly adapted to deal with any proposed changes to the system.

BDA Scotland advocates that infants are introduced with their families at as early an age as possible to their dentist, and certainly have dental check-ups by the age of one. Risk should be assessed early on in teething and weaning, and this is when dental visits should begin. It is acknowledged that in addition to the advice offered by health visitors, etc., bottle feeding can cause rampant childhood caries well before the age of two.

In relation to the OHRA it is the view of BDA Scotland that this should commence at the age of two when a child’s deciduous teeth have erupted, further assessment at age six, when the first molars erupt and between ages 11 and 12 when the second molars/premolars erupt and the deciduous teeth have been shed, and then subsequently between the ages of 16 and 18 when many young adults lifestyle change and oral hygiene can deteriorate at that point. Providing a dental health score to take into account the risk factors at these developmental stages, would also motivate patients and parents to share the responsibility for their children’s dental health. Some patients may already be experiencing the effects of smoking and alcohol consumption on their oral health, and it was suggested that an OHRA might include tobacco and alcohol screening from the age of 16 or earlier. SG must look at ways to reduce the availability of tobacco and alcohol for older children. BDA Scotland suggests this should include increased tax on both of these addictive products. The above mentioned scoring system could follow a child throughout their lifetime.

There is no mention of the recent SDNAP guidelines, (Restorative Dentistry, Orthodontics and Paediatric Dentistry). These were compiled over several years and took the opinions of all stakeholders into account. BDA Scotland is concerned that these important documents are not referenced with regard to these services in Scotland and represent a major omission.

The OHRA description states: “An OHRA involves a full dental examination and includes a discussion between the dentist and patient about associated risk factors such as smoking, alcohol intake and medication”. However, it fails to recognise SG findings reported at Section 3.10 Oral Cancer Pathway, that 66 percent of smokers in Scotland take up smoking before age 18. BDA Scotland
suggests in reality there is a missed opportunity to target the patient cohort in providing the target age group with the right advice, at the right age.

The OHRA does not mention diet as a risk factor to be addressed in oral health e.g. fizzy drinks, sugary foods. Poor diet is contributing significantly to non-carious tooth surface loss (erosion) which is very costly in terms of restoration, not to mention obesity, and gastrointestinal problems which are also associated. BDA Scotland suggests that this is a serious omission as more people might be retaining some or all natural teeth, but a high number of young adults present with tooth erosion and the deterioration in function, before 25 years of age.

A patient-centered approach involving patients in managing their own oral health, would surely require investment in a public health campaign to raise the importance of dental health. This would raise public awareness and allow patients to manage their health accordingly.

BDA Scotland also suggests that the consultation misses the importance of prevention on the ageing population, who attend GDPs, and fails to highlight the need for preventative measures for the older patient age group. These measures include the application of fluoride varnish, high fluoride concentration toothpastes etc.

BDA Scotland suggests that there are many areas in the OHRA where guidance could be provided from stakeholders, and BDA Scotland would ask for assurances that it be involved in the future development of the OHRA.

Patient Charges

Section 3.25 The existing payment system is clear and understandable for patients, in that they pay for each item of care they receive, however, the GDS is underfunded. An illustration, of the underfunding is the exponential increase in laboratory fees.

SDPC suggest that palliative restorative care especially for elderly patients, could be paid for through capitation.

SDPC has provided the following suggestions to simplify the charging system. These include the following:

- Consider exploring the development of a system where treatment provision is assessed based on the clinical needs of the patient, similar to the system of Item of Treatment Need (IOTN) used orthodontics. This proposal has been brought forward by the SDPC Working Group on the Development Programme of for Adult Dental Services to encourage the formulation of a more objective framework which will guide practitioners in assessing treatment provision for their patients available within the SDR.
- Simplify the SDR which was originally set up for a ‘paper-based’ system and is not compatible with current IT systems.
- Requirement for additional funding into the SDR.
- Introduce more realistic reimbursement to cover laboratory fees.
- The Scottish public must be made aware that costs to patients are lower in Scotland than in other parts of the UK and Europe.

BDA Scotland would like to see that adults and children with poor oral health have access to the preventive treatment pathway since both pathways will overlap.

Enhanced Service Model

Section 3.28 Enhancing skills of GDPs to deliver intermediate care is challenging. SCHDS suggests that adequate training of undergraduates should be ensured in order to face future challenges. Enhancing skills will require investment in dental schools and academic staff training and is cheaper
and potentially easier than providing training at postgraduate level to the less interested. SCHDS also suggests that development of postgraduate courses in dental hospitals (day release courses for example) would offer support to practitioners and would help dentists to maintain their skills.

BDA Scotland believes it is wholly inappropriate to include the provision of orthodontics as part of the enhanced service model. The current system and service is well managed and resourced, and provides an excellent service to children and young adults who make up the majority of their patients.

It is SDPC’s view that oral surgery is grossly underfunded and that PSD are strict in their rulings with regard to more complex treatments such as extractions and flaps, and this does not encourage GDPs to provide more complex treatments in primary care. SDPC suggests it is important that GDPs, where appropriate, will still be able to treat their own patients without necessarily having to refer to the enhanced service. SDPC suggests if there is to be enhanced services in primary care, referral criteria and evidence of the required specialist expertise such as sedation and delivery of domiciliary care would need to be in place. In addition, SDPC are concerned that there may be potential for an enhanced service practice to cause tension between existing practices and expressed concern that the public may view the “enhanced service provider” as superior to non-enhanced provider practices.

SSDC refers to the quote in the consultation document ‘inappropriate referrals’ are with regard to the Public Dental Service (PDS) and HDS…” and asks what the inappropriate referrals are.

Where referrals are more complex than the treatment provided by a GDP they may be suitable for enhanced service GDPs. If these referrals require a higher level of complexity then they would be referred onto the HDS.

BDA Scotland questions where GDPs training to acquire ‘enhanced skills’ will be recruited from, and whether they would be recently qualified practitioners or existing experienced practitioners and will there be sufficient remuneration to attract GDPs to take on these new roles. Concerns were expressed by SDPC that funding for these services might be reduced.

The view of the SCHDS is that GDPs who undertake clinical skills development as part of a move towards enhanced services should be required to continue to provide a designated volume of services to NHS patients as part of the agreement on the investment in training.

There are also concerns that an ‘enhanced service’ for elderly patients and domiciliary care might impact on the PDS, since the service already offers special care dentistry and there are concerns that funding for these services might be reduced, and also that the PDS would lose its’ current skill base. There is also the potential that any subsequent treatment pathways could be ‘patchy’ from area to area depending on service uptake, skills availability and interest from practitioners etc.

SSDC is concerned that monies may be diverted from the PDS to incentivise enhanced contracts and that this could lead to underfunding and fragmentation of the PDS.

Section 3.29 BDA Scotland condemns the proposal to involve H&SCPs in strategic planning and commissioning, a role the BDA committees disagree with, since they are not an appropriate organisation and currently do not undertake any oral health needs assessment planning. Other concerns from committee members in BDA Scotland include the financial limitation on the budget, geographical inequalities and disparity within areas and regions.

Many practitioners believe that the commissioning process favours DBCs, as these large health care companies have a different business model for dental care than the traditional family dental practitioner. BDA Scotland is concerned that commissioning dental services will herald the end of the dentist owned family dental practice who has built up a reputation within a community.
Domiciliary Care for Dependent Older People in Care Settings

Section 3.30 BDA Scotland supports the referral of elderly patients who have complex needs and require specialist expertise to the PDS. Patients who can be safely and appropriately treated by their own GDPs should remain with their practice.

If complex domiciliary care as with other services is to be commissioned, BDA Scotland questions who would be responsible for monitoring the quality of treatment and members have also expressed concerns regarding the need for specialised training and accreditation of GDPs to carry out this work.

Emerging Technologies and Treatments

Section 3.31 BDA Scotland is disappointed by the statement in this section that SG has not made a stronger commitment to emerging technologies and treatments and that this is a missed opportunity.

Finance

Section 3.32 BDA Scotland is opposed to the proposal for H&SCP s to take on greater responsibility for the financial planning and management for the GDS, concerned that this might result in meaning a smaller fragmented allocation being spread thinly over a larger sector. The committees are also concerned that this could lead to a replication of the worst aspects of the commissioning in England. BDA Scotland questions how the contracts would be awarded, and the additional pressures at the contact re-tendering stage. It is widely acknowledged that the English system is unsatisfactory and the BDA would not wish to see the profession in Scotland move in this direction. Members were also concerned that the proposal might lead to limiting the number of practices or amount of work that is carried out or who does it. Independent GDPs would want to avoid this type of situation as it is in England, where a contract is not necessarily kept in place when a practice is sold. It is BDA Scotland committee member’s unilateral view that the GDS budget should remain a single and unified budget maintained and managed by the SG through the Chief Dental Officer and her team.

Administrative Arrangements

Section 4 BDA Scotland is concerned that this section fails to address any concerns which have been voiced previously by GDPs and is of the view that all the suggestions are solely restrictive, unhelpful and discouraging for an average GDP. Committee members suggest that implementation of additional, onerous regulation provides no benefit to GDPs or their patients. Consideration should be given as to whether GDC-registered practice owners, or GDC-registered directors of a dental practice, providing GDS should be required to provide a minimum number of hours of NHS clinical care per week in each practice location as there appears to be no reason or logic to these proposals. BDA Scotland believes the proposal to provide a minimum number of hours of clinical care is wholly unworkable.

Section 4.3 BDA Scotland has concerns about the casual reference to “GDC referrals” under the proposal to centralise certain tasks to increase the support available to NHS Boards in carrying out day to day administrative functions, as if this is an everyday occurrence.

The view of BDA Scotland is that NHS Boards should hold and maintain NHS dental lists, conduct Practice Inspections, manage NHS Disciplinary Committees and GDC referrals including local resolution arraignments.

Contractual Arrangements for Dental Contractors
Section 4.4 The BDA’s legal advice surrounding the recovery of over-payments was based on a contractor having a contract or an agreement with an NHS Board i.e. SG claimed it was an agreement and as such the five year limit on claims was not applicable. In BDA Scotland’s opinion, the contract and agreement would be the ‘same’ and that Contractors’ have a contract with the NHS Board to provide GDS. It is the view of BDA Scotland committees that SG should clarify in legal terms the perceived difference between a legal contract and an agreement.

BDA Scotland’s concern is that the proposal outlined in the document is seeking to address the contractual business model operated by DBCs, which does not have the same implications for independent practice owners. The proposal to implement a legal contract between a GDP and an NHS Board for a contractor who is carrying the risk of employing staff, investing in equipment and running the business whilst the contract for those services can be terminated at any time by the NHS Board is wholly unacceptable to the BDA. Under these circumstances, it would be difficult to see why an independent GDP would seek to become a practice owner in a NHS practice in Scotland. This approach again favours the DBCs’ business model.

Section 4.5 BDA Scotland would like to see more information about the proposed contract with the practice owner. Members are concerned that the practice owner will become responsible for their associates conduct and clinical accountability and for the treatments they carry out.

BDA Scotland suggests that the introduction of a new dental contract would require sufficient time for consultation and negotiation with BDA Scotland and furthermore, how would the introduction of a new dental contract sit alongside the GDS (2010) regulations since, BDA Scotland believes the GDS regulations is the contract dentists currently have with NHS Boards.

BDA Scotland is not in favour of a formal contract between NHS Boards and practice owners. The individual practitioner is professionally responsible for the patient care provided.

SDPC understands that there are circumstances by which practice owners cannot be identified by NHS Boards and this is one reason SG has suggested new contractual arrangements. SDPC believes setting up new contracts is a contentious issue and suggests that such information is already recorded in a number of ways as listed below:

- SG has the authority to carry out unannounced practice inspections at which time they could obtain the relevant information.
- Scrutinise dental list number information.
- Clinical Directors within DBCs are responsible for dental practice and should have this information.

Section 4.6 states “a formal contract between NHS Boards and the practice owner(s)” this implies that associates will no longer be contracting directly with the NHS Board.

Any practice based contract must have measures in place to ensure that treatments/preventive action can be related directly to individual dentists. The performance of these measures must be linked to incentivise the behaviour of dentists.

A practice based contract may also have a significant and detrimental effect on the self-employed status of associates in Scotland. It is important to maintain a direct contractual relationship between associates and NHS, to preserve their income in relation to commitment payments and other individual allowances.

If dentists were to find themselves in a situation where their income was reduced due to the change in their employment status, then this could greatly affect the desire of dentists to work in Scotland and might subsequently create an ‘access issue’.
Locality Planning of Dental Services

Section 4.7. BDA Scotland is concerned about the proposals that H&SCPs should take on the strategic planning and commissioning of NHS dental services. H&SCPs currently have no experience or expertise in this commissioning of dental services and BDA committee members are concerned that the least expensive service would be commissioned with no consideration to the fact that good quality patient care comes at a cost. DBCs would have an advantage in being able to offer low tenders compared to independent practitioners. Some committee members have suggested that this could lead to privatisation of services.

Earnings and Expenses Information

Section 4.10 As independent contractors SDPC is opposed to the suggestion of supplying practices’ financial information as part of their “Terms of Service” and have concerns about the security and use of this commercially sensitive information.

Patient Registration

Section 4.11 BDA members believe that if patients were to become registered with a dental practice and not with a dentist, it would mean an end to the current continuing care and capitation payments. It is important that there is a direct relationship between patient and clinician.

The BDA’s view is that dentists are clinically accountable and responsible for the treatment that they provide and so an NHS contract where patients remain registered with individual dentists, is a more appropriate contractual mechanism.

Associate agreements typically state that the goodwill and the registered patients remain at the practice when an associate leaves. Associates have to provide their NHS Board with three months’ notice to leave the list, and typically would have to provide the practice with the same notice. This ensures the stability and smooth transfer of patients to another dentist at the practice when a dentist leaves.

The current system of a departing dentist transferring their patient list to an incoming dentist ensures that the amount of work each dentist has carried out is accurately recorded, and ensures that both dentists are fairly remunerated for the work that they have carried out. It also helps clarify the levels of accountability should a dental legal matter arise e.g. a patient complaint. Any change from the current arrangement will need to ensure that when there is a change of dentist the accountability for the work that both dentists carry out, can be easily identified and also appropriately remunerated.

Concerns were also noted that the proposed changes to the GDS system would shift towards that of the GMS system with no attributed dentist for the patient. BDA Scotland questions what would happen if a dentist left a practice, and the practice was unable to find a replacement. There would not be a list number which could be deregistered and the remaining GDPs in the practice might find it difficult to cope with the additional numbers of patients.

BDA Scotland questions SG’s reasoning in proposing that patients be registered with a practice and not a GDP.

Patients have a responsibility to manage their own health in between appointments, this has more of a bearing on their oral health than the treatment provided by a dentist in a single appointment. However, BDA Scotland supports the principle that GDPs should have shared responsibility to support the improvement or maintenance of oral health for an individual patient. There is concern that this section might read as if the GDP would be liable for someone’s oral health deteriorating.
Future Provision

Section 4.13 The Dentist’s Act requires the majority of directors in the company to be dentists or DCPs. A DBC does not necessarily need to have any dentist directors, the majority of directors could be DCPs. Alternatively would it require each DCP director to provide a minimum number of hours? In particular, how would this be achieved in respect of dental technicians?

Dentist directors may well be forced to spend time travelling between premises in order to meet the requirements and therefore lose clinical time treating patients. Such a consequence may well lead to a reduction of NHS registered patients.

The majority of members opposed changes that impact on how GDPs run their businesses. To insist on practice owners working in every practice is unworkable and to ask for practice accounts is also unacceptable. SG has several mechanisms to monitor the delivery of services, quality of care and the workings of NHS practices.

BDA Scotland is concerned that this proposal would appear to disadvantage a partnership versus a DBC. A practice owner cannot necessarily work in all the practices they owned, however, this proposal may not affect a DBC.

Section 4.14 Dentists may have chosen to incorporate their business, however they may prefer to have an individual contract with the NHS Board. There may be considerable financial disadvantages to a dentist’s business if the DBC has to contract with the NHS Board. This may result in dentists leaving the NHS and concentrating on wholly private dentistry.

BDA Scotland asks how will matters such as NHS allowances, including NHS sick pay, family leave payments, and superannuation will be addressed to ensure there are no financial losses. If the DBC is listed will that mean that the individual dentist (both the practice owner and associate) will be prevented from also being listed?

Allowances

Section 4.15 – 4.16 Allowances are essential to support and to maintain the viability of NHS practices and NHS services and must be protected at all costs. This is a critical issue to the profession due to the ongoing erosion of practice incomes in dentistry. BDA Scotland asks for assurances from SG that funding will not be reduced and that the funding currently allocated through allowances to NHS practices and practitioners, be maintained otherwise the business viability of NHS practices will be threatened.

Over the last five years independent GDPs level of income has substantially been reduced and this provides practices with less funding to improve patient care and invest in dentistry. Scottish Government must provide more detailed planning on how they will invest in dentistry, particularly for equipment with the ever demanding standards required by practice inspections and ever increasing costs of dentistry.

Professional Leadership at NHS Boards

Section 5.3 BDA Scotland recommends that the proposed role of Director of Dentistry in each NHS Board should have a broad clinical academic background, together with a substantial GDS background. It is important in a post of this type that the post holder would have sufficient experience and expertise to enable to them to take a strategic oversight of all aspects of NHS dentistry.

SDPC is concerned that these posts should be filled with experienced GDPs rather than recent graduates or dental public health specialists.
BDA Scotland questions whether the Director of Dentistry will be required for all NHS Boards in Scotland, possibly two in the larger NHS Board areas and what administrative staff support they will require in this role. The proposals outlined in relation to the planning and management of NHS dentistry appear to disperse these responsibilities across a range of organisations including Integrated Joint Boards, NHS Boards, a proposed centralized administrative function and a Clinical Quality Monitoring Service. Apart from the ongoing roles provided by the PSD and what if any might be the future role of SDPB. BDA Scotland has raised concerns that these complex arrangements are unnecessary and a waste of public monies and would prefer to see NHS Boards (however many might be part of any reorganisation of NHS Scotland) as the single key organisation responsible for the management, planning, delivery and monitoring of NHS dental services.

The Scottish Dental Practice Board

Section 5.5 It is the view of SDPC that SDPB should be disbanded since it no longer provides a fulfilling and meaningful role in support of NHS dentistry. The major reasons for SDPC’s recommendation are major concerns relating to how the organisation performs, these are listed below:

- Lack of public accountability.
- Total lack of transparency.
- Lack of published activities of the Board.
- Lack of willingness to engage with the dental profession.

Clinical Quality Monitoring

Section 5.7 BDA Scotland questions the need for the creation of a Clinical Quality Monitoring Service. The consultation document only refers to the new preventative pathway in relation to the Clinical Quality Monitoring Service, and not the treatment pathway.

Quality Improvement Activities

Section 5.8 BDA Scotland suggests a further quality indicator for ‘referral patterns’ should be considered. Key indicators of quality would have to be clearly evidence-based and in cooperation and agreement with dentists.

SDPC is concerned that these quality indicators would drive a level of unnecessary bureaucracy since the payment Verification Scheme, Combined Practice Inspections and Inspectors already provide a considerable amount of monitoring information. It should also be noted that PSD now hold tooth specific data.

Protected Learning Time

Section 5.9-5.10 BDA Scotland strongly supports Protected Learning Time (PLT) for practices however such an initiative would need to be funded directly by SG. PLT works well in General Medical Practices where staff are salaried and it is relatively well-funded. PLT is important for the development of all dental staff and whilst it would be beneficial if applied to dental practices and teams, it cannot be implemented where it will result in a loss of earnings at a time practices are struggling to meet their existing financial practice commitments.

E-Dental Programme

Section 5.11 BDA Scotland is in agreement and supports the e-Dental Programme and that it should be prioritised by SG. Currently there are NHS Boards which are unable to progress their e-Dental programme due to a lack of funds. BDA Scotland believes that as with e-Dental Programme there needs to be a greater level of consistency and continuity across the NHS Boards.
A Changing Workforce – Future Priorities

**Section 6** BDA Scotland suggests that robust workforce planning is essential and desperately needed. Independent GDPs are concerned that the consultation lacks inclusivity towards GDPs, and that it fails to recognise, correlate and address the pressures that GDPs are currently facing, and how this could improve patient care if they were to be resolved. It lacks details and evidence on all the contractual changes proposed.

BDA Scotland agrees with the proposal to “review our training requirements to ensure we train staff who can meet the care and treatment needs of the Scottish population” and that it should be a structured and logical approach to the Scottish Workforce Plan. BDA Scotland acknowledges that there are many uncertainties in the current environment, including the current impact of Brexit, which may affect the supply of dentists and DCPs in the dental workforce.

BDA Scotland acknowledges that there is a ‘mismatch’ with the techniques and materials that students are trained to use in the undergraduate setting in comparison to the techniques and materials which are available for patients under the current SDR. This issue must be properly addressed.

The consultation document states that to “ensure training is focussed on the setting in which the clinicians will be required to work” and BDA Scotland suggests this will need elaboration. Dental Schools currently train dentists to provide the best possible standard of evidence-based care, regardless of the system of remuneration. BDA Scotland suggests it cannot be ignored that the majority of Scottish graduates will work under the GDS.

Regarding the statement ‘Work with UK partners to determine how best to ensure a steady and timely flow of secondary care consultants and academic staff from the smaller specialties’ this line only appears in the summary and seems to be an afterthought if such wholesale changes are being planned for the dental profession. SCHDS considers this is a tacit admission that something is going wrong with the ability of Dental Schools and NHS Boards in Scotland to attract applicants from the rest of the UK although it is not confined to the smaller specialties. However, SCHDS welcomes that the problem has been acknowledged.

The current job plan arrangements, the 9:1 split between Direct Clinical Care and Supporting Professional Activities, and the on-going freeze of Distinction Awards are of major concern to the profession. The Terms of Service in Scotland are much less attractive to prospective applicants and therefore there is a shortage of appointable applicant to many of the Scottish consultant and academic posts. The recent changes to the pension’s arrangements for practitioners working in Universities which disadvantages academic staff in comparison to NHS staff, an arrangement which is peculiar to Scotland and which contributes to the difficulties in the recruitment and retention of academic staff.

SCHDS asks SG to recognise that the Dental Schools in Scotland are producing the workforce of the future and need to operate within a robust workforce strategy. Failure to address the current difficulties is putting the quality of education and academic dentistry and dental research at risk.

**Section 6.2** The enhanced practitioner scheme might be based on established Diploma/MSc programmes available at Scottish universities. Recognition or accreditation for such practitioners needs careful consideration as to standards and accrediting bodies. Hospital based medical colleagues are debating this issue currently.

**Section 6.3** BDA Scotland is unilaterally opposed to the proposal that DCPs can set up and operate independently out with the dentist lead team. We understand that the current position of Scottish Government is that DCPs should only be operating as part of a dentist led team, and
that this proposal represents a significant and worrying change in SG’s position.

Committee members also have concerns that by allowing for direct access under the GDS, the existing limited dental budget would be spread even more thinly. There are concerns that there is a potential lack of continuity for patients treated under direct access, and there is no clarity about the arrangements for DCPs to refer on to the dentist. It also removes a safeguard for patient care and further reduces the need for qualified dentists.

Conclusions and Next Steps

Finally and in summary, the proposed changes are being brought forward at a time when GDP incomes have reduced by 30 percent in the period 2008-2013 and continue to decline year on year. This fact was evidenced in the recently issued “Dental Workforce Report 2016” published by NHS Education for Scotland which states that “The Health and Social Care Information Centre publishes information on gross earnings, expenses and taxable income i.e., gross earnings minus expenses, for primary care dentists in Scotland. This information is based on anonymised tax data for full and part-time principal and associate dentists with some self-employment earnings from the GDS and is expressed in 2015-16 prices using the “Gross Domestic Product deflator”. There are major funding shortfalls in NHS dentistry creating the ongoing erosion of GDP incomes, and there is no recognition in this document of the considerable problems practitioners face in running small businesses. With a 30 percent drop in GDP earnings between 2008 and 2013 and the lowest average incomes in the UK and morale amongst the profession at an all-time low, the BDA seriously questions the Minister’s optimistic assessment in her introduction of how NHS dentistry has changed significantly for the better.

Therefore, before any major changes are embarked upon by SG, GDPs need a degree of reassurance that practitioners will not simply be working to a new SDR which will see them doing more for less whilst incomes continue to decline further.

The view of BDA Scotland is that NHS dentistry requires a major injection of additional new funding in order that independent practices remain financially viable and the high quality care which GDPs, the PDS, academic and NHS consultants provide to all their patients can be maintained.

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