
Annex G Consultation Questionnaire**RESPONSE OF THE BRITISH DENTAL ASSOCIATION****The case for change**

Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

Yes No

Based on the background information the Scottish Government has provided in this section of the consultation, particularly given the rapidly growing older population in Scotland and its associated health and wellbeing needs, the BDA agrees with the proposal to focus initially on improving outcomes for older people. This is in alignment with BDA policy, some further detail of which is referenced at the end of the consultation questionnaire.

Outline of proposed reforms

Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

Yes No

The “disconnect” between health and social care is of little relevance for most dental care in Scotland. Where this “disconnect” mainly applies to dentistry is in the oral healthcare of older adults. Although many have good oral health and access to services, a significant percentage rely on services provided through care homes. We believe that the “disconnect” between health and social care for older adults should be addressed through the Scottish Government’s Oral Health Improvement Strategy for Priority Groups.

National outcomes for adult health and social care

Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

Yes No

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Yes No

The BDA has no comments on this question.

Governance and joint accountability

Question 5: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

Yes No

The BDA has no comments on this question.

Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

Yes No

Chapter 3 of the consultation document outlines the Scottish Government's priority "*to improve people's experience of health and care services and the outcomes that services achieve, and to ensure that the substantial proportion of Scottish public services spending that support these services is used to the very best effect*".

In determining the numbers of Health and Social Care Partnerships, due consideration should be given to the additional costs of bureaucracy and clinical involvement that would be required.

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

Yes No

The BDA has no comments on this question.

Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

Yes No

There is relatively little detail on the performance management arrangements, save to say that "*performance support will be offered and, where critical, put in place to assure the delivery of targets.*" This brief statement does not enable the BDA to comment on how sufficiently robust these arrangements might be.

Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Yes No

The BDA has no comments on this question.

Integrated budgets and resourcing

Question 10: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need “health” or “social care” support?

Yes No

The BDA has some concern with the potential funding arrangements for dental services and we go into more detail on this in our response to question 12.

Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

Yes **No**

Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

Yes No

The non-cash limited budget for general dental services is currently controlled and held centrally. The BDA would not wish to see any

divergence from this arrangement by devolving the funding to individual integrated budgets of the NHS Boards and Local Authorities.

Similarly, we would not wish to see any change in the current arrangements for the funding of secondary care dental services. These should remain with NHS Boards and be included in any local integrated budgets.

With regard to primary care salaried dental services, however, which will be the main providers of oral healthcare to priority groups, it is important that adequate funding is allocated to dentistry at local level so that the necessary patient care can be delivered as part of the Scottish Government's Oral Health Improvement Strategy for Priority Groups.

Jointly Accountable Officer

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

Yes No

The BDA is unable to comment on this question.

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

Yes No

The BDA is unable to comment on this question.

Professionally led locality planning and commissioning of services

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

Yes No

The BDA does not consider there is a need for local commissioning to be applied to non-salaried general dental services (GDS), which are delivered by independent contractors through a national contract and whose budget is centrally held. We recommend that the status quo is upheld for the funding of the GDS. This arrangement, under the accompanying GDS Regulations, also allows NHS Boards to determine the level and quality of provision for the local population. Area Dental Committees, and their GDP Sub-Committees, have close links with the NHS Boards and we would wish to see these arrangements continuing.

Salaried primary care dental services (that is, the salaried GDS and community dental services (CDS)), on the other hand, are already largely integrated into Community Health Partnerships and, in some cases directly managed by them, and so there would be a case for including them in the integrated Health and Social Care Partnerships.

Dentists working in the salaried GDS and CDS are the main providers of oral healthcare to older people in supported care and the arrangements for the planning of these services should be determined locally. For locality planning to be effective it is vital that there is clinical expertise and so it is important that Clinical Dental Directors and Consultants in Dental Public Health play a leading role in the planning and decision-making processes.

Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

Yes No

In 2006, BDA Scotland consulted the dental members of each Community Health Partnership (CHP), where one had been identified, seeking information on how each individual CHP dealt with dental matters, how it obtained information, how it informed the dental community of its decisions and how effective the dental nominee on the CHP felt their contribution was when dental matters were discussed. The replies highlighted a number of issues. It emerged that:

- most dental members on CHPs felt that dental issues were rarely if ever discussed by CHPs.

- the ability to fulfil the remit of CHPs in relation to dentistry was not clear
- meetings were lengthy and largely irrelevant to dentistry
- there was a lack of clarity as to how the dental nominee was appointed
- there was a lack of clarity as to how they should gather views from the profession and to whom they should report back
- there were concerns about the amount of time spent and costs of attending meetings and loss of earnings

As a result of these issues, the BDA developed its own policy for Community Health Partnerships in Scotland. Our policy recommends that any management or operational role for a CHP in the delivery of dental services should be developed in full and wide discussion with representatives of the dental profession. We would, therefore, support the Scottish Government's proposals that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, and this should include dentists working in primary and secondary care. NHS Boards' Area Dental Committees and their GDP Sub-committees would be the most appropriate bodies in this respect.

Our response to question 15 also supports this recommendation.

Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

Our response to question 16 has highlighted some of the issues that face dental clinicians in their involvement in CHPs. It is important that the new Health and Social Care Partnerships address these issues, and recognise that clinicians' primary roles are to provide care and treatment to patients. Practical arrangements should be put in place to allow them the time required to be involved in local planning. If it is intended to include independent contractors, then funding for any loss of earnings incurred as a consequence of time away from clinical care must be provided. This should be at the British Dental Guild Rate that is current at the time.

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

Yes No

The BDA has no comments on this question.

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

The BDA has no comments on this question.

Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

Yes No

The BDA has no comments on this question.

Do you have any further comments regarding the consultation proposals?

The BDA shares the Scottish Government’s vision for greater integration between health and social care, and is particularly keen to ensure that good oral health structures are in place to deal with the oral health needs of an ageing population.

In 2003, the BDA published its policy document **Oral Healthcare for Older People 2020 Vision**. Although many older adults have good oral health and access to services, a significant proportion rely on services provided through care homes, arranged by family members or carers, or are limited in accessing services as a consequence of reduced mobility. Poor access to routine preventive and expert dental care can lead to poor oral health, and this can have a devastating impact on overall health. This can manifest itself in many ways, from pain and ulcers caused by ill-fitting dentures to dehydration and malnutrition caused by difficulties with eating.

Our policy document was reviewed in January 2012 and it highlighted several outstanding recommendations on which BDA is keen to see progress being made. Amongst these is the need for standardised assessments to be carried out by a dentist on all people admitted to a care home.

It is notable that the **National Standards: Care Homes for Older People** includes standards on dental care and it is important that these standards are maintained and built upon.

The BDA is encouraged to note that the Scottish Government intends to work closely with NHS Education Scotland and other stakeholders to define the priority education and training requirements that will be required within an integrated health and social care environment. It is BDA policy that CPD and postgraduate courses must be offered across Scotland to equip dentists and dental care professionals with the clinical and communication skills they will need to treat the increasing number of older people.

The BDA supports the Scottish Government's intention for all Health and Social Care Partnerships to share good practice. We have been encouraged to note a good example of the NHS and Social Care working together to improve the oral health of older people in supported care, implemented by NHS Fife. *The Fife Oral Healthcare Award* aims to train care home staff to better recognise the oral health needs of their residents. This could be the sort of initiative that could be shared across all Health and Social Care Partnerships.

Do you have any comments regarding the partial EQIA? (see Annex D)

No comments.

Do you have any comments regarding the partial BRIA? (see Annex E)

No comments.