

Foreword

Dear Colleague,

As 2009 draws to a close we have several key initiatives which are now rolling out or are close to fruition; the guidance on bisphosphonates has been issued, the dental standards are ready for consultation, the dental earnings survey has been published, the Northern Ireland Caries Prevention In Practice trial has started, the Adult Dental Health Survey is underway and we are hopefully close to finalising the policy around the regulation of private dental care. All these initiatives have involved much input from colleagues within the DHSSPS, the HSCB and the Trusts and I would like to thank them for all their help throughout the year.

We have also published our annual report for 2008/09 on our website which details the various areas of work with which Dental Branch is involved within the DHSSPS.

There are other areas which will impact greatly on the dental profession in the coming months such as the new dental structures in the HSCB which may lead to the dental staff in the Board working differently with the profession in the coming years.

Very importantly, the work on the new dental contract continues. The various components of the new contract are close to completion with the detail of weighted capitation now developed. The next stage will be to work on the issue of how patient charges will be applied and this will be a particularly challenging piece of work. We would hope to be able to provide more information on the shape of the new contract in the next issue of CDO News.

In parallel with the work on the new contract, a group comprising DHSSPS and BDA representatives is looking at the set up of the pilot sites. Again we hope to be in a better position to give an idea of the timetable of the pilots in subsequent editions of CDO News.

In closing, I wish all in the profession a peaceful Christmas and a happy new year.

Donncha O'Carolan



Acting Chief Dental Officer
November 2009

Shortage of Dental Contract Numbers

There has been a standing problem in recent years regarding availability of DS numbers for new dentists.

This is caused by the old CSA (now BSO) IT system being limited to three digits and current total numbers constantly in close proximity to the maximum.

The number of dentists in practice has increased by about 100 in the last four years and this has put increased demand on available numbers.

There are many reasons for the current problems but the three main areas that need to be addressed are:

1. **Numbers having to be retained for a period following** sale of a practice, retirement or dentists moving between practices. The SDR allows Contractors to submit claims up to six months after the completion of a course of treatment. The BSO hold a contractor's DS number for eight months after retiring from the list before reissuing the number
2. **Dentists requesting multiple numbers** for accounting or other reasons. For example, while there are 997 DS numbers shown on the Dental list only 480 unique bank account numbers are recorded.
 - 270 with 1 DS number associated
 - 101 with 2 DS numbers associated
 - 51 with 3 DS numbers associated
 - 34 with 4 DS numbers associated
 - 24 with 5 DS numbers associated
3. **Dentists holding a DS number while holding few, or no, patients** and having little, or no, financial activity on their accounts. BSO have identified 20 DS numbers with fewer than 30 patients and less than £1,200 claimed per annum.

While the long-term aim is that a new IT system should be introduced which can cope with greater numbers of dentists, the current position is that we need to take steps to facilitate new dentists. It is

no longer sufficient or practical to rely on the BSO *cleansing* the system on an ad hoc basis.

If the BSO reduced the recycle period to six months, on average 33 additional contractor numbers would become available. The greatest impact would be to look at merging of DS numbers under the bar system to reflect the banking arrangements.

Recent discussions have taken place between the Department and BSO officials to consider possible 'fixes' for the system, on a short to mid-term basis. It is proposed to reduce the recycle period from 8 to six months in the first instance and then work on merging the DS numbers under the bar system to reflect banking arrangements as this will give the best long-term solution. It would involve a change to the monthly statement to ensure that the same information per practitioner can be extracted.

In all cases, the existing rights of dentists regarding their status as self-employed professionals will be retained. It is not anticipated that this change will cause a detrimental impact on existing dentists, and all steps will be taken to ensure this is the case.

Departmental and BSO officials have engaged with the Dental Practice Committee of the BDA to discuss the practical implications of such a change.

The current system of allocating DS numbers is not sustainable. Remedial action is required, and urgently.

The BSO will begin the process of contacting all those who are likely to be affected by the changes as soon as possible.

Vetting and Barring Scheme

From the 12th October 2009, the definition of regulated position under POCVA will be replaced by the definition of regulated activity under the *Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 (SVG Order)*. The SVG Order will establish a Vetting and Barring Scheme (VBS) in Northern Ireland. The VBS in England and Wales will be established under similar legislation, the *Safeguarding Vulnerable Groups Act 2006*, *Scotland* will establish a similar scheme under their own legislation.

Those providing any form of care for, or supervision of children or vulnerable adults, or any form of treatment or therapy for these patients will be in regulated activity.

Regulated activity is carried out with the permission of a regulated activity provider (in most cases this will be the employer). From 26th July 2010, those taking up regulated activity for the first time will be required to become registered with the Independent Safeguarding Authority (ISA).

The ISA is a non-departmental public body (NDPB) of the Home Office and will act on behalf of England, Wales and Northern Ireland. The ISA will maintain a register of individuals where there is no known reason that they are unsuitable to work with children or vulnerable

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adults.

Regulated activity providers will be required to check that an individual is ISA registered before permitting them to work in regulated activity. The ISA will also maintain lists of individuals barred from working with children and vulnerable adults.

Those that are self-employed will not be required to become ISA registered, as they do not have a regulated activity provider, however, we will strongly recommend that they do so.

In essence, what this means for dentists is that any dental staff who are in an employed position will be required to register with the ISA from 26 July 2010.

Self-employed dentists are not required to register but may voluntarily do so. In the long term it may become a requirement for any dental professional who is registered with the GDC to also be registered with the ISA.

Earnings Survey

On August 4, 2009 the NHS Information Centre released details of the earnings and expenses of General Dental Services (GDS) dentists in Northern Ireland in 2007/08. This is the first time that an overview of self-employed GDS dentists' earnings and expenses has been produced for Northern Ireland.

This statistical publication presents results based on anonymised tax data for dentists with an accounting year ending in 2007/08. As a first overview, this report has been labelled as *Experimental Statistics*, in keeping with the UK Statistics Authority's Code of Practice. Experimental Statistics are new, official statistics undergoing evaluation. They are published as such, to involve users and stakeholders in their development, and as a means to build in quality at an early stage. It is not meaningful to discuss the average earnings of an average dentist as there is great variation in the different financial arrangements. However, the key findings are given below.

- Average taxable income for Principal dentists was £121,174, compared to £66,134 for Associate dentists. For all dentists this figure was £89,756.
- Average expenses for Principal dentists were £190,053, compared to £37,462 for Associate dentists.
- Average gross earnings for Principal dentists were £311,227, compared to £103,595 for Associate dentists.

- The Expenses to Earnings Ratio (EER) for Principal dentists was 61.1%, compared to 36.2% for Associate dentists. The EER for all dentists was 53.4%. The EER is the proportion of gross earnings taken up by expenses.

The Report is published at:

<http://www.ic.nhs.uk/pubs/dentalearnexp0708ni>

The DHSSPS will continue to take part in the earnings survey and is working with the NHS Information Centre to further develop how the information is collected and refined. As part of next year's survey, the DHSSPS and BDA are participating in a survey of primary care dental practitioners to examine working patterns and this should hopefully inform the WTE figures of general dental practitioners in Northern Ireland.

In a separate piece of work, the DHSSPS has been gathering information to submit as evidence to the Doctors and Dentists Review Board. One area we have looked at is the trend in distribution of payments through the GDS for item of service, capitation & continuing care and block payments.

This is detailed in the table below, which outlines the shift in percentage terms from item of service payments to block payments over the last three years.

These percentages will change further in 2009/10, due to the increase to the commitment payment which will further increase the percentage paid through block payment.

	2006/07	2007/08	2008/09
Items of Service	65.6%	62.3%	58.3%
Capitation & Continuing Care	21.6%	21.0%	21.9%
Block Payments (allowances)	12.7%	16.8%	19.8%

RQIA Sedation report

In July 2000, the Department of Health published *A Conscious Decision. A Review of The Use Of General Anaesthesia And Conscious Sedation In Primary Dental Care*. It recommended that when a general anaesthetic is considered necessary for dental treatment, it should be carried out in a hospital setting where there is the immediate availability of a critical care facility. The report went on to say that

...conscious sedation should be available as an alternative to general anaesthesia but that high standards must be attained.

In Northern Ireland, as a result of *A Conscious Decision*, all general anaesthetics in general dental practice effectively ended on 31 December 2001. As a consequence, there has been a growing use of conscious sedation in Primary Dental Care settings.

The Regulation, Quality and Inspection Authority (RQIA) published the Review of intravenous sedation in general dental practice in May 2009. The review process had three key elements:

- Self assessment
- Pre-visit analysis
- Validation visits by a review team.

Based on CSA data, forty-one practices were identified as carrying out dental treatment under intravenous sedation at the time of the survey.

The RQIA review team visited a stratified random sample of 10 out of the 41 practices and reported on their findings. In most cases, areas for improvement were not serious enough to warrant major concern, however in two cases the review team felt that there were sufficient concerns to merit further action.

During the practice visits, most dentists told the review team that they were unclear as to what standard they had to reach in relation to IV sedation

Summary of recommendations:

1. As a matter of urgency the DHSSPS should develop Northern Ireland standards/guidance for the provision of conscious sedation in dental practice or make it clear to practitioners that another guidance document is taken as the expected standard.
2. DHSSPS/NIMDTA should carry out a review focusing on the availability, appropriateness and standardisation of intravenous sedation training.
3. Boards (HSC Board) must ensure that all dentists who carry out treatment using intravenous sedation are practising in line with the NPSA safety bulletin "Reducing the risk of overdose with Midazolam injection in adults".
4. Boards (HSC Board) should ensure that all practices carrying out treatment using intravenous sedation have training in dealing with medical emergencies. Practices should also have access to an appropriate range of emergency equipment including AED's.
5. Boards (HSC Board) should develop a specific inspection protocol for dental practices that treat patients using intravenous sedation and carry out a separate, specific inspection of these practices.
6. DHSSPS should implement a process for the regulation of private dentistry.
7. Consideration should be given to the formation of a *sedation peer group* perhaps through the peer review and clinical audit system.
8. Although not recognised as a speciality by the GDC, DHSSPS should consider under new contractual arrangements only awarding contracts for the provision of intravenous sedation to those practices that can demonstrate that they meet appropriate standards

The full report is available at

http://rqia.org.uk/publications/rqia_review_reports.cfm

Following receipt of the RQIA report, the DHSSPS asked the HSCB to follow up on the two dental practices where significant concerns were noted and this is being addressed by the HSCB. Furthermore, the DHSSPS requested that RQIA undertake inspections at all of the dental practices which carry out IV sedation.

During the practice visits, most dentists told the review team that they were unclear as to what standard they had to reach in relation to IV sedation. In relation to this point, the GDC clearly state in *Standards for Dental Professionals* that they expect dental professionals to follow the guidance set out in *Conscious Sedation In The Provision Of Dental Care, Standing Dental Advisory Committee, Department of Health 2003*.

In a parallel exercise, the DHSSPS issued a Rapid Response Report (RRR) on 31 December 2008 *Reducing risk of overdose with Midazolam injection in adults*. This report requested that, following NPSA advice, Medical Directors, Nursing Directors, Dental Directors, Primary Care Directors and Chief Pharmacists in HSC organisations working with relevant pharmacy, medical, nursing staff and primary health care practitioners, should:

- i. Ensure that the storage and use of high strength Midazolam (5mg/ml in 2ml and 10ml ampoules; or 2mg/ml in 5ml ampoules) is restricted to general anaesthesia, intensive care, palliative medicine and clinical areas/situations where its use has been formally risk assessed, for example, where syringe drivers are used;
- ii. Ensure that, in other clinical areas, storage and use of high strength Midazolam, is replaced with low strength Midazolam (1mg/ml in 2ml or 5ml ampoules);
- iii. Review therapeutic protocols to ensure that guidance on the use of Midazolam is clear and that the risks, particularly for the elderly or frail, are fully assessed;
- iv. Ensure that all healthcare practitioners involved directly or participating in sedation techniques have the necessary knowledge, skills and competences required;
- v. Ensure that stocks of flumazenil are available where Midazolam is used and that the use of flumazenil is regularly audited as a marker of excessive dosing of Midazolam;
- vi. ensure that sedation is covered by organisational policy and that overall responsibility is assigned to a senior clinician which, in most cases, will be an anaesthetist.

Hospital Workforce review

In the early part of this year, the Department undertook a review of the Hospital Dental Workforce, which followed on from the previous Dental Workforce review, published in 2006.

To assist in this review, an advisory group was convened comprising Dental professionals from each of the specialties listed below, the Acting Chief Dental Officer for DHSSPS and the Head of Workforce Planning Unit for DHSSPS.

A further dental review is scheduled for later this year so this work, carried out on the hospital workforce, will form part of the overall dental review.

The Hospital Dental Service in Northern Ireland comprises the following areas:

1. Restorative Dentistry
2. Paediatric Dentistry
3. Orthodontics
4. Oral and Maxillofacial Surgery (including Oral surgery)
5. Oral Medicine
6. Oral Pathology and Oral Microbiology

Each specialty was examined under the following headings:

- Current Clinical Service
- Future clinical service
- Current human resource
- Policy Drivers

A series of recommendations for each specialty are outlined in the report and the DHSSPS is working with the Trusts and QUB to implement these recommendations. An update on progress will be prepared for inclusion in the full Dental workforce review.

Dental Branch Annual Report

The 2008/09 Dental Branch Annual report is now available on the Dental Branch website at:

<http://www.dhsspsni.gov.uk/index/dental/dental-pubs.htm>

Osteonecrosis Associated with Bisphosphonate Usage: Advice for Health Care Professionals

Background

In December 2006, the DHSSPS issued a letter to Boards alerting them to the risk of osteonecrosis associated with bisphosphonate usage and providing advice as a result of a serious adverse incident received from the former WHSSB in November 2006. The Department's current position is to follow the advice of the MHRA advice for Healthcare professionals (*Drug Safety Update Vol. 1, Issue 3 October 2007*) which states:

- Dental examination, with appropriate preventive dentistry, should be considered before bisphosphonate treatment in patients with concomitant risk factors (e.g. cancer, chemotherapy, corticosteroids, and poor oral hygiene);
- During bisphosphonate treatment, patients with concomitant risk factors should avoid invasive dental procedures if possible. For patients who develop osteonecrosis of the jaw during bisphosphonate treatment, dental surgery may exacerbate the condition;
- Whether discontinuation of bisphosphonate treatment in patients who need dental procedures reduces the risk of osteonecrosis of the jaw is not known. Clinical judgment should guide the management of every patient on the basis of an individual benefit-risk assessment.

In order to address some of the practical problems encountered by clinicians with the current advice, in May 2008 the Department convened a group comprising dental, medical and pharmaceutical professionals to consider the issue further. The British Dental Association (BDA) and British Medical Association (BMA) were represented on this group.

Overall numbers of patients affected in Northern Ireland is low and consequently the response to the problem should be proportionate

Conclusions of the Group

- The problem of osteonecrosis associated with bisphosphonate therapy is not fully understood and is an evolving issue. The precise relationship between bisphosphonates, osteonecrosis and dental care will require further research.
- The current literature on the topic suggests that the likelihood of developing osteonecrosis associated with bisphosphonates is very low for patients on short term oral bisphosphonates, higher for patients on long term oral bisphosphonates and more so for those receiving intravenous bisphosphonates.
- The risk of developing osteonecrosis associated with bisphosphonates is much lower than the risk of developing bone fractures with their considerable morbidity and mortality should the bisphosphonate therapy be withheld, i.e. currently the benefit of bisphosphonates is considered to outweigh the risk associated with their use. However, the risks should be explained to patients before bisphosphonate therapy commences. Patients must also understand that they have a role in reducing the risk and take responsibility for this in respect of dental care.
- Bisphosphonates are incorporated into skeletal tissue without being degraded and persist in the skeletal tissue for many years. The risk of associated complications seems to increase with the increased time of bisphosphonate use for both oral and IV preparations. Thus the duration of effect of bisphosphonates extends well beyond the duration of treatment.
- Overall numbers of patients affected in Northern Ireland is low and consequently the response to the problem should be proportionate.
- Prevention of osteonecrosis is key. In this respect, elimination of comorbidities (e.g. poor oral hygiene, oral infections, and smoking) should, ideally, take place before, or shortly after bisphosphonate therapy begins and preventive oral care should be a priority for patients undergoing

bisphosphonate therapy.

- There appears to be some confusion and concern amongst prescribers and dental practitioners in relation to the management of patients who are about to commence, or are currently receiving, bisphosphonate therapy. Management of these patients appears to vary across Northern Ireland. In view of this, the group felt that some further advice would be helpful for health care professionals and patients.
- There is currently no consensus guidelines on how to manage patients who are currently on, or have previously been, prescribed bisphosphonates. The group would endeavour to develop guidelines. Any guidelines or advice issued by the DHSSPS would lack an evidence base and would be based on expert opinion. However, in the absence of any evidence-based guidelines, expert opinion is the best option. Any guidance issued should be consistent with the MHRA advice and would be superseded

should more robust guidance emerge from a recognised body.

The group has developed new guidance to assist medical, dental and other healthcare professionals in the management of patients undergoing bisphosphonate therapy. This guidance is based on expert opinion as there is currently insufficient information available for evidence-based guidelines to be issued. Health care professionals should therefore view the guidance in this context and, as with any guidance, final clinical opinion will be based on the assessed needs of the individual patient. Should more robust guidance emerge from a recognised body then the attached guidance will be revised.

The guidance was issued on 23 July 2009 and is available to download at:

http://www.dhsspsni.gov.uk/hsc_sqsd_54_09_osteonecrosis_associated_with_bisphosphonate_usage-2.pdf

Dental Nurse Funding

The DHSSPS has assumed responsibility for both the policy and funding of dental nurse training from June 2009.

Previously the Department of Employment and Learning (DEL) funded dental nurse training through the Higher and Further Education sector. In recent years, there has been much discussion around the type of dental nurse qualification which DEL was prepared to fund.

DEL had decided that it would only fund the NVQ in dental nurse training in the coming years as this qualification was the only one currently endorsed by Skills for Health.

The situation was further complicated by the GDC's mandatory requirement from July 2009

for dental nurses to hold a recognised qualification in order to come on to the register. This requirement changed the status of the dental nurse training and DEL felt it more appropriate that DHSSPS took over responsibility for dental nurse training.

Human Resources Directorate (HRD) within the DHSSPS has policy lead on all health care training and they are currently working with the colleges who deliver dental nurse training to agree the way forward for the coming years.

We will keep the profession updated on any further developments in dental nurse training.

Dental Standards

The *Minimum Standards for Dental Care and Treatment* will be published for consultation on the Dental Branch website in late 2009, having been approved by the Departmental Board on 19 June 2009.

The standards describe what patients can expect from private and Health Service dentists in a primary care setting. Their purpose is to ensure that patients receive consistently high quality care and treatment from primary care dental services in Northern Ireland.

In the future, RQIA will use these standards to regulate and inspect dental practices which provide private care, while the HSCB will use these standards to commission dental services of appropriate quality for Health Service patients. The delivery of dentistry in Northern Ireland will also be monitored against these standards by RQIA and the HSCB.

The standards have been established following a process which involved seeking the views and advice from a working group and a reference group to identify all standards in Primary Care. They have been adopted from the **Scottish Executive National Standards for Dentistry***

These standards seek to achieve a commonality of good dental practice for both Health Service and private dentistry driven from patient perceptions and expectations. They set out what can be expected of the people who provide dental services and they will be used to assess the performance of dental services in Northern Ireland. The standards do not deal with availability of Health Service dental services in Northern Ireland.

* *National Standards for Dental Services, NHS Quality Improvement Scotland (Scottish Executive), December 2006*

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There are 15 standards in total which are cross-referenced against the relevant quality theme from *The Quality Standards for Health and Social Care*.

Accessible, flexible and responsive services

- Standard 1 - Choosing your dental service
- Standard 2 - Before your appointment
- Standard 3 - Your visits

Safe and effective care

- Standard 4 - Assessing your needs
- Standard 8 - The quality of your care and treatment
- Standard 12 - Medical and other emergencies
- Standard 13 - Control of infection
- Standard 14 - Your care environment

Effective communication and information

- Standard 5 - Deciding and agreeing your care and treatment
- Standard 6 - Receiving your care and treatment
- Standard 9 - Expressing your views
- Standard 10 - Confidentiality and information about you

Promoting, protecting and improving health and social well being

- Standard 7 - Ongoing care
- Standard 15 - Children, young people and vulnerable adults

Corporate leadership and accountability

- Standard 11 - The dental team and service management