To refer or not refer – that is the question

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The NHS dental contract is designed primarily to provide the necessary treatment to secure a patient's oral health.

Whilst the contract takes different forms in England and Wales with UDAs being the metric of choice and Scotland and Northern Ireland retaining a fee per item remuneration model, the delivery of care is predicated on need rather than want.

Many practices have built success on 'mixed practices', that is the delivery of private care alongside NHS dental care to individual patients.

The rules around mixing in England and Wales are quite clear. A dentist may, with the consent of the patient, provide privately any part of a course of treatment (except sedation and general anaesthesia) but shall not, with a view to obtaining the agreement of a patient to undergo services privately:

- advise a patient that the services which are necessary in his case are not available from the contractor under the contract; or
- seek to mislead the patient about the quality of the services available under the contract.[1]

The GDC also make it a professional and ethical requirement not to mislead patients about the availability of treatment[2] and warn about not pressurising patients to accept private treatment that could be available on the NHS:

- 1.7 You must put patients' interests before your own or those of any colleague, business or organisation
- 1.7.3 You must not mislead patients into believing that treatments which are available on the NHS (or equivalent health service) can only be provided privately. If you work in a purely private practice, you should make sure that patients know this before they attend for treatment
- 1.7.4 If you work in a mixed practice, you must not pressurise patients into having private treatment if it is available to them under the NHS (or equivalent health service) and they would prefer to have it under the NHS (or equivalent health service).

And so we come to delivery of periodontal care by hygienists. From their training and experience and under their scope of practice they are the ideal members of the dental team to deliver this.

The business model operated by dental practice owners makes the provision of this service difficult to operate under the NHS since the hourly rate many hygienists command make it difficult to offer their services on the NHS. This is because most hygienists would like sufficient time to spend delivering their oral health messages, monitoring patient compliance and carrying out treatment. This is often a 30 minute appointment in which they have to carry out a range of hygiene services as well as infection control procedures before and after patients, unless they have the luxury of a dedicated nurse

So it seems it is difficult for practices to fund a hygienist on the NHS which is why the service is inevitably delivered under private contract.

And that is where the problems start especially when practice owners want the hygienists to be busy and for the service to be cost effective.

Associates are sometimes 'incentivised' to make the referrals by a small referral fee for each patient referred for treatment – fees of anything between £3 and £15 per patient.

Whilst this might on the face it appear a reasonable encouragement to associates to make a referral, the GDC has some concerns about the perceived ethics of this:

- 1.7.6 When you are referring patients to another member of the dental team, you must make sure that the referral is made in the patients' best interests rather than

for your own, or another team member's, financial gain or benefit.

The same applies to incentives or referrals by other practitioner for implants, perio referrals etc either internally or from local practices. Vouchers, bottles of wine or cakes count as 'benefit' for the purposes of referrals.

More problematic is when the referral to the hygienist for treatment under private contract when they are NHS patients.

The typical scenario is a patient is seen under the NHS for a check-up. A BPE is done and scores of 2s and 3s are noted. The patient is told about their gum problems and advised to see the hygienist. The patient accepts the recommendation of the dentist and makes the appointment. That's all fine until they ask at reception if they could see the hygienist on the NHS.

'No' they are told, the hygienist only works on a private basis.

That is of course factually correct if that is what happens at that particular practice but the patient has not been told that, as an NHS patient, they are entitled to have the treatment they need under the NHS and the hygienist is simply an alternative option they can chose to have. In England and Wales the patient is not registered as they are in Scotland but they are still deemed to be an NHS patient if they have had an NHS examination.

At best, the patient has been misinformed about their options, at its worst the dentist has been deliberately misleading or dishonest.

And now we are in the territory of professionalism and ethics and the GDC.

It can be reasonably argued that the patient has not given their consent for the hygienist treatment as they were not made aware of the alternatives. Confusingly for patients, fees to see the hygienist can be similar to NHS periodontal treatment charges so they might not always be alerted to the fact they are not being seen on the NHS.

Implicated in this, along with the dentist who may be an associate or Foundation dentist, is potentially the practice owner who may be said to either exert control over the working practice of the associate be incentivising the dentist with financial inducements to make the referrals.

How is it that dentists find themselves at odds with professional guidance in this matter?

When asked by patients why they should see the hygienist for the gum treatment they need they are sometimes offered reasons such as '*they can spend more time with you*', '*they can tailor the treatment to your particular needs*', '*they specialise in this and do it all the time*', '*they are better than dentists and they can do a better job than I can*' and so on.

The reality is that none of these reasons really stand up to even the most perfunctory of challenges.

Hygienists do provide an excellent service to patients and can be a real practice builder, supporting dentists in delivering high quality care on the solid foundations of healthy periodontal tissues.

When patients are made aware of their gum problems, via its manifestations of bleeding gums, bad breath and recession for example and they own their condition and the consequences with a process of co-diagnosis patients will readily take up offers to solve their problems once they understand the benefits. It is very much a matter of shared decision making[3] that engenders this trust between clinician and patients so that the patient can make an informed choice about what is the best form of treatment that effectively manages their gum condition.

The solution to this apparent impasse is that NHS patients should be making a deliberate choice to see the hygienist under private contract having been told by the treating dentist that the treatment they need is also available on the NHS at the practice.

To ensure there is no confusion, the offer of NHS and private hygiene treatment should be recorded in the notes and where the patient agrees to any form of care, an FP17DC estimate form should be completed

Information leaflets explaining the options patients have are also useful to demonstrate the transparent discussion that takes place.

Dental practices have also developed alternative business models where their hygienist service is provided under the NHS. In this case periodontal pathways[4] can be usefully established within the practice to determine the precise criteria for referral to the hygienist for periodontal treatment which would attract UDAs under Band 2[5] or periodontal fees in an item of service that operates in Scotland and Northern Ireland in accordance with the Statement of Dental remuneration (SDR). Whilst there are no stipulations about the number of visits or time intervals between appointments for periodontal treatment in England and Wales there are in Scotland and Northern Ireland.

In the end, many patients accept the advice and recommendations they are offered by the dentist and as long as there is no coercion, subterfuge or deception, practices and their teams should be safe to offer hygienist services under private contract without fear of breaching NHS regulations or ethical and professional guidelines. •

References

1. National Health Service (General Dental Services Contracts) Regulations 2005 Sched 3 Part 2 Para 10.
2. Standards for the Dental Team General Dental Council 2013 para 1.7.3.
3. Ryan F, Cunningham S. Shared decision making in healthcare *Fac Dent J* 2014; **3:** 124-126.
4. Providing Periodontal Care on the NHS in England and Wales. Available online at: http://reenawadia.com/perio-on-the-nhs/ (Accessed May 2017).
5. National Health Service (Dental Charges Regulations) 2005 Sched 2.