Tier 2 NHS services in primary dental care – where are the risks?

L. D'Cruz[1]

Key points

- Outlines what Tier 2 services are in primary care and how services will be commissioned through practices and accredited Tier 2 dentists.
- Suggests that the increase in referral from primary care has more to do with the 2006 NHS dental contract than any other factor.
- Suggests the unintended consequences of creating Tier 2 services will result in the deskilling of GDPs, increased referral of treatment that used to be carried out by GDPs and the creation of quasi-legal standards that will be exploited by claimants' lawyers to sue dentists.

NHS England and the Office of the Chief Dental Officer have set out plans for the accreditation of Tier 2 services in primary care, the first of which will be endodontics. This Opinion article examines the unintended consequences of the development of this service whose need has arisen for a number of reasons including the current UDA activity-based NHS dental contract, undergraduate training and the quality and quantity of endodontic services being delivered in primary dental care.

At the very same time that Health Education England are setting out their revolution[1,2] on how training and education for the future dental workforce might evolve, NHS England are quietly developing Tier 2 NHS services in various clinical disciplines. The intention is to accredit practitioners so that they can deliver NHS services that are not covered by GDS mandatory services via a referral service within a local managed clinical network (MCN).

First out of the blocks are the Level 2 accreditation specifications for oral surgery and endodontics.[3] Soon to follow are periodontics and prosthodontics. No one can quite say why these Tier 2 services are now required but we at least know that no more new money will be available to fund it and therefore funding will have to come from some other part of the dental budget. NHS London have started the ball rolling with the intention of commissioning care through a consultant led triage service going live in April 2019. The contract will sit with providers who will be tendering for the bid to deliver the Level 2 services with accredited practitioners delivering the services in premises that fulfil essential equipment criteria including operating microscopes for endodontics.

[1]General Dental Practitioner, Woodford Dental Care, UK
Correspondence to: Len D'Cruz
Email: lendcruz1@gmail.com

Refereed Paper. Accepted 8 May 2018
DOI: 10.1038/sj.bdj.2018.440

Essentially, a Level 1 practitioner in the NHS is a general dental practitioner who does the range and complexity of treatment expected of a foundation dentist who has just finished their year-long training. We can debate exactly how much they have learned in that year,[4] but that is the benchmark being used.

Then there are other treatments or individual teeth whose treatment would be considered more complex and these in the future would be the remit of Level 2 accredited practitioners. A list of those complexities are available and indeed in some form or other have been around for some time, except they have not previously been applied to commissioning primary care dental services in the way that is currently envisaged.

Why now and why at all?

This is a brave move and perhaps a laudable attempt to resolve an issue of increased referrals to secondary care of particular treatments and also to inject some equity back into how those referrals are dealt with by the recipients of those referrals from primary care.

Endodontics is notoriously complex and achieving high quality results in a general practice environment is not easy.[5,6] Attempting to raise standards is certainly a worthwhile endeavour though in a cash limited NHS system it is questionable to what extent this can be sustainably delivered using Tier 2 practitioners who cost more per case than GDPs.

Some might argue that the increased referrals have arisen out of the unintended consequences of the 2006 contract. The payment system, based on UDAs, has clearly influenced the behaviour of dentists[7] as this study suggests along with other qualitative reviews.[8] Opinion leaders have talked about the 'ridiculous expectations attached to UDAs by way of limitless amounts of treatment for the same fee'[9] and the manipulation of the NHS dental contract having 'corrupting effects on the behaviours of some members of the dental profession' (Figs 1 and 2).[10,11]

Dentists did not suddenly overnight in April 2006 lose their ability to carry out endodontics. They were simply disincentivised to do so by the system they were thrown into. Quite simply, dentist's clinical treatments have been influenced, unsurprisingly, by the method of remuneration on a grand scale. An ethicist might consider this unethical behaviour but might equally argue the system itself is poisoned and those that use it are not bad apples but the barrel itself is bad.[12] Commentators have suggested that simply tinkering with the

Official journal of the British Dental Association.

Fig. 1 Number of extractions vs year. Reproduced from McDonald R, Cheraghi-Sohi S, Tickle M *et al*. 2010. 'The Impact of Incentives on the Behaviour and Performance of Primary Care Professionals'. A Report for the National Institute for Health Research Delivery and Organisation Programme (SDO Project (08/1618/158), HMSO

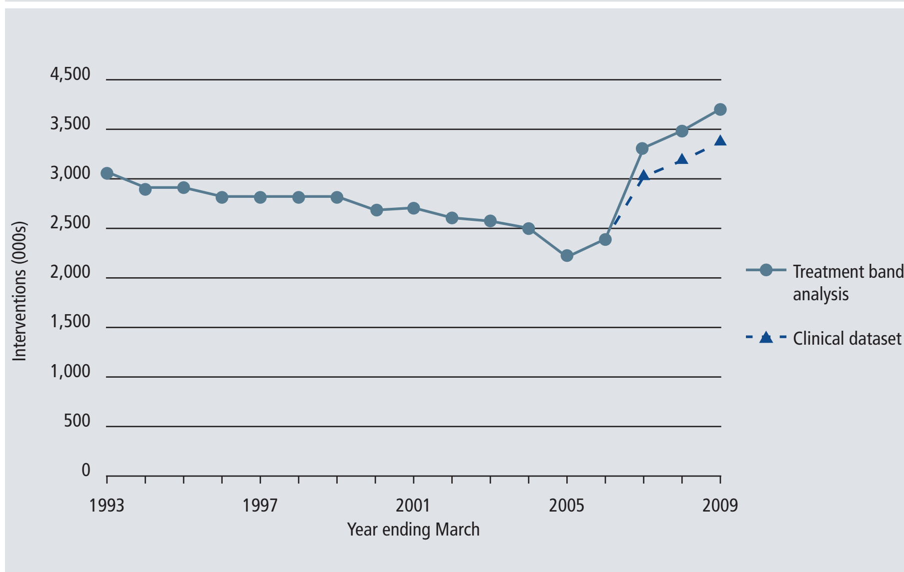
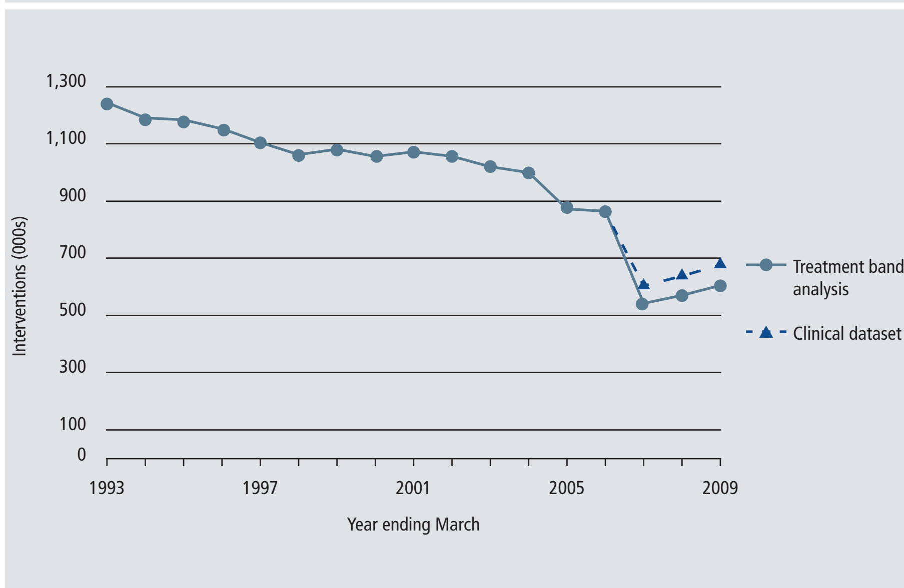


Fig. 2 Number of root fillings vs year. Reproduced from McDonald R, Cheraghi-Sohi S, Tickle M *et al*. 2010. 'The Impact of Incentives on the Behaviour and Performance of Primary Care Professionals'. A Report for the National Institute for Health Research Delivery and Organisation Programme (SDO Project (08/1618/158), HMSO



current UDA system, so it reflects both volume of treatment required for an individual patient and complexity, will deal with these perverse incentives. Others argue that the need for Tier 2 dentists has arisen out of the lack of experience of dental undergraduates entering vocational training with less technical ability and training than their predecessors. While this might be the case, it seems odd that the solution to this would be to encourage these very same practitioners to refer out to Tier 2 practitioners and avoid the challenge (and risks and rewards) of up-skilling themselves.

There are some other unintended consequences of creating Level 2 practitioners who provide these services under the NHS on referral. There is a disincentive for a GDP to do the complex treatments themselves. While there is nothing preventing the dentist providing the treatment, as they may well be doing now, because they have the skills, facilities, experience and love of doing it, albeit for three UDAs, that altruism may evaporate very quickly for economic and business reasons when a Level 2 accredited practitioner is getting paid more to do that same work. The inclination to refer would doubtless be very strong.

The alternative approach a GDP may take is to offer the complex treatment on a private basis. They may for example have an MSc or MClin Dent or be a registered specialist in one of the mono specialities. They could legitimately offer to provide the treatment under a private contract if the NHS does not commission services from them. Just because they can do it does not mean they should do it on the NHS if they have no NHS advanced mandatory contract to provide the service, or have not been accredited as a Tier 2 dentist.

Another unintended consequence might be that private patients would demand a referral to these services and arguably would be entitled to access them via an NHS referral system. Endodontists treating patients under private contract might find their work diverted to this new breed of dentist.

There is another more pernicious reason which might prompt a referral from the high street GDP. There is a danger that the criteria for referral, now part of the accreditation process, becomes the *de facto* limits on what a GDP should be doing on the NHS under a mandatory services contract. This becomes the extent to which a GDP would normally be expected to deliver their care and to stray beyond this creates a vulnerability that sharp-eyed personal injury lawyers may seek to exploit in the event that treatment does not go according to plan. The argument deployed by claimants' lawyers will be of the dentist not providing the standard expected by the patient who should have been offered a referral to the Level 2 or 3 practitioners and have failed to follow the guidelines.[13]

A regulatory lawyer in addition might argue that the Standard 7.2.22 had been breached: 'You should only deliver treatment and care if you are confident that you have had the necessary training and are competent to do so. If you are not confident to provide treatment, you must refer the patient to an appropriately trained colleague.'

When is anyone always and ever 'confident to provide treatment'? They will become increasingly less so as they gradually deskill consequent to their change of referral behaviour.

This defensive approach to treating patients cannot be good for the patient or the profession.[14,15]

Official journal of the British Dental Association.

This surely cannot be the intended purpose of creating Level 2 accredited practitioners delivering their service in the NHS. It will have the unintended consequence of increasing the numbers of referrals to the Level 2 practitioners way beyond what they can cope with within reasonable waiting times, currently being set at four weeks for the first appointment, and it creates other moral hazards along the way. By a circuitous route, an NHS definition of what is available under a mandatory service contract may emerge within particular clinical situations. Level 2 services can then legitimately be referred on the basis of complexity under the NHS or offered on a private basis. Chances are, if the patient trusts the dentist, they will probably accept the private treatment with their own dentist in a familiar practice and surroundings. It is hard not to feel that is what the Government want in the long term. Equally it is hard not to believe that the profession would have too many objections about this direction of travel either.

Looking at what treatment was provided under the NHS over the years in primary care would suggest that it was not a lack of skill or ability that triggered the changes we now see in referral patterns of oral surgery and endodontic procedures in particular, but periodontics as well. It might be the fear of litigation[16,17] of course, but it is probably just the current method of remuneration in the contract. Sort that out and I am not really convinced that we need Level 2 practitioners.

1. Ward P. Dentistry Jim: But not as we know it! *Br Dent J* 2018; **224:** 1.
2. Health Education England. Advancing Dental Care: Education and Training Review – Final Report. 2018. Available at https://www.hee.nhs.uk/sites/default/files/documents/advancing_dental_care_final.pdf (accessed June 2018).
3 Office of Chief Dental Officer England. Accreditation of Performers of Level 2 complexity care. OCDO, 2017.
4. Oxley C J, Dennick R, Batchelor P. The standard of newly qualified dental graduates-foundation trainer perceptions. *Br Dent J* **222:** 391–395.
5. Kirkevang L L, Horstad-Bindslev P, Orstavik D, Wenzel A P. Prevalence of apical periodontitis and frequency of root filled teeth in an urban Danish population. *Int Endod J* 2001; **34:** 198–205.
6. Dummer P M H. The quality of root canal treatment provided by general dental practitioners working within the general dental services of England and Wales. Part 2. Dental Profile. *J Dent Prac Board Eng Wales* 1998; **19:** 8–10.
7. McDonald R, Cheraghi-Sohi S, Tickle M *et al*. 'The Impact of Incentives on the Behaviour and Performance of Primary Care Professionals'. A Report for the National Institute for Health Research Delivery and Organisation Programme. (SDO Project (08/1618/158). HMSO, 2010.
8. Chestnutt I G, Davies L, Thomas D. Practitioners' perspectives and experiences of the new National Health Service dental contract. *Br Dent J* 2009; **206:** 1–7.
9. Ward P. Nihilistic dentistry. *Br Dent J* 2017; **222:** 405.
10. Kelleher M. State sponsored dental terrorism? *Br Dent J* 2017; **23:** 759-764
11. Milsom K M, Threlfall A, Pine K, Tickle M, Blinkhorn A.S, Kearney-Mitchell P. The introduction of the new dental contract in England – a baseline assessment. *Br Dent J* 2008; **204:** 59–62.
12. Trevino L, Youngblood S A. Bad apples in bad barrels: causal analysis of ethical decision making behaviour. *J App Pscychol* 1990; **75:** 378–385.
13. Samanta A, Samanta J, Gunn M. Legal considerations of clinical guidelines-will NICE make a difference. *J R Soc Med* 2003; **96:** 133–138.
14. Hancocks S. Defensive dentistry. *Br Dent J* 2014; **217:** 327.
15. Hellyer P, Radford D. An evaluation of defensive dentistry: w(h)ither the profession? *Br Dent J* 2017 **223:** 885-888.
16. Cabral M. NHS dentistry: culture of fear. *Br Dent J* 2018; **224:** 392–393.
17. Al Hassan A. Defensive dentistry and the young dentist – this isn't what we signed up for. *Br Dent J* 2017; **223:** 757–758.

Official journal of the British Dental Association.