Dental Advisers Yorkshire and the Humber - newsletter Xmas 15

This is a first attempt at collating and disseminating information that we feel may be useful to share.

Please let us know your thoughts on the newsletter and please let us know of any useful information for sharing by emailing: england.sybprimarycare@nhs.net

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NICE guidance: oral health promotion

NICE has published “Oral health promotion: general dental practice (NG30).” This guideline covers how general dental practice teams can convey advice about: oral hygiene and the use of fluoride; diet; smoking; smokeless tobacco and alcohol intake.

https://www.nice.org.uk/guidance/conditions-and-diseases/oral-and-dental-health

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Provision of Bite Raising Appliances:

This is the time of year when we think of tinsel and angels, snow and Santa, shepherds and kings….and UDAs.

It does seem that the last 3 months of the year sees a hike in BRAs for some practices where a potential UDA shortfall looms large. It also seems that patients who fall into exempt groups grind their teeth more than the rest of the population. There is also a tendency for single visit Band 3’s where the imp is taken for the BRA and its ‘Pick up from reception next week’

Without going into the Evidence Base for all of this (which is actually pretty weak) it could be said that the UDA tail is wagging the dog. Are all of these bite raisers really justified clinically?

We have been working closely with the Dental Services clinical advisers to see what should happen where a BRA is the treatment of choice……

A BRA is provided as part of a Band 3 course of treatment and NHS regulations require that the patient records should include a full, accurate and contemporaneous record of a comprehensive examination.

Dental Services expect to see:
Signs/symptoms - *appropriate investigations and special tests (including study models where appropriate)*
Diagnosis - *justification to treat or monitor or refer,*
Treatment plan *- record of impressions and bite registration,*
Fitting of appliance *- with instructions and advice to the patient,*
Follow-up appointment *- to review the patient's symptoms and to provide any adjustment to the appliance,*
Any further advice *- a recall interval appropriate to the diagnosis and the provision of any other treatment required as a result of the examination…….*hardly a single visit then?

An absolute minimum of 3 visits would be required before a claim would be submitted.
E.g. (1) Exam diagnosis and impression…….. (2) Fit…… (3) Review.

Helpful check list to ensure you're doing it right:

- Full examination recorded with a record of signs and symptoms and conversation with the patient about the TMJ issue or the bruxism tendency
- Appropriate investigations which may include x-rays to exclude other pathology
- Diagnosis and Treatment Plan including consent, FP17DC, justification to treat and monitor or refer
- Record of impressions/bite registration - lab ticket in notes
- A second visit for the fitting of appliance with indication of robust instructions and advice as to wear and care
- Follow up appointment to review symptoms, provide adjustments and give further advice
- A recall interval appropriate to the diagnosis and treatment provided

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Inlays – why we do them with some EB Dentistry

The provision of an indirect restoration is more destructive to tooth tissue than a direct restoration and is normally irreversible; you cannot easily go back to a direct restoration once an indirect restoration has failed. So we need positive clinical reasons for prescribing this approach - a direct restoration should be the default restoration in the absence of compelling clinical reasons for prescribing an indirect restoration.

Direct or indirect restorative dentistry: Waning A, Dental Update, January 2011

The suitability of the patient/tooth and prognosis for the restoration should be fully assessed before any restoration is provided, particularly in the case of these expensive restorations. This should include assessment of the size and position of the cavity in relation to the pulp chamber and the presence of apical pathology. The availability of a diagnostic periapical radiograph would normally be expected to assist in this assessment.

FGDP (UK) Good Practice Guidelines: Selection Criteria for Dental Radiology.

So as a guide as to the rationale for inlay provision -

A Not really a sound approach but what we see in some occasions:

- Inlay Patient is exempt
- Only one inlay ever needed in any single patient at a time
- Practice is short of UDAs or have a large no of UDAs to deliver towards year end
- The local lab is doing a deal or have to justify the inlay machine I've bought

B What should be the rationale to justify:

- Loss of tooth substance which necessitates cuspal coverage in restoring (Though modern bonding techniques/materials could address this issue)
- In cases where a rest seat for a Chrome denture is required
- A radiograph of tooth is normally required
- Tooth should be asymptomatic
  Bottom line: Can you justify the further tooth tissue loss?

Repeated failure of inlay and multipler e-cementing/remaking sort of begs the question – practices need to audit this as part of best practise.

So the questions that should be posed:

- Has the patient/tooth been assessed comprehensively?
- Was the examination thorough? Had the periodontal status, patients risk of developing dental disease, tooth vitality status, bitewings been assessed?
- If you provide inlays but never take bitewings and a patients develops interproximal decay , this can leave you vulnerable
- Was the tooth recently symptomatic? Can you be assured of continued tooth vitality in the short term?
- Have you considered the provision of a bonded direct restoration before the provision of the inlay?
- Why have you planned an inlay for one tooth and yet a direct restoration at another tooth which demonstrated similar clinical signs or symptoms.

Be aware that Dental Services will also look at the pattern of provision on the basis of:

- "If inlays are such a good option how come you only ever do one per course of treatment (COTs)?"
- "Does the patient then go on to have multiple Inlays in subsequent CoTs?"
- "Why does the profile show that the inlays are provided almost exclusively on exempt patients?"

Fluoride Trays for kids

Some of us struggle to understand the high numbers of Band 3's that are claimed on children for some practices.

Some of these have turned out to be fluoride trays provided for children. Not sure where that is referred to in Delivering Better Oral health.

Duraphat varnish (other high F preps are available) seems to be the best route for introducing F. We have checked with dental services and whilst an F tray would involve a lab bill it is not a Band 3 treatment.

If it is something that is provided it comes under prevention and is in fact part of a Band 1.
If you are doing these, then a Band 1 should be claimed.

Urgent Claims and Denture eases

Urgent claims for denture eases following a fit of a recently fitted denture

Q. Patient has a denture made and returns to same dentist after 3 months for an adjustment to the denture. What is the charge to patient and the UDAs to dentist? What if patient returns after 1 month / 6 months?

A. If the ease is required soon after the denture has been fitted this would be considered part of that treatment and no further patient charge or UDAs are appropriate. If the patient returns after a greater length of time urgent treatment under band 1 charge and 1.2 UDAs would be appropriate. The decision regarding time frames is at the discretion of the dentist. However, the NHSBSA will look at the frequency of all activity under the contract and where activity is unusual the contractor may be asked to provide an explanation regarding treatment.

Since the start of the contract the BSA have advised that until the appliance has achieved satisfactory fit and function then adjustments made to achieve fit and function are part of the original CoT, and therefore included in the original band. Therefore if a patient develops a sore spot say 12 weeks after fitting with no other problem in the meantime, it would probably be appropriate to claim a B1U. If the same patient had been back once every week then this would be part of the original CoT as fit and function had not been achieved. The contract requires both parties to act reasonably- claiming repeatedly for easing of dentures within 2 or 3 weeks of completion would not be acting reasonably. Basically the adjustment of a recently fitted denture would be seen as normal follow-on care, part of the original CoT unless there were extenuating circumstances.

♬ "Christmas (opening) time, Mistletoe and Wine" ♬

Just a little reminder……. (Letter sent in September)
Common sense seems to have prevailed. Practices can make provision sensibly.

Dear Provider ***30 September 2015***

Re: Christmas and New Year Arrangements 2015

As you are aware the NHS faces increasing pressure, particularly over the Christmas period but we are aware that the demand for routine dental care is low. We are therefore contacting you to ascertain if your practice will be open for the period between Christmas and New Year 2015 and what arrangements are being made to manage demand for urgent dental care.

We appreciate that practices may wish to close early or indeed shut during this period. However if you are planning to stay open less than your contracted opening hours during the Christmas and New Year period NHS England would like to ensure there are suitable alternative arrangements being made for patients.

As a minimum

- ***Buddying arrangements must be with a NHS Contracted dental surgery who will provide emergency appointments on your behalf;***
- ***A dedicated emergency mobile phone number may be used for patients to access emergency care and or advice during normal in hours;***
- ***Answerphones should be set to reflect the arrangement and notification of changes should be clearly displayed on the door of the practice;***
- ***A Practice should not state that it will be closed with no alternative arrangements in place or redirect patients to the OOH service in hours and is deemed to be in breach of its contract if no alternative arrangements are made, or if the patients are being directed to OOH or 111 in hours***
- ***A Practice must not state that it will be closed with no alternative arrangement in place. It must not redirect patients to the OOH service during contracted hours, nor refer patients to NHS 111. To do so would be considered a breach of its contract.***
- ***A Practice should ensure that arrangements for cover do not disadvantage the patient who is undergoing an open course of treatment (i.e. through patient charges);***

Access to Dental Care of People Living with HIV Report – Leeds Healthwatch

Leeds Healthwatch sought the views of local residents with HIV regarding their experiences of accessing local dental services. The survey was carried out between November and December 2014 and the final report was shared with stakeholders including NHS England, Public Health England, Leeds Local Dental Committee (LDC) and Leeds Dental School in July 2015.

The full report can be accessed at the following link:

http://www.healthwatchleeds.co.uk/sites/default/files/uploads/HIV_and_Dentistry_report_new_DH.pdf

The report was discussed at the West Yorkshire Local Dental Network (LDN) meeting in July. Members recognised that the majority of people living with HIV, who are well, should be able to access primary dental care without restriction or modification to their dental treatment. It was noted that the issues raised were also associated with managing the dental care of people living with blood borne viruses (BBVs) and was of relevance to all dental teams across Yorkshire and the Humber.

The following actions have been agreed:

- The Dental Public Health Team to lead on developing an e-learning resource and a dental team fact sheet to support the management of patients with blood borne viruses including HIV.
- Health Education Yorkshire and the Humber to commission PHE to develop and deliver dental team training sessions during 2016/17.
- NHS England and PHE to attend a Leeds Healthwatch stakeholder workshop on 25 January 2016 to discuss the issues raised in the report and the actions required.
- Chair of Leeds LDC to liaise with Leeds Centre for Sexual Health and Leeds BHA Skyline with a view to hosting a training event for local dental teams, potentially extending this to teams across West Yorkshire.

HPVACTION.ORG

Jabs for the Boys …….

November is behind us now as are all the moustaches and Mouth Cancer Awareness month
Peter Baker of the BDHF spoke passionately in the House of Commons in support of vaccinating not just girls but boys too against HP virus…….as in Australia, Austria, USA Canada Israel, Switzerland, Italy, Germany……..

Please go to the website and give your support www.hpvaction.org

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January Campaigns

National Obesity Awareness Week and Dry January

There are two important national public health campaigns in January that are relevant to oral health.

National Obesity Awareness Week

National Obesity Awareness Week runs from 11 to 17 January 2016 and is a good opportunity to inform patients of the recent guidance to reduce sugar consumption to 5% of daily dietary energy intake as part of a healthy diet.

Sugar should be no more than 5% of daily calories

The Scientific Advisory Committee on Nutrition (SACN) recently published a report on the evidence linking consumption of carbohydrates, sugars, starch and fibre and a range of health outcomes including dental caries.

It found that high levels of sugar consumption are associated with:

- A greater risk of tooth decay
- A greater risk of high energy intake

and that:

- High-sugar beverages result in weight gain and increase in BMI in teenagers and children
- High-sugar beverages increases the risk of developing type 2 diabetes

It recommended free sugars should account for no more than 5% of daily dietary energy intake and the consumption of sugar-sweetened beverages (e.g. fizzy drinks, soft drinks and squash) should be minimised by both children and adults.

The full report can be found at:
https://www.gov.uk/government/publications/sacn-carbohydrates-and-health-report

An explanation of the SACN recommendations about sugar and health and changes in dietary habits needed to reduce consumption of free sugars to 5% of dietary energy are described in *Why 5%* available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/446010/Why_5__-_The_Science_Behind_SACN.pdf

The SACN recommendations have been accepted by the government and the areas for action are published in *Sugar reduction: The evidence for action* available at:
https://www.gov.uk/government/publications/sugar-reduction-from-evidence-into-action

Terminology

The term ‘free sugars’ replaces the terms Non Milk Extrinsic Sugars (NMES) and added sugars. Free sugars are those added to food or those naturally present in honey, syrups and unsweetened fruit juices but exclude lactose in milk and milk products.

Dental caries link to obesity

A recent report on the relationship between dental caries and obesity in children found evidence of a weak to moderate relationship between dental caries and obesity prevalence at age five years. However, it is not currently known if this relationship exists in older children.

High intakes of free sugars are known risk factors for dental caries and obesity. Interventions that reduce the intake of free sugars have the potential to reduce their impact on both dental caries and obesity.

The report can be found at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/466334/Caries_obesity_Evidence_SummaryOCT2015FINAL.pdf

The National Obesity Forum has a website dedicated to National Obesity Awareness Week *Do something good for jan-**U**-ary* with advice on what *you* can do, such as recipe and exercise tips:
http://www.jan-u-ary.co.uk/about/

Dry January

You're all probably aware of the national *Dry January* campaign designed to support people reduce their alcohol intake. The aim of this campaign is to encourage people, including the dental team and your patients to experience a month without alcohol or to reduce consumption. You can sign up at http://www.dryjanuary.org.uk/ for support.

As well as signing up to the campaign, dental practices can take practical steps to participate in *Dry January* including appointing a *Dry January* champion, having a non-alcoholic work social, having promotional materials in the practice, talking with patients, as well as brief intervention and signposting people that need more help.

Delivering Better Oral Health, an evidence based toolkit for prevention – 3rd edition gives dental professionals advice on how to support their patients to reduce alcohol intake by giving brief interventions and signposting to appropriate services. It also includes tools that can be used to assess alcohol consumption such as the AUDIT C tool.

Where is Santa??? http://www.noradsanta.org/

Just a bit of fun for the children really but the age of the child is undetermined:

In 1955, an advertisement told children how they can phone Santa to see where he was on his travels; unfortunately they listed the wrong number and It gave out the highly sensitive* North American Aerospace Defence Command (NORAD) number by mistake!!

NORAD's Colonel Harry Shoup instructed his staff to answer calls with an update on Father Christmas's current position. Since then with IT progress the NORAD tracker has become more advanced and follows Father Christmas on his journey this month.

The service has its own Facebook, Twitter and YouTube accounts.

https://www.facebook.com/noradsanta/

https://twitter.com/NoradSanta

https://www.youtube.com/user/NORADTracksSanta

Or simply google NORAD to discover the hype.

(*NORAD was established during the Cold War fulfilling a homeland defence role by monitoring aerospace to identify and intercept threats approaching Canada and the USA….. Russian jets etc.)

Final thought….

From all the LPN Chairs Y&H, Dental Advisors and Public Health Team