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The conversion of need into demand

Prevention

A workable NHS dental system

The meeting concluded that the current NHS system does not reward prevention and is ill-suited to convert need into demand. The banding system is inadequate and creates perverse incentives.

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The Dental Stakeholder Group is based on the right of dental professionals to be heard on an equal basis. Unless specifically stated, all views are those of the contributors.

Dental Summit 2007

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About This Publication

This publication reflects the proceedings at the Dental Summit organised by 2020health.org and the Dental Stakeholders' Group (DSG) on April 26th 2007 in the Grand Committee Room, House of Commons. The event was chaired by Dr Andrew Murrison MP. A recording was made of the proceedings, from which a transcript was produced. It was agreed in advance that the three main speakers would have their speeches attributed, but otherwise the discussion would be under Chatham House Rules. Comments on the proceedings were invited from interested parties and these follow the transcript of proceedings.

2020health.org and the Dental Stakeholders' Group have not altered the text apart from minor adjustments for repetition, typographical and grammatical errors and formatting in order to produce a presentable report.

2020health.org is very grateful to the Chairman of the DSG, Derek Watson, for all his support in bringing the Summit together, and to the sponsors for enabling this event to take place. We are indebted to all sponsors for their funding, on which we depend. As well as enabling our ongoing work of involving frontline professionals in policy ideas and development, sponsorship enables us communicate with and involve officials and policy makers in the work that we do. Involvement in the work of 2020health.org is never conditional on being a sponsor.

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Synopsis And Questions For Further Debate

This is a summary of the main points made by the invited speakers and participants. It is not intended to be a comprehensive or detailed commentary on the new dental contract, although as every section of the dental profession was represented at the Summit, it should reflect the majority of grass roots opinion. It is hoped that it will stimulate discussion of the issues raised.

A brief background section has been added for the benefit of readers outside the dental profession who have an interest in healthcare policy.

The final section concerns the future of dental services and a number of questions are posed on key issues raised in this Summit. 2020health.org and the Dental Stakeholders' Group believe that the views of the grass roots members have a vital role to play in helping to formulate future healthcare policy. Readers are therefore invited to post their comments on the 2020health.org website. These will be collated by 2020health, passed onto the member organisations of the Dental Stakeholders' Group and will form the basis of a future dental summit designed to take the process forward in reforming the current system.

Background

- 1 The Prime Minister, Tony Blair pledged in 1999 at the Labour Party Conference that everyone would have access to NHS dentistry within two years.
- 2 'NHS dentistry' is not free at the point of delivery. It requires patients to contribute a co-payment of approximately 80% towards the cost of their treatment. Children, pregnant women and those on benefits are exempt. Private treatment is not constrained by issues of time, quality of materials or laboratory work. In general, the cost of private treatment is two to three times more expensive than that on the NHS.
- 3 £1.8 billion was spent on NHS dentistry in England in 2006 - 2007 and is now matched by the amount spent on private dentistry.
- 4 Figures issued by the Department of Health indicated that in England only 51.5% of adults and 70.5% of children had been seen by an NHS dentist in the previous 24 months as at the 31st December, 2006.
- 5 The new dental contract was introduced on the 1st April 2006 and was designed to end the 'drill and fill' treadmill mode of service.

The main features were:

- i) The budget for NHS dentistry was passed to the Primary Care Trusts who have a statutory duty to provide NHS dental services. This budget is capped and based on historical activity.

- ii) Simplification of the payment system (from the previous approximately 400 separate payments) into three price bands; patients are charged a standard fee for a course of treatment within a particular band, for example,

Band 1	examination, x-ray and scale and polish (if necessary)	£15.90
Band 2	one to six fillings, root canal work	£43.60
Band 3	crowns, dentures, bridge work	£194

- iii) Introduction of the Unit of Dental Activity (UDA)

Courses of dental treatment earn UDAs, which are then used to monitor and compare service levels, and set targets. It is the main contract currency for General Dental Services (GDS) contracts and Personal Dental Services (PDS) agreements. All NHS dentists or dental practices have a contract with a Primary Care Trust (PCT) which specifies how much treatment, measured in UDAs, they must perform. Contracts are guaranteed for three years and worth at least the value of previous NHS earnings, but with a 5% reduction in the courses of treatment that have to be carried out.

Summary of summit discussion

Although some systems were piloted leading up to April 2006, the new contract itself had not been piloted and did not have the support of the dental profession. Problems associated with the new contract are as follows:

1 Patients

No improvement in patient access to dental services

A BDA Survey of dentists indicated that 85% of dentists did not think that the new contract had improved patient access to dental services. This is supported by a report from the National Association of Citizens Advice Bureaux which revealed that 77% of the 4000 respondents to their survey could not find an NHS dentist who would accept them.

Less transparency in costs to the patient

The banding system was designed to simplify the payment system for patients. Evidence from dental help lines has indicated that patients understand the new system better, but overall it has not worked in their interest as they have ended up 'paying more for less'.

The new contract has resulted in a perverse system of charges for the patients and perverse incentives for the dentists (the fewer and simpler items of service provided within a treatment band, the greater the income).

Synopsis And Questions For Further Debate

For example, patients pay the same fee (Band 3 - £194) for a simple plastic denture as for a very complex metal-based one. However the laboratory fee is only about £35 - £40 for the simple denture and for this particular item the patient would be better off financially, having their denture made privately rather than on the NHS. This is not always clear to patients.

Limited access to complex treatments

The banding system discourages the dentist from offering complex treatments on the NHS. Consequently access to complex treatments on the NHS has become more limited to the detriment not only of patients, but also dental laboratories (see below). In effect the new contract has led to a subtle form of rationing by dentists.

Impaired continuity of care

Most dentists believe the new contract has impaired continuity of care.

2 Dentists

Loss of NHS dentists

Approximately 1,650 dentists left the NHS on the 31st March, 2006.

No incentives for prevention

The UDA system fails to incentivise prevention.

Perverse incentives favouring fewer and simpler treatments

As described under 'patients' above

Contractual underperformance

A survey has found one PCT in which 30% of dental performers are at least 25% behind in the pro-rata delivery of their UDAs for up to the third quarter of the first year. Pressure on dentists resulting from attempts to catch up in year two or due to a reduction in remuneration under some form of clawback may affect their ability to put aside time for rational discussions with the PCTs.

Lack of detailed performance statistics

The Department of Health now only monitors the number of UDAs delivered; it no longer collects and publishes data on the specific treatments that are being offered. This makes it very difficult to determine the changes that have occurred in the delivery of various items of treatments since the new contract was introduced.

3 Dental Laboratories

Reduction in NHS work and job losses

Laboratories have seen severe cuts in the amount of work being performed under the NHS. Dentures have decreased by around 63%, chrome work down by almost 80% and an 84% reduction in bridgework compared to this time last year. Consequently over 500 technicians have lost their jobs over the last 12 months and the majority of laboratories are now reliant on private work (which has increased by 12%) to survive.

4 Dental team

The extended roles of team members should be encouraged within a practice such as in the delivery of prevention.

i) Dental nurses

No recognition of preventive work, funding of education, access to NHS Pension Scheme.

Dental nurses are a valuable resource and play an important role in encouraging prevention and smoking cessation. Community work includes visiting scout and guide groups, schools (interest in prevention by parents may follow), colleges and care homes.

However under the new contract there is no recognition of preventive work undertaken by nurses, neither is there any funding for dental nurse education. Many have to pay for it themselves (not helped by their low pay) or employers are expected to fund it. Much of it has to take place outside practice hours in the evenings.

Dental nurses cannot join the NHS Pension Scheme.

ii) Receptionists and practice managers

Receptionists and managers are on the 'front line' and may experience the whip end of people's frustrations and concerns with the new arrangements.

Synopsis And Questions For Further Debate

5 Primary Care Trusts (PCTs)

Deficit in PCT dental budget

£58 million has been identified up to the end of the third quarter. It has been speculated that this may be due to exempt patients accessing NHS dentistry or that some of those who pay the 80% co-payment are either not seeking or able to access treatment or are choosing the private sector.

Patient charge revenue is devolved to PCTs as a necessary part of their budget. It is known that some have instructed practitioners in ways of working to raise the patient charge revenue

Accountability

No mechanisms currently exist to hold PCTs accountable for matters such as deficits in the provision of services or long waiting lists.

The Future

Service Planning

i) **Converting 'Need' into 'Demand' – Flexible services**

'Need' refers to patients with very poor oral health who have need of a dentist, but are reluctant to seek treatment. 'Demand' on the other hand refers to patients who are very keen to go to the dentist, but tend not to have much work done.

In Derek Watson's practice, the peak ages of patient attendance was mid-teens and mid-50s. The oral health of the 'missing' age group, 18 – 35 was of the most concern.

Flexibility is thus crucial in attempting to incentivise the 'needy' to attend, and consideration must be given to the type of service they want rather than what the profession thinks is best for them (see Dentaline below), and to alternatives to the traditional nine-to-five course of treatment model, such as the after-work or even the after-the-pub model.

ii) **Recognition of the type of service required by patients**

DentaLine, which at one time operated in Kent, only provided an out-of-hours emergency service, but was phenomenally successful, although few patients subsequently registered with a dentist for follow-up work as was originally intended.

iii) **Business risk and NHS dentistry**

Dentists are self-employed, small business people who may sub-contract from the NHS. The Government and PCTs must therefore understand the business risks associated with a particular NHS dental scheme if dentists are to be persuaded to work within it or to set up practice in a particular location.

Revision of the banding system

The DPA supports an increase in the number of bands in the short to medium term.

Due to the wide range of treatments within each band there are disincentives to carry out the treatments at the top end of each band (identified by DPA). One proposition is to increase the total number of bands to five by splitting bands 2 and 3 into 2a and 2b, 3a and 3b respectively. Patients would still only pay a fixed band 2 or 3 fee. Overall it would be cost neutral. This would help to remove the disincentives to do certain types of extensive treatment.

Prevention

There should be recognition of preventive work through the UDA system.

It was acknowledged that schemes outside the NHS have successfully incorporated prevention. The question was how could something similar be incorporated into NHS dentistry.

A registration and capitation scheme would incentivise prevention.

Nigel Carter from the British Dental Health Foundation is working on a prevention manual that is going to be distributed to all primary dental care practitioners. This may give PCTs some guidance in judging what should be delivered in terms of oral health education in practice.

Change in dental funding by PCTs in 2009

The current ring fencing of funding for dental treatments will end in 2009. It is not known what the new financial arrangements will be with PCTs. It is therefore vital to develop relationships with PCTs in order to emphasize the importance of prevention and influence future funding decisions.

Registration and capitation system

A similar system to that of General Medical Practitioners was proposed by one participant. This would allow for continuity of care and encourage preventive work.

It was noted that under the capitation scheme in PDS, dentists stopped undertaking complex treatments. Furthermore there is a tendency for under-prescription of treatment. Mechanisms to prevent these would therefore need to be developed.

Synopsis And Questions For Further Debate

Mixed economy schemes and patient choice

A mixed economy scheme is supported by the DPA which believes that this is exactly what the patients want. Informed patient choice with cost and quality transparency would drive the type of service provided. Laboratories could be paid directly by the patients.

Under the old system it was not possible to mix NHS and private items within a particular course of treatment. Unfortunately under the new system it has become even more difficult to operate a mixed economy.

Longer term dental funding and NHS core services

Improvement of the nation's oral health relies on properly funded dentistry.

At present the standard and extent of NHS treatment offered to a patient is largely determined by what the dentist feels he/she can provide within the current structure. However rising treatment costs and a limited pot of public money will lead in the longer term to fewer variations in the provision but a lower overall level of care throughout the country. Politicians will be faced with having to define minimum levels of care that all the public can access under the NHS with the available funding. The cost of all other treatments would have to be paid for, in full, by the patient or through a private insurance scheme. NHS core services would therefore need to be identified. Should they be limited?

A grant-in-aid system where there is co-payment between the patients and the government into the private sector could be looked at to help patients pay for their treatment.

Standards

A role for NICE was proposed in setting national standards in preventive oral health. This would provide benchmarks for PCTs to work towards. However it was recognised that no real measure of oral health currently exists, may be impossible to quantify and there is no agreement on what levels of oral health the population should have.

The Healthcare Commission was suggested as a body which could investigate adequacy of NHS provision by PCTs and unity of service provision across the country.

Access to NHS pension scheme

Dental nurses should have access to the NHS Pension Scheme.



Synopsis And Questions For Further Debate

Key Questions

These questions relate to the main issues raised in the Summit. Please submit your views on these or any other relevant issues to Julia@2020health.org.

1 Improving and encouraging patient access to dental services

- 1a What type of dental service do the public really want as opposed to what the profession think they should have?
- 1b The peak ages of patient attendance are mid-teens and mid-50s. How can the 'missing' age group 18 – 35 be targeted to attend?

2 Improvements in the current contract

- 2a How can dentists be attracted back into the NHS?
- 2b How should the banding system be revised or should it be replaced by another system?
- 2c How can the current contract be revised to incentivise prevention?
- 2d How can funding of continuing professional development of members of the dental team be factored into the contract?
- 2e Should dental nurses have access to the NHS Pension Scheme?

3 Improving transparency and patient choice

- 3a How can transparency be improved in terms of the range, quality and costs of available treatments?
- 3b Would direct payment by the patients to the laboratories be helpful in this respect?

4 Oral health standards

- 4a What are acceptable levels of oral health for the population?
- 4b How can oral health be measured?

5 PCT Accountability

- 5a How should PCTs be made accountable for the services they provide?

6 Alternative models of dental service delivery and funding

- 6a Would a registration or capitation system be an improvement?
- 6b Should only core services be available on the NHS? If so what would constitute such services? Should they be limited to emergency provision only?
- 6c How could a mixed-economy system be implemented?
- 6d Is there a role for a mixed funding system (for example, core service provision by the NHS, private dental plan (? compulsory) for all other treatments)? Would this guarantee access to a dentist, improve access to complex treatments, facilitate continuity of care and encourage regular attendance?
- 6e Are there lessons to be learnt on provision from the optical and community pharmaceutical services?

For further information please visit www.2020health.org



Executive Summary

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Prevention

A workable NHS dental system

The meeting concluded that the current NHS system does not reward prevention and is ill-suited to convert need into demand. The banding system is inadequate and creates perverse incentives.

Many dental care professionals feel isolated and excluded (for example from the NHS pension scheme). Decisions are taken in an arbitrary fashion and there is a lack of meaningful consultation with the professions.

The group suggested many improvements to the system, including greater transparency in charging and an expansion of the banding system and felt that some changes must be made to the current system in the short term to safeguard patients' interests.

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Welcome & Introduction

Dr Andrew Murrison MP

Introduction

Good morning. What the man in this chair usually says here is ‘Order! Order!’ and I have been wanting to say that for the last six years since I have been a member of parliament, so I will do it now. I am Andrew Murrison, the MP for Westbury and am a shadow Health Minister. I have been asked to chair this morning’s meeting. It is really good to see so many people here and it is a really good representative gathering. What I hope we will do today is get as wide a range of opinions in the short space of time available to us to inform our deliberations. Certainly, policy makers, and that is what this place does, will be listening to the views of healthcare professionals. I hope they will and certainly the opposition will, and is, in the run-up to the next general election, which is probably two years off and for which all the main political parties will want fairly copper-bottomed proposals on how we might go forward with NHS dentistry.

The Prime Minister’s Pledge

I think I will start with the words of the Prime Minister, just to set the scene, because we will all remember in 1999 we were told that everyone would have access to NHS dentistry within two years. I will just read what he said in the House of Commons yesterday in response to a parliamentary question. He said, and this was to do with access to NHS dentistry, ‘it is and has been a real problem and I entirely accept that. The reason is very simple. Even though we have increased the number of NHS dentists, we cannot stop dentists going outside the NHS if they wish to do so. They are entitled to do so and despite the fact that we are paying dentists far more and hiring far more of them in the NHS, we have not been able to fulfil that pledge. The majority of people can access an NHS dentist in their area if they want to do so, but the figure is not 100 per cent. I accept that. Ultimately, that will be dealt with only by increasing still further the number of NHS dentists and that is what we intend to do.’ So, that is the Prime Minister, probably in his last weeks of office reflecting upon one of the pledges he made in 1999. A remarkable pledge at the time; we all sat up and listened when he made that pledge and welcomed it, but I am afraid that the reality, which I think we will all accept, and indeed the Prime Minister accepts, has been very different. The question is what we do about that.

The new regulations and their supporting measures were introduced on 1 April 2006. The chief objections that many of us had at the time were a lack of piloting of UDAs, a failure to incentivise prevention, contrary to the specific requirements of Options for Change published in 2002, and a failure to talk to the people that are represented here today. In contrast at that time, I recall that PDS pilots were going quite well; 30 per cent of dentists had moved voluntarily to them. I would have to say for my particular organisation this morning, it being non-partisan, is that we have recommended a system based on registration and capitation. We have felt that it would incentivise prevention in a way that is uniquely available to dental practice among all of the clinical disciplines. I think the idea that perhaps if we can incentivise good oral health that will increase value in practices and therefore, dentists will be very keen to do it and will programme it into what they do. I cannot think of any other area of clinical practice where that potential exists in the quite the same way.

We are one year on into the contract. I think we have to take stock and look at what might have gone well, what has not gone well and what we should do about it. We find that Primary Care Trusts are £55 million in the red on their dental budgets, but the Department of Health quite rightly insists that we have to await the final quarter’s figures to be clear about the extent to which PCTs appear to be in the red on dentistry. The Department of Health implies this is a good thing, that it is the result of more exempt people being able to access NHS dentistry.

And it is possible that there is a grain of truth in that, as those who are paying an 80 per cent subsidy perhaps realise that the cost of NHS dentistry and the cost of private dentistry for the treatments that they want to access are not vastly dissimilar.

BDA Survey

The British Dental Association, and I will not mention the BDA too much this morning because they have not turned up today¹, but I will mention their survey, which I think is quite useful. It was conducted towards the end of the first year of the new dental contract and looked at how the new dental contract had succeeded or otherwise against criteria set by the Department of Health. The first thing we have to consider is whether patient access and experience has been improved, which is clearly an explicit requirement of the new contract. 85 per cent of dentists feel that the new contract has not improved access. Even more felt in the survey was that it has not improved access to orthodontics. As the father of five daughters, who have each had to have orthodontics, that is of particular interest to me. The Citizens Advice Bureau thought that the position was pretty static; Which?, the consumer magazine was a little kinder, but the Department of Health’s own figures show that 69,000 fewer patients had been able to access a dentist at December 2006 compared with March 2006.

We know that 2000 dentists left the NHS in April 2006; that is the Department of Health’s own figures, and we do not know how many have joined. Virtually all dentists thought the new contract had impaired continuity of care, and I think it is very important as we consider how general dental practice can mirror general medical practice, when continuity of care is so very important. I think many in the dental profession would say that they would like to have some of those features of general medical practice within what they do, particularly in connection with registration and preventive health. Overwhelmingly, dentists felt that the new contract was no good for preventive care. Overwhelmingly, they thought that their new contract did not improve affordability and fairness in patient charges and, overwhelmingly again, they felt it had not improved levels of choice for patients.

¹ The BDA chose not to send a representative to the Summit, but they attended the press conference held afterwards.

Welcome & Introduction

Confidence in the NHS

Looking at improved working lives, there was clearly a fall in confidence in NHS dental practice evident from the survey. Dentists recorded a fall in confidence about the future of their practices and so on. I think the bottom line is that there is a general feeling that the new contract has not helped very much at all, either in terms of patients or in terms of those who spend their working lives trying to improve oral health. So the question for us is what we can do at this juncture to

put pressure on policy makers to re-visit the contract and improve it, so that we can remedy a lot of the problems that are clearly evident. I think we need to particularly look at how we can address dental health inequalities, how we can encourage preventive oral health and how we might address some of the perversities, including the perverse incentives both on the part of practitioners and patients, that are inherent in the current UDA and banding system. If we can get some answers or ideas that address some of those points from today's meeting, I think that would be extremely useful.

We have a relatively limited period of time this morning so I am going to wrap up at that point. What I would like to briefly do is to go around table and if people could give us your names and who you are representing, that would be extremely helpful and hopefully when I come to call for contributions, I will not have to squint at the labels in front of you. Please make sure your labels are facing me.

Introductions

Chairman

Thank you. The first item on our agenda today is how might we convert need into demand and that is going to be introduced by Derek Watson. I think what we should do is keep our speakers' contributions relatively brief so that we can get some roundtable discussion. We are recording what people say but it is Chatham House rules so it will be non-attributable.

How Might We Convert Need Into Demand?

Derek Watson BDS

CEO, Dental Practitioners' Association

Introduction

I would like to welcome everybody and thank you for supporting this event. I am delighted to kick this off because I love policy and talking about policy, and could probably do it all day but I am suffering from a head cold.

Need v Demand

Need versus demand: this is a very important subject which is close to my heart in that the words 'need' and 'demand' tend to be used interchangeably by people who are not really thinking about health policy. They are very different and the difference between them is very critical. To put it simply, there are patients in areas who are very keen to go to the dentist but tend not to have much work done. I have practiced for most of my life on one of those areas, in Canterbury, which I tend to summarise as the leafy suburbs. Latterly, I have worked in Sittingbourne in Kent, which is the exact reverse. It is an area where people have a massive amount of oral health problems, absolutely hate the dentist and will never go. It was a big challenge to try and get these people to attend for the treatment that they so desperately needed. The emphasis was on trying to divert NHS funds, which are limited, into areas of high need.

DentaLine

It is not always true to say that patients with high need do not demand treatment. In my experience of 20 years in general practice was that some of these patients could be the most demanding patients of all; when they wanted treatment, they wanted it yesterday afternoon, because yesterday evening would be too late. In thinking about this question, it occurred to me that we have to look at systems where need has translated into demand and try and pick up on the features of those. One such system in Kent was DentaLine and this predates several dental contracts; it was a time when we still had Family Health Service Authorities (FHSA's). Kent decided to provide an out-of-hours service for dental patients. Basically, it was open in the evenings and it closed about midnight, and was open at weekends. It was phenomenally successful; it picked up lots of patients very quickly, there were three centres across Kent and it very quickly became the most successful dental group in Kent. The people who attended were supposed to go once for pain relief and then find themselves a dentist, but of course, they did not; once they were out of pain, they went back to work and three months later, when they were in pain again, they went back to DentaLine and got their quarterly antibiotic. That is how it went on.

I think the point with DentaLine was that to a certain extent, we were imposing our own values on these patients. What we would have done in their circumstances would have been to find and register them with a dentist, have a course of treatment leading through to a conclusion, but that really was not what they wanted. By imposing our own values on those patients, we did them a disservice. We saw a very basic pain control, anti-biotic and extraction service as a step backwards to 1948, 1950s, but for those patients, it was a step forward.

How Might We Convert Need Into Demand?

So one thing I would like to say at this forum, because we have always been very good at thinking the unthinkable, is that perhaps we have to go backwards to go forwards with some of our patients.

Communication

What I think we had with these patients was a failure to communicate. I think that we tried to tell them what was best for them and they were trying to tell us what they wanted, but we did not listen to them. That opens up other questions such as core service. If we are going to target public money towards

extractions and pain relief, should we make that a service which is available to everybody and therefore easier to fund, rather than the alternative, which is to make every treatment available to everybody? This spreads the jam so thin that the whole system tends to collapse. The alternative is to offer a full service for only very few people and leave a large number of people disenfranchised and with access problems. It also opens the question of whether it is beneficial if people leave the NHS. I had a very interesting argument with one of my patients, who stated quite clearly that it was everybody's duty to use the NHS because if everybody did not, it would become a service for the less well-off and therefore, the level of service offered would go down. From my experience in practice, as people left the NHS, it actually freed up resources. So, the people who could leave were actually doing the people who could not leave a favour. That is a bit controversial but is my experience from looking at how things work in practice.

Practitioner Perspective

Finally, I am going to deal with another type of conversion of need into demand. It is certainly true that the NHS dental service at the moment needs dentists. How could we arrive at a situation where dentists were demanding to come back into the NHS? It sounds a bit far-fetched at the moment and perhaps not even a question that we might want to think about, but why not? Why should dentists not be keen to work in the NHS? They certainly were in 1981 when I qualified. I think the key to that is to understand that dentists are self-employed, small business people. Because they sub-contract their work from the NHS, they tend to work and make decisions in ways that reduce their business risk. When setting up practices, for example, they will locate themselves in areas that will maximise their return on capital. So they are not like doctors, and I think we suffer a bit from being treated in the same way as doctors. Until such time that the NHS adopts the entire business risk of practicing dentistry, we have to ensure that the risk of NHS practice and private practice are equalised as far as possible.

So, my units of talking activity have almost come to an end so I am going to wind up now. The points that I would like to add to this debate are the following. Firstly, the Government and politicians cannot adopt a centralistic, commander-control approach because dentists must adopt the business risk of any hare-brained scheme they are given and they do have a choice. Secondly, high-need patients are telling us what they want but perhaps because it does not conform to our modern ideas about what they should want, we are not really listening to them. That means that what we do for them is not successful. Because of that, perhaps we ought to be thinking of moving away from the nine-to-five, course of treatment model to a service which they have demonstrated that they do like: the after-work model, even the after-the-pub model.

These people are not impossible to get through to and I think we have an obligation to help those most in need. Thank you.

Observations

Chairman

Thank you Derek. What I suggest we do know is ask for questions and observations, and then ask Derek to respond to them collectively or individually. So do we have questions or points?

Participant

I would just like to say thank you for the introduction, but when you said about the dentists, I am sure that you meant the delivery of primary dental care is the responsibility of the wider team to ensure that dental nurses are involved in oral health education, that we see the role of the dental therapist expand, the role of the dental hygienist expand and now the clinical dental technician. We must not forget that we are talking about a team approach and not just the dentists.

Participant

I think that is absolutely right, and many of us who are not part of the dental team are sometimes guilty of not fully appreciating that and hoisting it on board in the same way I find that my colleagues in the House of Commons, when they talk about the NHS and what it provides, automatically think it is surgical operations, which is a sense of huge frustration for me as a non-surgeon. So, I think that is an extremely well made point and the representation around the table today clearly shows it is a team effort. Hopefully, we will discuss this morning how broad a dental team might be used in order to improve NHS dentistry, which is something my party is very keen on and will rely upon in terms of trying to improve that NHS dentistry. Although I appreciate its controversy in some sectors.

Participant

Can I raise the point that what you have suggested is that there is an understanding out there in the public of a need. But, if we are not careful we will look at a quick fix for that need rather than looking at the education of the next generation coming through and trying to educate them into a healthier lifestyle. I do not know if you have any comments on that?

Participant

We will have a few observations first.

Participant

I have caution against the idea of the after-pub model. I think the NHS has already had some experience of after-pub attending.

Participant

I would just like to make the observation that I have practical experience of education and it is very valuable point. When we set up our practice, we actually encouraged young children to

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attend and we made it fun. We had preventive dental units set up and we involved the whole dental team, the nurses and the receptionists in greeting parents, and parents would bring their children. We even had a crèche, so that parents could drop their children off while they were going to work or whatever for a short period of time. During that time, we made it fun for the children, and they would then get used to the idea of coming to see the dentist. Also, by bringing in the children, it brought in the parents and we found that a very useful model to adopt, and I can see some nodding heads there. I would like to see that side of things being able to be rolled out across the board, but unfortunately at this point in time, prevention is not a high priority. But I do think that it is actually getting to the children and encouraging them through schools and through school associations, for example, we had involvements with the scout movement and we went out and gave presentations at scout and guides' evenings. We have competitions and fun club. We made it fun, which is what I am driving at, and it brought the children in and the parents then followed thereafter.

Participant

Can I ask—do practices still do little tubes of toothpaste? I remember when I was about nine or ten, having little tubes of toothpaste that my dentist used to give me every time that I went to the dentist. I am not aware that those are done anymore.

Participant

No we do not have that, but one thing that is very popular with the children is the tablet that shows up plaque, and they love leaving the dentist with bright red teeth. It is great and it involves them.

Participant

But I think the question for policy makers is how we incentivise that because the difficulty is practicing prevention and the criticism I am getting of the new contract is that there is very little within it that actually incentivises that. The point was made that practices tend to be run as businesses and I know they do a lot of work on a pro-bono basis, but if we are serious about practising prevention, we need to incentivise it.

Participant

Yes, and I think you made the point about registration and capitation. We were able to do that when we had that kind of system in position, but not at this point in time.

Participant

Was that under PDS pilots?

Participant

Yes.

Participant

With regards to prevention and dental nurse education, we have the national occupational standards for dental nursing, and it requires the dental nurse to provide that service in the

workplace. But increasingly, as a tutor and assessor myself, I find it very difficult for the dental nurses to actually carry that duty out in the general practice because there is no structure within the contract for prevention, and time and time again, the dental nurses are having to go outside the workplace to achieve what should be part of the job.

Participant

Ok. So what are your proposals? What are you suggesting we should be doing?

Participant

One could be the use of the students. I work in a college and we try to use students that we have in the college for the dental nurses to educate them. I think the thing is that oral health education is part of a bigger picture of public health in general and I think we could all come together, not just in the dental profession, but also for health in general. I know in Scotland they have gone out into communities and used lay people to give initial oral health messages to their peers; they are giving the basic education to people which will then encourage them to take up oral healthcare.

Participant

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Participant

So, it is outreach in a sense and is perhaps similar to the situation that pharmacists are meant to be operating in with their new contract. Built into their contractual arrangements, or in the change in working arrangements, is this ability for them to leave their pharmacies and do work in the community. So, it would be something similar to that.

Participant

Dental nurses are ideal to go out and educate people on their basic needs.

Participant

Under the capitation scheme in PDS, one of the main problems that we noticed was supervised neglect, where complex treatments came to a grinding halt and any dentist that we were aware of doing a PDS contract just stopped doing complex treatments. So how do we put a mechanism in place with any sort of capitation service that stops these complex treatments from disappearing?

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Derek Watson

My apologies to everyone if I have started to talk like a dentist. I talk as a dentist no more, and I do appreciate the team, which was one of my motivations in persisting with this group; we are all equals. As far as educating the next generation, I take that point. I have nothing to say against educating children and passing the message on to the next generation at a time when they are very receptive to that message. What I did find when I plotted a graph of the ages of my patients was that we had two bell-shaped curves. One peaked around 15-16 and one is peaked around 52. The youngsters get dragged along by their parents, they have no choice, but in many ways, the only criticism that I would make of people who immediately say children are the future, is that they are an easy target. But are they the right target? They are a good, worthwhile target but the problem with that graph in my surgery was that at 18, patients vanished off the dental radar and disappeared, because they come to a time in their lives when their mother or father or grandparents have said to them, 'I can't take you to the dentist anymore, so you are going to have to sort it out yourself'. They think, 'great, this is my excuse not to go', and in general, they then do not go for 15 years. They start to come back on the radar around 35 because by then, they are getting a bit more confident about paying for things; they are married and are starting, as they creep towards 40, to think about their teeth in their old age. I would be very concerned about that missing group, the 18 to 35 group. Children in a way are not our biggest problem and child decay rates are falling.

My appeal was to have flexibility in terms of how to deal with these people and to do things on their own terms. I remember a patient who came in, who was a very regular attendee and had only come in because he had had a succession of problems with his teeth and was in pain on both sides, because when you have pain on one side, you can still chew. So, I sorted his teeth out and he said to me that his wife was petrified of the dentist and she had never been. I said to him that he should get her to come in, but he said she never would. When I asked where she was, he told me she was at home. I told him to ring her and tell her to we were going to come around. We got in the car and went to this chap's house, which I will not go into further except to say there is a lost valley in Canterbury, which I have never found since that day. There she was, and only because we responded with my offer to go and see her on that one day, did we manage to access that lady and help her with her dental problems. So, I am saying that we have to be very flexible and think about meeting these people on their own terms.

Lastly, with regard to the point about capitation leading to under-prescription, this is a well rehearsed argument and dates to the days when Steven Noar was setting up Denplan. He was very frequently asked why capitation should not lead to under-prescription and his answer was that if the dentist has an ongoing relationship with the patient, what is the advantage to the dentist in leaving things to get worse? If the dentist is going to be ultimately responsible for sorting the problem out anyway, it is not really in his interest to leave it until it becomes a major problem or a small problem turns into a big problem. It is not quite as simple as that because there are very expensive items which do not really count as under-prescription if they are not provided. But then you have to look more at the totality of care.

But, capitation can lead to under-prescription if it is not done correctly in the same way that fee-for-service items can lead to over-prescription and perhaps the answer is sitting somewhere in the middle. There are now many good systems that have addressed this and do sort that out.

Participant

So we are seeking the middle way between fee for service and capitation. If we can find that, then it will be a good thing. I think hard to reach groups are an issue and you have touched upon that. From my own position, very often that involves a community dental nurse and very often, that is forgotten about in our deliberations and that seems somewhere deep in the lost value that you referred to. Can we have more observations?

Participant

It strikes me that we can talk about the unit of dental activity and it may be an iniquitous unit and we may want to change it. But if there were units of dental activity granted for education, would that bring education into the mainstream delivery of dentistry, which is what we are asking for?

Participant

I wonder if anyone else feels the same way. Certainly the 5 per cent that we have built into the new contract is widely held to be inadequate and the intention of ministers, I think, was to include a great deal of that activity within this 5 per cent or 10 per cent limit that was debated; the 5 per cent, of course, being at the lower end of what was being discussed in the run-up to the new contract. I suppose the question is how we factor education into any revision of the contract that may be appropriate in the future.

Participant

I just wanted to comment that it had been said to me by the largest provider of domiciliary services in London that there is no longer any room for health promotion among the elderly and those in care homes, either among them as individuals or among the staff, again, because of the way the new contract has been organised.

Participant

With regard to an earlier point, you have 28,000 dentists and 28,000 dental nurses. You have a resource of dental nurses that are trained on how to do oral health education; it does not matter whether they are working with young people or elderly people but they are a flexible resource. Instead of a dentist going out to that lady mentioned earlier, it could have been a dental nurse quite easily. Use the resources and the extended roles of dental nurses as part of the team.

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Participant

I think that brings us neatly on to a topic that I am interested in and that is the extended role of the dental team. I would be delighted to hear from people as to how we can make that a reality. It seems to me that across all the various disciplines in medicines, dentistry has been the last to exploit the wider team; everyone else, including GPs and general medical practitioners, appear to be going down that road at a fair speed and dentistry has held back. I wonder if people have some observations on that point.

Participant

That is absolutely right. The wider team is now only becoming part of the commissioning strategy of PCTs. Previously, there was really no direction to use them in NHS care and what we currently need is a bit of a balancing act about how we use the old PDS style and how it can be better performance managed, but within that, there is greater autonomy that individual members of the team can use their skills widely. I think really it needs the Department of Health to give clearer direction about what they want as treatment outcomes. The difficulty we have got at the moment is about actual treatment as opposed to something you can physically measure, whether it is making a denture, making a plan or doing two fillings. The problem is in terms of oral health is that there is no real measure. There is great deal of work done about how important it is but it is actually how we can empower people. We have to accept that we cannot measure it and we need to make sure that PCTs, as performance managed, do have prevention as part of their overall strategy. At the moment, it is just about how many UDAs are achieved and what forms part of the UDA count, and about patient charge income.

Participant

It is a bit like the target culture within the acute hospital centre, where what gets done can be measured.

Participant

I want to make the point that one reason that dentistry does stand a little at the fringe of the NHS teamwork is because people working within dentistry probably do not feel as team members that they are part of the NHS. A simple example is that I do not believe nurses can join the NHS pension scheme.

Participant

I think that is an important point and although we are at risk of widening the scope of our discussion, it is an important point to put on the record. It is something that I had never really considered. Let us be clear that the Government has been quite keen to brand lot of things NHS, which is why it has used the logo of a pharmacist and various parts of healthcare in the countryside. The Government probably recognises that but would you like to make a few observations on the NHS pension scheme?

Participant

Dental nurses feel they are missing out greatly. Our association feels passionate that the dental nurses should be able to access this pension because they are working in practices for the NHS.

Also, they are low paid workers in the NHS. Even within the high street general practice, the variation in salaries is huge. I have students that come to me and they are on £12,000 a year, working from 08:00 to 18:00 at night. The fact that they could access a pension may help but they are low paid. I appreciate we do not want to divert too much but I think at this point, it is also important to bring in the point of the funding of education of dental nurses. We are talking about educating the patients but presently, the education of dental nurses and funding is so up in the air. Many nurses fund their own education or their employees are expected to fund it and that is unfair on dentists. They are a small business, trying to run their business efficiently and having to pay for the education of this person. The biggest problem we also have is that the dental nurses are expected to be educated in the evening at colleges so that they are not taken out of the service and patients can still have that service during the day. It is an unacceptable way to educate nursing professionals to expect them to work all day and then go to college in the evening. There is a bigger picture that does impact on the care of patients because the dental nurse is taken away.

Participant

I recognise a lot of that. I am particularly interested in the differences that exist between general medical practice and general dental practices. It seems to me that general medical practices are far more integrated in the mainstream NHS, and that includes pensions, for example, which they have access to.

Participant

The practice nurses and general practice can access the NHS pension, but dental nurses cannot.

Participant

I think that is something we can explore.

Participant

And just to pick up on that, dental technicians working in the dental laboratories away from the dental practice are very often neglected. They are not part of the dental practice and are not seen as part of the dental practice. They may be doing work that is 100 miles away, but at same time, to be part of the team and to develop that teamwork together for the benefit of the patient's care needs the opportunity to do the extended roles which you alluded to.

Participant

I think what we are looking at here, which has not been widely recognised, is nationalisation of the NHS dental system by stealth, and this is where a lot of these problems come from. When NHS came in, in 1948, general medical practices effectively were bought out and brought into the medical system, and as a result, their whole team became part of the NHS. What the current system and the current change in the contract has tried to do is carry out that nationalisation within NHS dentistry without actually paying for it. As result, the role of the team and the team members has not been recognised and people in general, certainly the public, do not recognise the difference between their medical practice and their dental practice. They do not recognise that their medical practice has everything paid for by the health service, from

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gloves, syringes, down to the staff and their pensions. It is really a key point that the aim of this recent change has been to try and bring dentistry into the fold but it has not been done in the same way and this is where all the anomalies are creeping on.

Participant

That point is extremely well made.

Participant

I would like to say that DCPs are vital team members and are very passionate about what they do. Their skills should be recognised and utilised within the profession.

Concluding Remarks

Derek Watson

Thank you. I have been fascinated to listen to people and you have come up with a lot of very good ideas which I think will have further scrutiny. In summary, the current NHS system, to which the dentists have ended up acting as gatekeeper by default, by virtue of the fact that they tend to hold the practice-based contracts, is singularly badly designed to convert need into demand and to target resources to patients in need. Rewarding the practice as it does, equally for patients whose oral health is very good and whose oral health is very poor and expecting a 'swings and roundabouts' approach to sort the problem out. So, I think that is one aspect of the current arrangements which hopefully will not last much longer. They cannot last much longer and will receive very early attention.



Prevention

Nigel Carter
Chief Executive, British Dental Health Foundation

Introduction

I think there has been a real missed opportunity in the changes that have taken place within NHS dentistry over the last 12 months. We have always had a drill, and fill and bill system, which was very good for the levels of dental disease that existed 58 years ago when the health service was set up, but which has been totally inappropriate in the 1980s and 1990s after fluoride was introduced into toothpaste and the levels of decay started to drop. In such a way as when communist Eastern Europe broke down there was a peace dividend, we could have expected a health dividend in dentistry. We started to focus on better oral health for our patients and that simply has not happened. Options for Change promised that we would start to look at the oral health of our patients and improving their oral health but when it came down to it, the Government and Department of Health in its wisdom decided that it did not trust dentists. So, as a result, they replaced one lot of drill, fill and bill with another in terms of introducing units of dental activity. Units of dental activity, by their nature and the way they are defined, are again about carrying out treatments. So this is not about providing oral health; this is about treating disease. There is a real missed opportunity here to actually look at improving the health of patients.

Derek has touched on local accountability and re-engineering, putting practices where perhaps the needs are greatest but how we generate that need into a demand. We do know that dental disease is a disease of poverty and disadvantage. The people who need most treatment tend not to access it. Fluoride has had a huge effect as a general health measure and can hopefully have greater effect if we see more water fluoridation systems. But at the moment, that is not happening so we are left with practice prevention. The 5 per cent notional loss or fewer UDAs allocated than previous levels of activity was supposed to lead to preventive activity by the dental practices. But realistically, if this was not recognised and was not paid in a system that was still driven by targets, it was never going to happen and is not going to happen. We need a change and we need recognition of prevention in practice. One participant has referred to the need for Primary Care Trusts to have clear health targets for their populations which they can then pass on.

But I think it is more fundamental than that. It has also got to go across into dental practices and the dental team delivering more in the way of prevention to their patients. In order to do that, it has to be recognised in the payment system, or, rather more radically, the units of dental activity have to be totally scrapped and we have got to look at providing oral health for a larger number of patients. It is challenging to say: -what is good oral health and what levels of oral health would we like the population to have? This is what we should be aiming at. It is not as simple as looking at having good teeth and healthy gums. Decay levels have reduced hugely over the last 30 years as a result of fluoride in toothpaste but we are seeing a levelling off of this and in some cases, we are starting to see children's decay levels rise. Half of our five-year-olds experience decay. This is simply not acceptable; it is not necessary and as a caring profession and caring dental teams, we are able to do something about this and the dividends in the

future could be great. Gum disease levels certainly are not falling for similar reasons. We see systemic health connections, such as oral health and gum disease being linked with cardiovascular disease, stroke, and diabetes, and there is a health dividend to broader health by achieving good dental health.

There is a real missed opportunity here. Practitioners in general and the dental team have not been rewarded for such things as routine fluoride varnishes for children. They have a role to play in smoking cessation, which obviously impacts on oral health and gum disease as well as general health. When I look at the Foundation's, Mouth Cancer Awareness Week we see mouth cancer is rising rapidly; it is one of the fastest growing cancers and kills someone every five hours in this country. In terms of oral cancer screening, the practice has a great role to play. So there is a real missed opportunity ; Options for Change has not been delivered and we are not going to see the health dividend that we should have been expecting to get.

Chairman

Thank you. That is quite an indictment. We look forward for the change in circumstances in three years time when dental funding will not be ring-fenced in the way it is at the moment, and the concern is what attitude the PCTs will adopt towards oral health. So, I think debates about prevention are absolutely vital at this point to ensure that the very real dividends that we may accrue are secured and not overlooked. I am not going to encourage people to talk about the pros and cons of fluoridation because I think that is a separate matter. But the other arm of prevention is practice prevention. Could we have some comments, observations and questions around practice prevention?

Participant

I would like to back up what was said earlier. It is those disadvantaged groups, particularly cardiac, diabetes and a whole range of systemic orders that have manifested themselves orally and will have an impact on the patient's oral health. All those areas have existing national frameworks; there is a huge amount of money that goes to Strategic Health Authorities and Primary Care Trusts to treat those. The missing link is that we do not encourage dentists to be part of the overall treatment plan of the patient and we do not reward them. So where they are seeing quite debilitated and difficult patients, there is no real method of rewarding them at the moment for providing that care. Therefore, patients are not getting the prevention and the long-term treatment that they actually need. In terms of access to care, they will leave it for as long as possible to access care and we should almost mark a patient; if they have diabetes, for example, there will be factors related to their oral health that they need to monitor. But we do not reward the dentist by giving them extra, unlike a GP. The money that GPs receive should equally apply to a dental practitioner and there are teams that are able to do that.

Participant

Can I ask whether or not people felt that PDS pilots were moving in the right direction as far as prevention is concerned?

Prevention

Participant

One of the problems with PDS is the fact that they were probably given too free a range; there needed to be a much better performance management system in place. But certainly moving the PDS-type system was a far better system than we have got now. The strongest part was that the patients knew where they needed to go, and with registration, it made sure that we knew where people were going and we could work out who was not going. We have sadly lost that.

Participant

With regards to the comment made about smoking cessation, I think this is a prime example of where dental nurses could really impact on patient care. A lot of smokers really do not have a clue that it affects their oral health; they know about lung cancer, etc, but they have no idea how it affects the periodontal status and gum disease. I think dental nurses could be key in delivering those messages within the practice. I know dental nurses are accessing that training and trying to bring it into general practice but again, the dentists are not rewarded for it properly, so it does not really happen. As someone who is passionate about dental nurses getting extended duties, this is a prime example of where we could use them really well.

Participant

It has been said that there is a real opportunity here—and there is with the new regulated team. They have put a lot of commitment and their own money forward for them to be regulated. Use the team and take them forward. The promotion of oral health through nurses and others in the team; they are always keen to do it but they are always going out on their own and working with scout groups, cubs or rainbows. It is all the extra work; it is there, it is a wealth that you can tap into.

Participant

The business model would be that if I had services that I could offer the PCT, I would go and talk to the PCT about those services and see what resources they have got to buy them with. Some of those services might be wider than just dentistry, but I am sure that the PCT has a budget for smoking cessation. I would be putting in a bid for some of that, and I would not necessarily be wearing my dental hat; I would be saying this is something we can deliver cost-effectively through this group of professionals. So is there more we can be doing? I am particularly conscious of what will happen in two years time when the ring fencing goes. I am very concerned that the attitude seems to be held that we fight the corner for dentistry once that ring fencing is gone. How we will get anything at all? I would be in there explaining to them, once that ring fencing is gone, why they have got so much more money they could spend with my practice and what I could deliver in the way of services that go beyond dentistry; whether it is keeping a check on people with diabetes or delivering less severe cases of oral cancer because you have tracked them earlier. How can reduce the cost of the PCT? How can you have a practical arrangement to do more?

Participant

2009 is going to be an interesting year for all sorts of reasons, but in dental terms, it is going to be fascinating because of the change in financial arrangements with respect to Primary Care Trusts.

Participant

Perhaps for the first time, dental will not be separated from medical; there will just be a budget for health.

Participant

There are dangers in that though, that I think we need to appreciate.

Participant

We have talked a lot about the team, but I think that one also has to bear in mind that the PCT has to form part of that team. There seems to be such wide variations across the country with PCTs. The experience that I have had with my own PCT is that we have tried to get them on board and we involve them as much as possible. And I write everything down so that every conversation I have is then followed up by a letter. There is record of everything that is done with respect of the PCT. However, that is not necessarily the norm. Prior to coming to the meeting this morning, I emailed the membership of the BDPMA and asked for feedback of their experiences. One email came back that stated when the new contract came in in April, their PCT was told to take two weeks annual leave. So there was nobody at the PCT for the first two weeks of the dental contract being implemented. I think that that is absolutely scandalous and I do think that when we talk about the dental team, in view of the comments made about 2009, we have to engage the PCT; there has to be some education with PCTs as well as education across the rest of the team members.

Nigel Carter

I think it is very relevant; clearly, we have had the missed opportunity in 2006 and we have to make sure that the boat is not missed in 2009 and we have got these two years to actually influence the system and to develop relationships with the PCTs. This also has to be led from the top. Classic management theory is that delegation is not abrogation. I am not sure that that is how the Department of Health regards delegating responsibility for dentistry to the PCTs. They seem to be washing their hands of it and leaving it to individual PCTs. As we have just heard, it can be very patchy and we need some central direction to achieve the sort of health benefits that we can actually get out of the new system.

Participant

We have the National Institute for Clinical Excellence, which focuses very largely on hospital disciplines. It is by way of setting national standards effectively and one wonders whether it needs to devote some time to preventive oral health, in the same way that it has devoted time to other wider public health issues in the past.

Prevention

Participant

That would be certainly valid; as it has moved into other public health areas, it is coming out with sensible practice. That would give benchmarks for the PCTs to be able to work towards.

Participant

My experience is that every successful system that achieves prevention has one factor in common, which is that the person who is in charge of achieving the prevention has some interest in any savings that are made. Currently, if a dentist who is doing ten fillings cuts that down to five fillings on the same number of patients, his or her budget is cut in half. That seems logical to the Treasury because they were paying for ten fillings and now they are paying for five. I know it is not done per filling now; it is done on a budgetary basis. But a successful preventive dentist is an under-performer in today's NHS and has no incentive to cut down on the work. But if you have a system where a dentist who used to do ten fillings cuts that down five but is then paid for seven, you have all the elements of a successful preventive scheme because the patient's decay rate is cut in half, the dentist is doing five fillings and being paid for seven, so he is happy, and the person who was previously paying for ten fillings is now paying for seven and effectively paying the bonus out of the savings that have been made. So there is no additional funding or bonus as such to pay. You reward the practitioners through the use of their own effort.

I think the PDS schemes were during a very particular time in dentistry and while on the face of it, they were to pilot a number of ideas, and they did pilot every idea that anyone came up with, including some which paid dentists and dental teams irrespective of how much NHS dentistry they did. They were to a large extent to get the dentists interested in the new GDS. Lots of money was put into PDS and I do not think we can realistically go back to that. But I think if we remember that prevention does work; it has not yet been made to work in the NHS, but there are many schemes outside the NHS work that have cracked this nut. If we can only incorporate the way they do it into the NHS system, I think it would work.

Nigel Carter

I think we have to not only look with interest but also try and take some actions over the next two years to change the system and ensure that the focus on dental health that was promised, is delivered. There are some signs of it happening and I am working on a preventive manual that is going out to all primary dental care practitioners and may give PCTs some help in judging what should be delivered in terms of oral health education in practice. But we need to make sure that is followed through and we need to get PCTs on board, in terms of their eventual cost savings. We have not really spoken about access and the fact that only 50 per cent of people access dentistry. It is not going to be a question of dentists sitting twiddling their thumbs because they have got all their patients healthy, there is the other 50 per cent of the population still out there to be got healthy as well. So there are huge benefits.

Chairman

We are going to move on, but you can make comments as part of the last session. Before I do that, can I welcome Lord Colwyn, who is from the House of Lords and will be known to many, if not all of you as dentists. He is a huge contributor to proceedings on dentistry and a range of other issues here in Westminster.

Lord Colwyn

(Referring to error in programme)—I am not a cross bencher; I am a Conservative. And I am a dentist!

Chairman

Yes, and you are a dentist. We are going to move on now to Richard Daniels, who is going to talk around the issue of which is the best system for people who have no choice but to use the NHS. This is an issue of real importance, particularly in the context of addressing health inequalities, which all politicians say we are exercised about and yet they appear to be getting worse.



Which Is The Best System For People Who Have No Choice But To Use The NHS?

Richard Daniels
Chief Executive, Dental Laboratories' Association

Introduction

This issue is so important that I am handing it over to someone who deals with it on a daily basis and who has spoken on behalf of the DLA on a number of occasions on this subject. He is Dave Smith, who is going to give us a summary of the situation.

Dave Smith

I would like to start by addressing another end of the spectrum of demographics, which is the fact that we are an aging population. As more of our population are getting older, their requirement for more complex intervention, especially orally and dentally, is on the increase. This shows itself throughout the Western world by an increase in the delivery of complex treatments. Yet, when you look at indicators as to where the UK lies in the Western world on these types of treatment, we are normally in the bottom five, and in fact in the bottom two on very expensive items like implants. This is including some of the new Eastern European countries as well. So why is it that the UK is languishing so far behind on this area of complex treatment?

The current contract, in our opinion, does not even deliver value for money and patients do not really understand the limitation of access to treatment, especially where complex treatment is concerned. The Government tells us all the time that they are spending more money in real terms on dentistry than they have previously and yet, from our figures, we can see that spending on complex treatments that involve laboratory work has reduced significantly. So, we have a situation in which the Government is spending more money but in our experience, it is delivering less treatments and I do not think that is an ideal outcome from the new contract.

Worse than this, in our opinion, is that the Department of Health does not even publish statistics on the different types of treatment that are being offered because it does not even collect the information anymore. It used to collect information on every time of treatment that was delivered under the health service, but now they just look at the number of UDAs that are being delivered; they do not look at items of treatment so we do not really know what types of treatments are and are not being delivered. It is now relying on doing some statistical analysis with our association to try and get an idea of drops in the complex treatment, which will help.

The system is perverse as well; it is perverse for patients and dentists. The less treatment you do, the more your income; that has to be a perverse system. Dentists are paid the same fee for a simple plastic denture as they are for a very complex denture. It is perverse when the cost of the complex denture is probably £150 to £200 more expensive than the simple one. It is the same again with bridgework. They are paid the same fee for a complex bridge as they would be for a single-tooth denture. It is an unbelievable system. They have condensed around 600 items of treatment into three and now you have this system of inequality of payment. It is not just perverse for dentists; it is perverse for patients. Patients pay £193 for either and there is

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absolutely no value for money for a patient in paying £193 for a single tooth partial denture. I think it was said in the address that there are some situations now where patients would be at least better off privately as far as cost is concerned. Certainly for this type of provision, patients would be better off having it done privately than having it done on the NHS. But I do believe privately, patients would have this sort of treatment done. Therefore, there is another issue of inappropriate treatment.

Discussion

Participant

Can I just ask you to clarify? For the simple denture, is the patients charge now in excess of the total cost of manufacture?

Dave Smith

Absolutely.

Participant

In effect, some element of that will be a straightforward money-gathering exercise.

Dave Smith

Absolutely. The laboratory fee for this type of treatment would be about £35 or £40. The patient's fee is £193. So, what is the outcome of all these perversities? Laboratories have seen severe cuts in the amount work being done under the NHS. Dentures have decreased by around 63 per cent; chrome work is down by almost 80 per cent and bridgework is down by 84 per cent; 84 per cent less is being done now than there was this time last year. So, these are not little changes; they are wholesale changes in the provision of complex treatments. So, I said at the beginning of my address about where we were in the western world, and these are based on figures of 2005. You can imagine where we sit today in that measure if we were in the bottom two before; we are probably off the edge of the graph now.

Worse is that it is not viable now for laboratories to exist in an NHS dental market. If it was not for private work, the majority of dental laboratories would not be surviving today, and most are finding it very difficult. We know that over 500 technicians have lost their jobs in the last 12 months and we know that private work in dental laboratories has increased by 12 per cent. So if it was not for these factors, we would not even be here joining in this discussion today.

To go back to the NHS principles, the principle of NHS treatments was based on a basis of need rather than the ability to pay. So what we have to do about getting some fairness back into the system is to remove the artificial funding constraints that the new contracts have put in place for prescribing. We need to develop ways of separating the choice of appropriate treatments from financial gain. We talked about access before and in some ways, when I look at the new contract with regard to access, and the NHS have a nice term for it now called access to an NHS dental experience; this is how they measure it now, and I think patients now have

easier access to an NHS dental experience, but that does not mean they have access to appropriate treatment and the two can be quite different. Therefore, we need to give patients choices based on the right advice from dentists and the rest of the dental team, so that they can make informed choices about what they feel is most appropriate for them. In other words, bring in a process of transparency to the system.

Exempt patients should still be offered a full range of treatments but obviously these are going to have to be cash limited by budget constraints. PCTs would have to set budgets and dentists would have to apply for funding for exempt patients; otherwise, you would never get control over the money being spent. For fee-paying patients, we should have a system where patients could pay laboratories separately as part of the overall bill, based on their choice of what treatment they want to go for from the advice of the dentist. The dentist would give patients a range of choices of treatments; give them the different types of costs and then patients could make that choice based on what they felt was most appropriate and what they could afford to pay. In this way, we would not get this artificial situation of the patients just not being offered expensive treatments in the first place.

Many of the choices now available for patients are even way outside the scope of NHS dentistry; things like implant dentistry, for example, are off the scope. Yet, we do not have this harmonisation between NHS treatments and non-NHS treatments that patients can easily understand. So patients do not really know when they are sat in a dentist's chair whether they are in an NHS experience or if they are leaving an NHS experience and going into a private experience. We need to get a simple system of transparency so that patients are able to make choices. When patients go and choose to have optical services, they may have an NHS examination and prescription, but we do not expect the NHS to then pay for Gucci glasses, but the patient might want to choose those glasses. That is fine and they can do so in this mixed economy and everyone has the best of both worlds in that type of economy. I think we need to look at delivering dentistry more in this way of informed choice for patients.

Participant

Thank you for a very broad and far-reaching discussion. It is interesting in optical services because they have been a huge success since the War. I think it is their ability to combine the public and the private in terms of how they are funded that has been part of the secret of their success and I do not get many complaints about access to those services. There is a great deal that we can learn from them. You mentioned the impact of not collecting information about treatments and you are right to do so. One of the consequences of this has been that one of the principle means that we had of assessing oral public health has been destroyed; it has been a huge blow to oral public health and we have the ability to have the finger on the pulse in primary dental practice because we simply do not know what treatments are being provided, only the banding.

You did not mention Cayton and Cayton is associated with the review of the banding system. He felt that the system of three bands was too little. Yet the principal argument was that it would introduce an element of transparency and simplicity that patients would be able to

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understand and what, it seems, has been caused by the three band system, which was not recommended by Cayton, is that there have been a number of perversities introduced into the system. On a personal note, I have benefited in a small way because I had a complex piece of bridgework done and did not pay for it; I paid for the standard band three. I will open it up to the floor.

Participant

As a small business woman, I would have real difficulty in managing the everyday running of a practice when you have got these anomalies with the fees; you cannot give a wide recommendation of courses of treatment and your hands are tied. What do you do? I think dentists have got a very hard time at the moment. From the lab. work perspective, the Denplan contract does work very well; patients do have informed choice and often they go with the higher standard of bridgework. Exempt patients quite often choose to join a payment plan; you would be surprised at what people will actually put their money towards when they want to. It all depends on their personal values. So, I do not know whether there is any way as a nation we can start taking responsibility for own health, rather than expecting the Government and NHS to be there at any given moment when have problem.

Participant

That opens up a huge debate. I think, although it is a bit of a cop-out, most politicians would say we need to provide whatever is necessary for people's clinical care. Dentistry is a problem in the sense that there is an overlap between what might be deemed clinically necessary and what is deemed to be cosmetic. Where that actually comes out most of all is in the question of orthodontics. I was wondering if we might talk about the private and public interplay in terms of what is provided.

Participant

That was the point I was going to make. When I saw an NHS dentist recently, they were quite happy to carry out the inspection under basic band one, which entitles you to a clean and scrape. But the clean and scrape is there if it is clinically necessary, at which point the dentist explained that it was not clinically necessary but I was welcome go and see the hygienist if I so wished and this seemed perfectly reasonable to me. Does the same thing not pertain when you are talking about dentures? Is it not possible for a dentist to say that you could have this done on NHS, but you could have this, this or this? Is there actually a bar to mixing the two at the moment? And if so, what is that bar and how do we overcome it?

Dave Smith

I think the issue there is that the patient walks into the surgery under the impression that he or she is getting NHS care, whatever that care is going to be. The Government will tell you that there are no treatments that are not available on the NHS anymore. That is the clever thing of getting rid of the Statements of Dental Remuneration. There are no treatments that are barred. The bar is there, by saying that the dentist gets the same fee irrespective of what they do. You get patients under the illusion that they are entitled to absolutely anything on the NHS. The reality is they are entitled to what the dentist thinks is appropriate within their funding

mechanism. That is not about complex treatments, the reality is about very simple treatments. Because we do not have natural system of transparency, unlike the optical services, patients do not naturally glide, when they are making choices, in and out of NHS treatment because they do not really understand where it begins and where it ends.

Participant

But we could do it if we wanted to?

Dave Smith

Yes, absolutely.

Participant

We could address the issue of how we educate the patient, although I am concerned about the optical model because I can buy glasses for £2 in the library and I do not particularly want to buy my teeth that way.

Participant

I am very interested in David's comments about mixed economy. As you will all know the DPA have been a great fan of a mixed economy approach now, for many years. I hesitate to say one of the many names that we have given it in the past because even mentioning what we have called it, tends to arouse hostility to the system. My experience of most dentists and general practice is that a mixed economy is exactly what the patients want, they really do. When a patient comes in on NHS, and you are quite right, the expectation is that, so far as possible and reasonable they would like to remain that way. When asking what they will obtain on the NHS, they are told that their treatment will be done as quickly as possible, it will be done using materials which are the cheapest available that do the job and using laboratories which are the cheapest possible, because in NHS the quality of the work is dictated by the price, because of this subcontracting arrangement. Many patients are not happy at all. The follow-up question straight away is—if I pay a bit extra, can I get better quality materials? Can you use a better quality laboratory and give me a crown that looks like a tooth and not some Armitage Shanks-type cheap porcelain crown. The answer under the old system came back 'No—we cannot mix' and under the new system if anything it has got more difficult. The powers that be will not accept that cheap and cheerful is not what everybody wants. It really is not.

We can operate a mixed economy in dentistry. As dental professionals, we are fully behind openness and transparency in mixing. I know that there is a tendency to assume that dentists have some vested interest in pulling the wool over patient's eyes in terms of what they are doing, I am not going to deny that in the past some dentists have taken advantage of complexity in the system, and some have patients have not spent the time trying to understand the system in which they are being treated.

The cross-subsidy that existed under the old system whereby patients could remain on the NHS because they had part of their treatment done privately, or dentists could remain on the NHS because they could cross-subsidise the NHS side of their practice from the private side of their

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practice, or they could keep the children on NHS because they had the adults on the private side of it, all of that is very much more difficult under the new system and I think that is greatly to the detriment of patient treatment.

Participant

It is relevant to pick up your point and it is picking up David's point on the banding and the patient charges as well. The way that this is currently working, with devolved need to raise patient charge revenue on to the PCTs is acting as a perverse driver in the system. We have got evidence of some PCTs who are actually almost instructing their practitioners in ways of working to raise the patient charge revenue that is a necessary part of their budget. At other end of scale, you have got selection of patients to fit in with the right bands and the right treatment. It is not working for the patient. In the current system it is difficult for the PCT to manage because the necessity to raise certain amount of patient charge revenue devolves on them.

Participant

Could you just explain how PCTs are able to do that without actually selecting patients who can access NHS dentistry?

Participant

There is some evidence of encouraging more patients who are probably not the patients in greatest need. Those exempt patients that we have talked about in poverty and disadvantage, that we would like to get more of into the system. They do not bring in the necessary patient charge revenue for the PCT. It is in the PCT's interest to actually have the patients from the leafy suburbs who are going to contribute a patient charge.

Participant

Yet we hear from the minister, that the deficit in PCTs dental budget is being attributed to people who are exempt from NHS charges accessing what NHS dentistry is available. The implication as I said in my remarks earlier is that those who pay 80 per cent co-payment are leaving, presumably to go into the private sector.

Participant

I think that is where the PCTs are ending up with shortfalls, the whole thing is acting as a perverse driver within the system and it is certainly something that needs to be addressed.

Participant

Earlier about the minister's comments on more needy people accessing treatment, what was the evidence of that?

Participant

I not sure there is any, I think that she was postulating that that might be the reason behind the deficit, I think £58 million has been identified, that is excepting of course the final quarter of the financial year, that has been attributed to PCTs for the dental services that they provide, she

is trying to explain why it is that they are in the red in this respect.

Participant

To come back to the idea of the dental laboratories being paid direct for the appliances and giving patients the care and the choice that they could have by that, included. If that was available, then the PCTs would have to start talking to the dental laboratories as a team member. At the moment the PCTs will not talk to the dental laboratories because they are not part of that process. It is an opportunity to pay the laboratories directly. Or the patients paying the laboratories directly for their appliances.

Participant

Has anybody got any comments on that? Actually although it seems a small thing I think it would be quite a radical shift. It would also of course involve a great deal of work on the part of PCTs.

Participant

Many laboratories work direct for PCTs now. They are paid directly by the PCTs. We deal with those now and I deal with nine or ten different PCTs around the UK directly, they pay the bill directly to me, it is not an unusual issue. I think most PCTs deal with the laboratories at some level.

Participant

It would of course be the case that dentists and practices had less control, arguably, on the work that they commission. One or two people this morning have observed that the new arrangements represent a nationalisation of dentistry, and I am wondering whether people feel that such a move would remove the control that the practice may have on the work that they commission, and whether that would be a good thing or a bad thing.

Participant

It would be a bad thing to move in that direction. It was bad enough when PCTs started negotiating with dental practices without really understanding what dentistry was about. To get them involved in the 'nitty gritty' of what dentistry is about, down to the level of the laboratory I can see that would be risky. I cannot think of a better negotiator on their behalf than the dentist quite frankly.

Dave Smith

It was not actually about direct payment it was about apportioning the costs to patients so that when patients came to pay, that they could see, itemised within their treatment what they were paying for. Then the transition from NHS treatment to private treatment would be much more transparent. The actual mechanism for making that treatment could still go through the dentist, there is not an issue there. That was not the main point of the issue; the main point was the fact that the patient was driving the choice of treatment.

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Participant

I am conscious that round the table we have some expertise that has not contributed greatly to our proceedings this morning and I would just say that I think it is reasonable just to have broad remarks at this particular stage, so if anyone feels that there is anything that more broadly they would like to mention this morning that need to be considered then please do not feel confined to our discussion around the issues that David has raised. I am sure that it would be worthwhile hearing them. Can I just mention the banding system? It seems to me that this is a source of real difficulty with the current contract. I am interested to know whether people feel that it needs to be changed, and if so whether we should remove it all together, which is possible or whether should be expanding the number of bands to remove some of the perversities that we have touched on this morning.

Participant

There is another thing been added in over the last week, with the requirement by the Chief Dental Officer that all endodontic instruments become single-use. Endodontics is already a problem within the existing banding system and there was some evidence from dental trade on increased sale of forceps and reduced sale of endodontic materials. There is a feeling that there are fewer root canal treatments being carried out. That is clearly not in the patient's best interests. The drivers that have been introduced by that banding system are actually not really in anybody's interest. I think it was put in, very much at the last moment, it was not how the system was developing when we were talking about 'new dentistry', and I think it was in an attempt to raise the patient charge revenue that a simple banding system was thought to be the best way. There has got to be a better way of collecting the patient charges and actually freeing the dentist up to actually provide what is best for their patients.

Participant

Within a banding system?

Participant

I would prefer to see it without the banding system, based on some sort of health assessment, there has got to be a better way of doing it which would be more effective, both in terms of collecting the revenue and delivering high quality treatment for patients.

Participant

The reason given for the banding system at the time was that it would enable patients to understand better what they were paying for, that it would give a degree of clarity to patients that might have been confused by the hundreds of individual items that previously they were faced with. I am not convinced that actually clarity has necessarily been improved as a result of the banding system.

Participant

Can I add to that?

Participant

Three bands are clearly simple, and we have some evidence from our dental help line activity, yes, patients do understand it better but it has not worked in the patient's interest. In most of those three bands they are ending up paying more for less.

Participant

Just to add to that, I have put down a question yesterday about these endodontic instruments, I suggested that the department would look at increasing the value of the UDA band threes in order to pay for root canal treatment. A lot of dentists feel that it is going to cost about another £32 to £34 per root canal treatment. I then spoke to Barry Cockcroft who says in fact he believes that it is only going to cost £250 throughout the whole year. There is a difference of opinion on that. Certainly I think it is something that we can follow up.

Participant

That is probably the expectation of it. That speaks volumes, an expectation of doing eight root canal treatments in a year.

Participant

He was using swings and roundabouts. You can do a single canal on a front tooth in three minutes but a posterior tooth is going to take a lot longer and obviously be more expensive.

Participant

Just as an aside, the government has 'previous' on new variant CJD and instruments. I remember when I was newly-elected six years ago and we had the issue of disposable instruments for tonsillectomy, which of course is the same issue in the sense that the concern was the transfer of organisms and bits of organisms that cannot be easily destroyed using straightforward cleaning. It is a problem area I suspect the government would be inclined to be extremely cautious. That is perhaps a side issue.

Participant

Talking about teamwork it would have been useful if the chief dental officer had spoken to us about the fact that he was going to announce to dentists generally that they needed single-usage instruments as of last Thursday morning. When we got the call saying, can we now have 500 sets of single-use instruments, which we simply do not have to supply. We know they are multi-use, more to the point I am just wondering about this banding charge, we have a banding charge that operates currently in the pharmaceutical industry, you pay a fixed price for a prescription. There are some chemists that will say, actually you can buy this cheaper over the counter, this is only a bottle of Aspirin to buy. I am not sure that the banding problem lies with the patients, a simplified method that gives the patient a charge to pay for what they are doing. It is where that banding is then attached to the dental side of the work as well that causes the problem. So a simple system to charge the patient we could stay with. Then we need a much more complex system and I think the only one that truly answers the point is item of service. Virtually if you are going to pay realistically for everything that is done. Or find a way that does not connect the dentist's income with what the patients charge happens to be, split the two.

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Participant

I do not know the answer to the question but is it possible for the PCTs to change the value of UDA as to reflect the cost of treatment?

Participant

No. Now the PCT has greater power to say 'we want you to do domiciliary care, we are going to increase the UDA value but you are still only going to claim three UDAs for a full set of dentures'. What they cannot do is say 'we are going to give you six UDAs for that'. The PCT now has the power to commission locally sensitive services so it might have a dentist with a special interest to do molar endodontics, for example, to pay a lot more but the UDAs remain the same.

Participant

The DPA very strongly supports an increase in the number of bands in the short to medium term. We understand that the system is based around weighted courses of treatment, to associate less closely the practice income from the number of fillings that were done. We recognise that that was a concern, previously. In going from over 400 fees to 3, they have oversimplified the system. There is such a wide range of treatments now in each band, we are seeing very real disincentives to carry the treatments at the top end of each band, as the DPA has identified. Now we do not need to put in all that many more bands to make it work. We could go as high as eight or we could probably do with five, just by splitting band 2 into 2a and 2b, and band 3 into 3a and 3b. That would not affect the patient's charges because the band 2a and 2b would still attract a band 2 patient's charge and overall, would be cost neutral. It would make the system work a lot better than it does at the moment and remove the disincentive to do certain types of extensive treatment. Which was so patently obvious before the system was introduced and was explained to people before they introduced the system and manifested itself from immediately when the system was introduced and has been explained again that it is happening and unfortunately because of the top-down nature of the way dentistry is governed at the moment no notice is being taken of what the people at the 'tooth face' are saying about this.

Participant

You are absolutely right, it was explained very clearly in advance what would happen, and sure enough it happened. I am questioning whether you think it was a surprise to people who imposed it in the first place?

Participant

It was the National Audit Office that told the department that this would happen.

Participant

It did, which implies that the department wanted it to happen.

Participant

I am conscious of fact of having not contributed. My business operates entirely in the private health sector rather than the NHS. Speaking with a general perspective on all of this I do not

think that anyone has mentioned the overall levels of funding, looking at dentistry from the perspective of the private sector. It seems that the improvement of the oral health of the nation has to rely on properly funded dentistry. Capitation schemes, whether they are full capitation or modified capitation or maintenance only, within the private sector are to my mind certainly an affordable way forward for the large majority of the population, even if it is just offered as funding option to patients on a regular basis where there is a regular 'buy in' for patients. That actually is something which increases the regularity of attendance just to ensure that access is continuous and not sporadic. I believe the future is in private dental plans.

Participant

I like to just wrap up David's part of this and then I am going to ask for a few more general remarks from around the table. David did you want to come back to any of that, particularly in relation to the banding?

David Smith

I think we could tinker with the banding, I think the proposal there about increasing the number of bands in band two and certainly in band three would be more helpful for us. We have to look at this blended approach of provision and making more use of the NHS to private transition, making that more transparent so patients feel comfortable about it. In that way increasing the likelihood of getting more money coming into dentistry from patients. Then going away with appropriate treatment and their choice, their choice of treatment which is the important thing, not the NHS' choice, not the dentist's choice but the patient making the choice of what is most important for them.

Participant

Quentin's point was interesting one. One we have not touched upon greatly today but I think for politicians it is an issue they would rather avoid and that is whether we should have a defined level of care, rather than the sort of pseudo-situation that we have at moment, where the Department of Health will say you can have whatever treatment you like but of course it is up to your dentist as to whether he feels he can provide that within the structure that currently exists, which seems a little unfair. We have seen an element of that of course in the reclassification of dental emergencies which I find to my horror no longer includes dental pain. I have tackled the minister on why she feels that dental pain at three o'clock in the morning does not constitute a dental emergency and whether she herself has ever felt dental pain at three o'clock in the morning. This is a sort of Alice in Wonderland approach to what is provided. I am wondering whether people have any thoughts on whether it would be perhaps a little more honest if politicians were prepared to say they think it is reasonable for the NHS to provide. Noting of course that the NHS in dentistry actually means something rather different very often than the wider NHS because of the co-payment.

Participant

There must be a possible opportunity to at least look into some kind of grant-in-aid system where there is co-payment between the patients and the government into the private sector.

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Participant

I think you have your finger directly on the point. One of the reasons in a democratic society that you elect certain people to certain roles is for them to make the decisions that you cannot necessarily make yourself. What I think is an absolute abrogation of this responsibility is to keep handing those decisions back to the general public on the grounds that it is your choice. You can have any kind of education that you need as a board of governors—here is the budget to run the school. Now if you think that you need toilets as well as teachers that is your problem, but you can have any kind of education system that you need. To my mind it is the responsibility of politicians to say there is finite pot, there is only 'X' amount of money, we will, with the best advice and the best wisdom that we can apply, work out fair ways of distributing that money. That seems to me should apply to NHS system, there are treatments, of course they are available, they are in the marketplace but they are not affordable out of common purse.

Participant

The point about the defined service is a very good point. For very many years, almost since 1948, the profession was asking politicians to tell us what they wanted and how much they were prepared to pay so we could make a decision about whether or not we wanted to provide that. Under the old system that was never done and of the few good points about the new system is that for the first time, we do have defined service. It is defined in terms of units of dental activity and in terms of contract values. I know we all have problems with units of dental activity and how they relate to oral health gain and what used to be called treatment. At least we have that now, as dental professionals we work within the system we are given, and that is one of our problems. When I was invited to make a comment on the radio, and they always say 'as a dentist, you are well paid, you have caused this problem, you have contributed to this problem', I always make the point that dentists and dental professionals are working within the system that we are given. Until now we have never really felt able to influence the system within which we work. I am hoping this meeting is going to be watershed in that respect; we are a powerful group in that we have good lines of communications for members, through the dental media and the national media. Any principles on which this group is in broad agreement will be given a great deal of weight and consideration. Thanks to the fact that the proceeding of this group, the first time this group has met in this format and the fact that the proceedings have been recorded and will be distributed to opinion formers and decision makers in dentistry. We may well, for first time, be able to influence the system in which we work. I think providing we carry on in this roundtable format with every one being given equal status. Those decisions can only improve the situation.

Participant

I would actually at this point invite, finally any contributions on subjects which we feel we haven't explored sufficiently this morning.

Participant

We have not actually spoken about the ways it has changed reception and they way we have to deal with it. Receptionists are getting worst side of it, obviously we have to explain everything, we are getting angry patients on the phone, when they are not being seen immediately when

they want to be seen. I think that is another point that we need to look into and how it is changing receptionists.

Participant

That is interesting observation. I am always conscious that the people at the front line in both general dentist and general medical practice are receptionists. They are often overlooked and often misunderstood but they certainly get the whip end of people's understandable frustrations and concerns. How do you think perhaps things might change, in order to make that less of an issue, less of a problem?

Participant

It is the actual waiting times of patients, they are waiting weeks and weeks to be seen. We really need to try to look into changing that but how can we change it?

Participant

So it is a reflection of demand? I wonder if any of our colleagues have any reflections on that.

Participant

On the back of what was just said, I think the whole administrative support within a dental practice is absolutely vital. Practice managers are more like business managers because they are managing businesses at the end of the day. The comments have been made on a number of occasions that dentists are primarily clinicians, they are not business people, so they rely upon a whole infrastructure within their respective practices. From receptionists, administrators, business managers and practice managers, if there is a problem, the dentists, therapists and hygienists they can almost 'hide' in their respective surgeries. It is the receptionists or it is the practice managers wheeled out to deal with the angry, irate patient. It is the receptionist or practice manager who has to deal with the front-line situation. That is very often overlooked, a lot is talked about the dentists and other clinicians within the practice but equal weight has to be brought in to bear when it comes to the considerable administrative support and infrastructure which now goes into running an efficient and effective business, whether it is private or NHS.

Participant

The point that David brought up earlier which was the downturn in prescribed requirements. That has caused certain members of the team, being dental technicians to actually have less work to do. As David suggested over 500 have left it as a career. It has taken over 10 years to gain those skills to be part of a team and because the forward planning was not done in the new way of funding and people were not taking that into account now we have lost those dental technicians from the workforce.

Participant

Starting off with the lack of access, I am conscious of the fact that for the first time that the PCT has a legal obligation to deliver dentistry to people within its area. What is the mechanism for calling a PCT to account for not meeting its obligations?

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I would suggest that a PCT that is running a waiting list of 25,000 is not meeting its obligations but I am not sure what the next process is to call them to account for it.

Participant

Perhaps we need to explore ways in which the Healthcare Commission can investigate the standard of care being provided by PCT, the Healthcare Commission has more than enough on its hands right now as you can appreciate, and I am sure would not welcome such a thing but nevertheless clearly we need to have some unity of service provision across the country. We are all tax payers who pay the same taxes and have a common expectation, broadly speaking of what we expect from the service. In areas of the country in dentistry as elsewhere we have a real problem with postcode differences as something that needs to be addressed. That is a good note to finish on, unless there are any other pressing points.

Participant

One thing that has not been touched upon is the issue given the time frames between now and 2009 is the actual contractual performance over the first year. We have been carrying out a survey on PCTs to establish the levels of serious underperformance. I have answer in front of me here – one PCT where more than 30 per cent of their dental performers were at least over 25 per cent behind in pro rata delivery of their UDAs for up to the third quarter of the first year. In the quickly reducing timescale, these dental practitioners are either going to find themselves under increasing stress to catch up the under UDAs in year two, or under stress because of their remuneration being reduced by some form of clawback. The likelihood that many of them are going to be in the state of mind to rationally put aside the time for rational discussion with their PCTs is going to affect sectors of the dental profession. I think that we are going to see some fairly dramatic ups and downs over the next year.

Participant

The 2 per cent always seemed to me to be extraordinarily prescriptive and the prospect of having an overshoot and the cost that that involves in practice are really too dreadful to contemplate for many practices and the penalty for undershooting are problematic. I am also interested by the month-by-month account that is being taken of how close one is to one's UDA target. I did raise this with Rosie Winterton, and suggested to her that towards the end of the financial year dentists may be coming up against a bit of a problem and indeed some practices of course that have satisfied their UDA target for the year might be less inclined to take patients on. She told me that this was not going to happen because PCTs would be monitoring on a month-by-month basis how well dentists were doing. I don't know whether that is being achieved, whether some PCTs have been doing it well in collaboration with dentists and some have not. I suspect that somewhere in there is the truth and we will find hopefully in the months ahead as we get the figures for the final financial quarter.

Participant

Whatever the actual truth is, there are still going to be wide variations between different practices in different PCT areas, with different circumstances from the base theorem on which their UDA volumes were calculated. There will be winners and there will be losers, whatever the average is.

Participant

The basic premise of allocating new dental funding based on the paucity of provision under the old system was clearly not going to get away from the postcode lottery and inequalities and there was also a real missed opportunity to recognise the difference in cost base of practices operating in different parts of the country. It is much more viable in a low-cost area to be able to run a practice than it is in a high-cost area and that is adding to the postcode lottery. That is something that needs to be addressed in any tinkering with the system in the future.

Closing Remarks

Dr Andrew Murrison MP

I agree absolutely. Which touches on our battle with health inequalities and indeed it appears that many of the changes that have been instituted are not just in dentistry but across the board and well intentioned changes have improved the situation for those who are not the target for our attempts to address inequalities. That means of course that those inequalities widen even further. I suspect dentistry and oral health is part of that picture, sadly.

I am going to wrap up proceedings this morning, ladies and gentleman. I would like to thank you all very much indeed. I think this gathering is something of a first. It has certainly been a repository of a vast experience and expertise, I would particularly like to thank 2020health and of course the Dental Stakeholder Group, under whose auspices this morning has been achieved and Derek Watson and Julia Manning for all their hard work leading up to this. We have come away with a lot of questions, a lot of observations and one or two solutions perhaps. I hope those involved in policy will reflect upon it, because as I say this is an authoritative gathering. If I can make my second partisan comment of the morning, in the run-up to new dental contracts, there was a perception and reality that those entrusted with formulating contract were not listening sufficiently well to dental professionals and inevitably the quality of the product that subsequently emerged was not as high as our patients deserve. I am certainly as a politician, in listening mode, and I hope you will find that in the two years running up to the next general election that politicians from across the party political spectrum will be in listening mode as they work out what they are going to offer the voters in the election to come in terms of dental healthcare. I can tell you this as a constituency MP it is a matter of very great importance to the general public.

Thank you very much for coming today, it has been hugely useful. We are going to transcribe the remarks that have been made in a non-attributable way and distribute them. I hope that the document that we produce will be influential in forming the views of those who will be entrusted with policy in the future, let us hope that we get it right. Thank you very much.

Comments

Campbell Montague International Ltd.

The financial wellbeing of dentists is crucially important to the future of an effective, inclusive NHS Dental Service. As specialist providers of financial services to the dental profession Campbell Montague International Ltd are pleased to sponsor and support the Dental Stakeholders' Group in its aims and activities.

The costs of operating a dental practice today are increasing significantly with the need to keep premises and equipment at a high standard of both hygiene and appearance.

The availability of new, high tech equipment and information systems designed to assist dentists in the efficient operating of the surgery means that additional investment in these systems is necessary. This in turn places an increasing burden on budgets that to a large extent and now fixed under the new Contract arrangements.

We see significant increases in the investment dentists are making by way of loan and leasing arrangements in order to fund this investment and are attempting to assist the profession with innovative and competitive financing arrangements to make this investment easy and affordable.

Supporting dentists with long term financial planning to ensure future security in retirement is also of crucial importance and we hope to continue to work with the Dental Stakeholders Group to ensure that these issues are fully understood in the overall planning of NHS dentistry in the future'

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Denplan Ltd.

Denplan Ltd is pleased to have had the opportunity to support this open and wide-ranging debate. We are aware that the new NHS contract has caused widespread distress and difficulty for patients and dentists across England and Wales.

Given this situation it is right that discussions should urgently continue on the future of affordable, high quality dentistry. For some patients and dentists the NHS is the only option.

This should impel representatives of patients and the profession, together with government, to give consideration to a sustainable and fair system for maintaining and enhancing the dental health of the population.

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Comments

Dental Payment Administration Systems Ltd.

Quentin Skinner has 18 years experience in administering private dental plans in the UK. He is the founder of DPAS Dental Plans, established 10 years ago, having previously been Managing Director of Denplan Limited.

At the Dental Summit, he observed that preventive dentistry could only work if properly funded. In order to improve the oral health of the nation, either a massive cash injection into NHS dentistry was needed, or otherwise the optimal way forward could only be achieved by means of private dental plans, easily affordable by the large majority of the UK population. Such plans encourage regular attendance, thus increasing the opportunity for any necessary remedial care. He suggested that a possible solution to the current problem may be to look at a system of grant-in-aid, where both patient and Government co-contribute to private dental plans as the optimal way of improving the nation's oral health.

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Dental Practitioners' Association

The DPA was formed in 1954 to support and represent dentists in general practice. We welcome the formation of the Dental Stakeholder Group which first met on 11 Nov 2005 as an inclusive forum that speaks on behalf of dentistry in the UK. We support the right of dental professionals to be heard on an equal basis.

We believe that the new NHS contract imposed on the profession in April 2006 is inefficient, inflexible and unfair and will severely hold back improvements in the nation's oral health. The Association's approach is one of prevention and payment for health gain.

In their 2001 manifesto, the Labour Party said 'By extending the use of NHS Direct and increasing the numbers of dentists, patients will get easier access to NHS dentistry wherever they live.' In its 2005 general election manifesto the Labour Party said 'We will undertake a fundamental review of the scope and resourcing of NHS dentistry.' Neither of these promises has been carried out.

We would support any future meeting between the Minister of Health and representatives of the Department of Health and the Stakeholders Group.

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