Current State of NHS Dentistry

Remuneration

- Any system of remuneration largely determines the activity of the dentist. Whilst it is desirable to think that a dentist will always do what is best for his or her patient, to a certain extent if you pay more for doing a certain type of activity dentists will be skewed more into doing it. Conversely if you pay a dentist less for doing something they are less likely to do it. The current banding system for the payment of dentists simplifies the patient charges into 3 levels;

Band 1 costs the patient £16.50 and covers examinations, x-rays and cleaning.
Band 2 costs the patient £45.60 and covers the above and fillings, extractions and root treatments – No matter how many are done!
Band 3 costs £198.00 and covers lab based items such as dentures and crowns and once again NO Matter how many are done!

A dentist will earn 1 UDA for a band 1, 3 udas for a band 2 and 12 udas for a band 3. The average fee for a UDA is about £22.

So a dentist will be paid the same for 1 filling as for several and the same of 1 crowns as for several. Whilst the patient may pay the same to have several fillings it will cost the dentist significantly more to provide them. This system of remuneration is not favoured by NHS dentists working in busy NHS practices and is a major disincentive to accepting new NHS patients as these patients tend to have high treatment needs. Root treatments are especially expensive to provide but the dentist is the paid the same as for an extraction so there can be no surprise to see extractions have gone up and root treatments have gone down. This system of remuneration is not in the best interests of patient care.

Cost of Providing Treatment

- The provision of dental services along with all of healthcare is an expensive service to provide. Out of the agreed contract value the dentist must pay for all the staff wages, equipment, materials and laboratory costs. On top of that comes the insurances, regulations and fixed costs, such as council tax, that all businesses have to pay.

- Costs are escalating in dentistry. UK is now the leading the world in litigation against dentists. The Fitness to Practice conduct committees of the General Dental Council (GDC) looking at the performance of dentists have a back log of cases of nearly 2 years. This is a product of the GDC making it a conduct requirement for a dentist to “whistle blow” plus the lawyers advertising no win no fees. You just need to see what the acute trusts have to pay out in compensation settlements. I heard of one case when an acute trust had to pay out a £42k

settlement for a negligence case. The patient got only £8k and the lawyers got £34k. The system allows lawyers to earn so much from pursuing this sort of litigation. So we have had a 20% increase in dentists indemnity cover and an over 30% increase in the GDC annual retention fee for the same reasons – cost of legal representation. On top of this we now have HTM01–05 (a decontamination directive) which for a 5 surgery practice locally is costing £60,000 to implement. Then there is the registration requirement for the Care Quality Commission (CQC) by April 2011. There are significant costs in this as well – I understand that it cost West Kent PCT in the region of £40k last year to register with the CQC the 2 medical practices they own. The CQC has advised that the cost of being registered for a dental practice will be about £1500 a year just to them notwithstanding the additional costs of implementing their requirements to the practice. This is at a time when dentists did not receive a pay raise and there is no intention to do so.

Whilst many of you may still think that dentists earn loads of money the majority of NHS dentists are worse off. The majority of NHS dentists are associates and not principals. You need to appreciate that dentistry as a profession is still the most stressful as measured by the rates of divorce, alcoholism and suicide. Doctors on average earn significantly more than dentists but the public don't normally complain so much about that as they don't actually have to pay them directly out of their own pockets.

<u>Practice Goodwill</u>

- One of the most perverse outcomes of the new contract is that whilst taking all the risks of the practice as a business when the dentist finally wants to retire they cannot sell the NHS goodwill of the practice to a potential buyer without the approval of the PCT. So if the PCT does not want to commission NHS services from that practice they don't have to. If the practice has a contract value of more than £25k the PCT will normally have to put the contract out to tender. This is to comply with EU laws.

- I did hear of a case of a dentist about 45 yrs old who was killed in a road traffic accident and was a single handed practitioner with a significant NHS contract. This left a widowed wife who was not able to sell the practice because they PCT had decided not to commission NHS dentistry from that location anymore. As a result the practice folded and not only did the lady lose her husband but she also lost her financial security.

<u>CQC Registration</u>

- This is a product of the Social Care Act and along with other health care providers, ambulance services and nursing homes, dentists must register. Although the claim is that the GDC regulates dentists and

CQC regulates dental services and facilities there are overlaps. CQC registration was considered a good idea as practices with no NHS commitment are not inspected routinely. However the nature of the registration process is so generic it becomes largely a tick box exercise. I am not here to promote or denigrate the CQC but I believe that the consequences of CQC registration in the short term will be counter-productive. We are now seeing a consecutive annual loss of more than 10% of dentists over the age of 55 who are so fed up with regulation and the bureaucratic burden of dentistry that they are withdrawing from the NHS or retiring early. This 50+ age group represent the cream of dentistry with the knowledge and experience they have and are certainly a loss to the nation. It would be an interesting exercise to measure the public benefit of CQC registration against the detrimental effects of it to the public at large. Recent surveys indicate that nearly 50% of High Street dentists have said their morale has fallen further in the last 12 months and 30% of these have said their morale is either low of very low. More than 60% said that growing bureaucracy was to blame. Rising expenses, continuing problems with the current contract and a lack of time to provide preventive care to patients were also cited as major factors in the professions decline in confidence.

- One of the most worrying things about CQC is that they will be also become responsible for regulating the performance of dentists in relation to patient care and fraud in the NHS. However, all 28 of the country's Dental Reference Officers have been made redundant. These are very experienced dentists whose job was to inspect the mouths of patients to make sure that their dental treatment had been properly provided. They were involved in complaints and where the PCTs had reason to believe that NHS fraud may be taking place. The CQC have refused to take on any of these dentists or any other dentist for that matter as practice inspectors. The CQC have stated that they have no need of dentists as their only job will be to tick boxes and not meet with or inspect any patients' mouths. Their intention is to take dental advice when they feel it is needed. So it would seem that the protection of the public with the CQC is more to do with making sure a practice has a schematic diagram of its water supplies in relation to legionella (when there is no evidence of any patient anywhere having contracted legionella at a dental practice) and that the practice can produce evidence of consulting with any ethnic minorities in its patient base than it has with the proper diagnosis and treatment of dental disease.

- It will be illegal for a practice carry out the practice of dentistry without registration after 1st of April 2011. The deadline for application completions for practices was the 31st of December 2010. It is my understanding that at least 2000 dental practices in this country have missed this deadline.

The Future

- Following the Publication of the White Paper in July 2010 "Equity & Excellence Liberating the NHS" the 4 key priorities for dentistry are:

Improving Access
Prevention
Improving Oral Health of Children
Reforming the Dental Contract

There are currently 3 types of contracts being piloted where remuneration is based on:
Capitation only
Capitation with some item of service payments
Capitation with some item of service payments and a separate consideration for enhanced treatments like crown bridges and molar endodontics.

The commissioning of Primary Care Dentistry will become the role of an NHS Commissioning Board. This Board will go live in 2012 as a separate statutory body. Strategic Health Authorities (SHAs) will be abolished during 2012 and PCTs are expected to cease to exist in 2013. The three PCTs in Kent will effectively combine from June this year (2011). There will be local engagement by the Commissioning Board and some of that will be with Local Authorities. There will also be a link with the GP consortia and other stakeholders.

Local Authorities are expected to:
Establish health and well being boards
Carry out joint strategic needs assessments
Carry out health improvement and prevention
Promote choice and local complaints advocacy
Join up health and social services.

The Myth of Prevention

I just want to say a few words about Prevention. Dental diseases are amongst the few that are entirely preventable. It is simply a case of effectively removing plaque from teeth on a daily basis. As such, disease prevention is entirely in the hands of the patient. Therefore the concept of "preventive dentistry" is a myth. Dentists and hygienists do not in themselves carry out prevention. The relevance of this is the continual reiteration that there is not enough funding for prevention. How can you fund prevention? How can you decide how much to pay a dentist for preventive dentistry? It is far more effective for a dentist to spend time showing a patient how to brush their teeth then to carry out a cleaning procedure but they are not and cannot be paid for this. Therefore the system revolves around making a payment for cleaning the teeth. Since most remuneration systems tend to look at rewards for outcomes you can see that a dentist would only be paid for prevention if the patients hygiene improved and not for how much time was spent in teaching

someone who will never be persuaded to do anything more than simply brush their teeth. How many of you in here are prepared to meticulously clean in between each of your teeth each day. And yet it is this area of cleaning that has the greatest effect on the incidence of dental disease.

In order to get patients to properly clean in between their teeth needs a whole life style change and I think the Local Authority could have the biggest impact on this. Dentists are trained to identify disease and disease risk. They are trained to fix things that go wrong. They are not trained in how to motivate those that will not be motivated. Look at the problems we are having with obesity, alcohol consumption and smoking. Do you now what it is like to try and persuade a smoker to give up smoking when he or she does not want to?

The best time to teach humans is when they are young. I think it should become a fundamental part of the schools curriculum and for it to be taught in such a way that it is “cool” not to smoke, not to eat bad foods and clean the mouth properly. Perhaps you as our Kent County Councillors have the best chance of ensuring this happens.

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