1. Does the Local Dental Committee consider that the provision of dentistry in Kent is sufficient to meet the needs of the people in Kent?

This question does not draw a distinction between NHS dentistry and private dentistry. However the best answer to it, based on the number of patients who access out of hours of emergencies who do not have a dentist, has to be "no". There is a significant number of patients who do not have access to a dentist but who are also not interested in attending for regular dental care. Many of these patients are really only interested in the availability of a dentist when they actually need one. There is certainly a lack of dentists willing to accommodate these emergency presentations, which is why many will end up in the out of hours emergency dental clinics (DentaLine).

Most dentists will have an acceptance policy for private patients so we feel that there will not be an access problem for the provision of private dentistry. However the new NHS contract of April 2006 which pays the dentist the same fee for whether they do 1 filling or many fillings results in a financial disincentive for the acceptance of new NHS patients. This is because new patients usually have not been to a dentist for some time and have higher treatment needs as a consequence. The system we have at present does not allow a dentist to first examine the patient to see whether they are willing to accept them under the terms of the NHS contract or whether the amount of treatment the patient requires would be a financial disadvantage to that dentist. This then results in some dentists creating a blanket policy of non-acceptance of new patients under the NHS contract. It would be interesting if it was possible for a dentist to be allowed to make a patient dentally fit under private contract as an initial course of treatment with a view to then accepting as an NHS patient for maintenance provided the patient agreed to attend at least once a year thereafter. This country does not allow these arrangements but other countries do. The policy would be that if a patient fails to attend annually then they lose access to State funded assistance and this you will find in 1 or 2 of the Scandinavian countries.

It is clear that that there are pockets in Kent where there are fewer NHS dentists available per head of population as for instance in the Tunbridge Wells areas. An initial needs assessment document has recently been completed by Chris Allen, who is the consultant in Dental Public Health, for West Kent PCT. This document has focused on what is the current provision of NHS care and how it is linked to population densities. However what is very much less clear is what the actual demand for NHS dentistry is. How you go about assessing the actual demand is very much harder and currently thought is being given to this question. In West Kent we are hoping to explore this before developing a strategy best placed to deal with it. The West Kent PCT has a new Director for Primary Care Commissioning called Stephen Ingram and he is developing a framework for addressing commissioning and hopes to involve a number of stakeholders to create momentum in this area. The LDC feels positive about this.

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2. Is the provision of NHS dentistry uniform across the county, or are there some areas where issues exist?
3. If the answer is no to either of the questions above, what does the Local Dental Committee consider to be the main issues limiting dental provision in Kent?

Some of the responses to the above questions lie in the answer to the first question.

4. What suggestions does the Local Dental Committee have for improving dental provision?

Medway PCT has developed a relatively successful system for dealing with patients who have daytime need of urgent care. There are many more NHS dentists in this PCT and it has one of the best access percentages for NHS care in that about 60% of the population has an NHS dentist. Dentists have been incentivised to see urgent cases for occasional treatment when they do not have to accept the patient to make them dentally fit but merely treat their presenting problem. They are given an enhanced UDA rate for having open access slots and provided they treat a sufficient number of these cases in a year they will receive their enhancement. In general Medway have done a lot better in being able to deliver on NHS dentistry because they have been able to allocate the full dental budget to dentistry. There are other financial constraints for the East Kent and Coastal PCT and West Kent PCT that has prevented them from being able to spend the full NHS dental budget on NHS dentistry.

In the main the New NHS Contract for dentistry introduced in 2006 has been extremely unpopular with dentists. If dentists wanted to continue to provide dental care under the NHS they had to sign it. A number of dentists refused to and went private there and then. Some dentists have moved into private sector since. Although the new contract has strived to improve the quality of dental care patients receive in the NHS and also improve access to NHS care the contract conflicts with the business of dentistry that any dentist, however ethical he or she may be, cannot ignore. The costs of providing dentistry in terms of business costs and staff wages is high and dentists must ensure their continuing profitability to remain commercially viable. A bankrupt dentist ceases to trade and by extension cannot serve anyone. Although the public may find this hard to believe bankruptcy has happened and continues to do so in dentistry. The Department of Health never properly consulted the profession about what would best work as agreements usually have to be a compromise taking into accounts the objectives of both parties. Win/Lose outcomes rarely work in the long run.

Dentists who wish to sell their business are no longer able to pass on their NHS contract to a potentially interested buyer as the PCT are now required to put the contract out to tender (if the contract value is £25k or over). The tendering or procurement process is protracted and involved and results in a disincentive for the purchasing party. This particular issue has been highlighted by the shadow government and it is their stated intent to change this aspect of the new contract. They will also bring back registration by trying to reintroduce a financial incentive for having patient registered with a practice under the NHS. The LDC feels that these would be positive measures but it would be a case of don't hold your breath as politicians have often promised much and failed to deliver. The Conservatives would need to win the election first.

Relations in Kent between the LDC and various PCTs have in the main been good. Although the LDC statutory requirement is to advise the PCT on NHS dentistry we feel that it must do so by representing the interests of dentists and their patients. We do feel that in the main the PCTs do appreciate this but there are times when the PCT finds itself caught

between a rock and hard place as it has to follow the directives of the SHA and Department of Health.

5. A list of the key questions which we have asked NHS Eastern and Coastal Kent and NHS West Kent is attached to this letter. This is for your information, but if there are any areas about which you would like to provide additional information, please do so.

At this point we would like to make you aware of the new decontamination policy being rolled out across the country. This is the Health Technical Memorandum 01-05 abbreviated HTM 01-05. The development of this policy by the Department of Health was in response to a perceived potential risk of developing variant Creutzfeldt-Jakob disease (vCJD), which is an abnormal prion protein, from contaminated instruments used in dentistry. There have been 167 deaths from vCJD in the last 20 years with a sudden fall off since 2000. The current prediction is that there is likely to be 1 or 2 deaths a year from now. The number of patients acting as carriers of this abnormal protein and the reason for the sudden fall off in deaths is not known. Not one of the deaths so far has been linked to dentistry. The cost of the implementation of the requirements of HTM 01-05 in dentistry is £millions with individual practices having to spend £1000s. It will not be possible for some practices to achieve the essential standards required and they will be faced with closure if the PCT insists that these standards have to be met. Some PCTs do not have funds available to assist with the costs and they will be faced with tough decisions such as do they turn a blind eye or do they insist on closure? If they do turn a blind eye how can this be equitable when other practices will be forced into this sort of expenditure?

So we do have problems in dentistry to come but at least nothing has changed in this respect. If you have any further specific questions you would like to ask then please feel free to approach the LDC at a later date.

Tim Hogan BDS
Chair Kent Local Dental Committee.