Nationwide mobile dental practice launched

The first nationwide mobile dental practice has been launched in the UK. DentalXpress hopes to improve access to dental care with its fleet of multi-clinic room portable dental units.

The idea is that in areas where a dental practice is needed, DentalXpress will be able to plug the gap with one of its mobile units.

DentalXpress spokesman Amarjit Gill said: “The population of the UK is projected to rise to 67m by 2051 and as NHS dentistry budgets decline, there is going to be even greater pressure on already limited resources as funding is further stretched. Primary Care Trusts are constantly looking for innovative solutions and don’t want to invest in fixed practices at a cost of £500,000 to £750,000 if the demand for dentistry does not materialise.”

Data from the NHS Information Centre released recently shows that only 58.3 per cent of the population saw an NHS dentist two years ending March 2009.

The government said in May this year ‘we aim to ensure that everyone who wants to see an NHS dentist can by March 2011’.

However, the same source said that after the last NHS dental patients did not take on any new practices.

Leicestershire and Rutland is the first Primary Care Trust in the country to introduce the service and DentalXpress is currently in discussions with six further PCTs to launch similar services in their areas.

Leicestershire is opening the first DentalXpress practice in the Sutton area of the county and aims to provide NHS dental care for 400 people a month.

DentalXpress is a social enterprise with an ethical principle to deliver lasting social change. It has pledged to reinvest 75 per cent of any profits it makes delivering NHS dentistry back into expanding its service and is currently exploring ways it can expand its provision to serve schools, the armed forces, domiciliary care homes for the elderly, universities and the homeless.

The mobile units offer all the amenities expected in a normal bricks and mortar practice; they have a reception area, four inter-connecting treatment rooms, a disabled toilet and a staff room.

Wherever possible all the dental instruments used will be disposable.

The organisation’s logistical expert will carry out an assessment of each location; the size of the space required to accommodate the mobile unit as well as access roads, power, drainage and so on.

Each unit will be staffed by two to three dentists and three dental nurses and served by one receptionist who will work continuously throughout the day. There will be a computer and telephone booking system (with a freephone number) and confirmations will be offered via email and text.

The aim is to set up a DentalXpress service in each PCT area it serves for four-six weeks and return to each of these areas on a four-six weekly basis.

The organisation is currently recruiting dentists locally to serve a particular community, which will help them build relationships with the patients they treat and local practices to which they will need to refer.

The objective is that these dentists will work as self-employed practitioners on a sessional basis and will be paid according to the number of patients they see, which should encourage them to build up a local following.

The dentists undertaking sessions for DentalXpress will be encouraged to join local Managed Clinical Networks, to liaise with other dental providers in the area to whom they may want to refer and establishing good local relationships.

Dental nurses will be employed by the company and will work with the same dentist in pairings to encourage team building and each unit team will have a receptionist.

The new one-year taught programme began last January with students attending a one month full-time training programme delivered by the course leader Dr Hemant Patel and other specialist orthodontists in the Institute for Postgraduate Dental Education at University of Central Lancashire (UCLan).

After this period the students returned to their clinical practices and worked with their clinical mentors (again specialist orthodontists) to treat patients under close supervision.

Over the past year, students have returned to Preston each month to pick up further clinical skills, working in the phantom head room in the university’s Greenbank Building, and having ongoing clinical and academic assessments.

One of the first successful students to pass the course was 59 year-old Linda Rice from Barking in Essex.

She said: “I have gained more confidence in myself and my abilities through doing the course, which I’ve really enjoyed. I liked the practical side of the course and as I gained more experience and got further into the course it was good to put the information I had received in lectures into practice and see my new skills at work.”

Course leader Hemant Patel said: “I’m delighted to see our first cohort of UCLan therapists do so well. They have all worked so hard and their success is well-deserved. The course has been a fantastic success and I think it’s wonderful that orthodontic staff now have the opportunity to move their careers in such an exciting direction.”

For more information on UCLan’s Orthodontic Therapy programme call 01772 895865 or visit www.uclan.ac.uk/dentistry.

Success for student orthodontic therapists

All fifteen students on the University of Central Lancashire’s first Orthodontic Therapy programme have passed its examination and are now eligible to practise as qualified orthodontic therapists.

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Programme Progress

Department of Health (DH) national director for NHS dental access, Dr Mike Warburton, has iterated that the template agreement, launched in November to procure additional dental access for patients through the Dental Access Programme (DAP), is having a positive impact.

Wolverhampton City, Brighton & Hove, Newham and County Durham PCTs are among the first to announce success in dental access communication pilots. These are intended to develop and assess methods of improving public perception about NHS dental access, through public engagement campaigns.

Speaking at a DH press conference in December Dr Warburton said: “The access programme is responding to patients’ demands with regards to improved access. This is to be achieved through giving support to PCTs in the procurement of new services, contracts and improved communications.”

He emphasised that the DoH is working closely with PCTs and providers to make them aware of the details about how to procure services. He said ongoing meetings with Strategic Health Authorities to talk through relevant data and ensure clarity about the national guidance on the frequency of patient attendance, had been well attended. He explained: “These meetings are organised to take providers and pilots through the rationale of the content. There seems to be interest in procurements and there has been a good response to adverts to date, which hopefully will continue.

“We are working with PCTs to improve contract commissioning and are launching a dental contract management handbook contract handbook, as well as ongoing workshops to facilitate.

Fuller dental contract change proposals will emerge out of the contract pilots, which are scheduled to start in March. These are in line with the implementation of Professor Jimmy Steele’s NHS Dentistry Review, NHS dental services in England, published in June last year.

The DAP is undertaking local patient experience surveys before the four campaigns begin and also after they have evaluate their success. Dr Warburton said the new patient experience indicator survey was an essential component of the programme. He said: “The patient experience indicator is validated as high when there is good NHS dental access and low when there is bad access.”

He added: “The survey will go to large numbers of people from each PCT and so we will know accurately if we are meeting the demand.

Patients need to know that there is good access and it is important to increase perception of this.”

The first PCTs will get their survey results in June 2010.

Chief Dental Officer for England, Dr Barry Cockcroft added: “The Which report last year stated that 88 per cent of patients who tried to access NHS dentistry, could do so.”

Dr Cockcroft said the latest NHS dental access data showed that 950,000 people have been able to access an NHS dentist in the last five quarters. But he did admit that although there was good access in some areas of the country, in other areas it was much lower.

More than £2.25bn of the £90bn NHS budget is allocated to NHS dental services each year, with patient charges adding a further £550-£600m. In 2008-09, the national budget for NHS dentistry was increased by 11 per cent, with a further 8.5 per cent in 2009-2010 to enable improvements.

PCT commissioners are being encouraged to make use of the new template agreement to procure additional access for patients which the DH claims, contains quality and access measures for the first time. This allows contract holders to be rewarded for high quality provision through specification of service quality standards by PCTs. The DH believes the measures will also enable providers to better understand what is required and price their services accordingly.

PCTs should seek advice before taking on one of the templates.

The DAP was set up by the DH in March last year to support the NHS to deliver its commitment of NHS dental access for all who actively seek it, at the latest, by March 2011.

The programme aims to:
• Increase access through opening new dental surgeries,
• Improve management of existing contracts to ensure patients receive the best service
• Ensure better information to patients about available NHS appointments
• Develop access measures based on patients’ actual experience.

A template letter for PCTs to send to their dentists, letting them know what is going on to improve dental access at both national and local level is available for PCTs to download and send out.

Dr Warburton said PCTs were already carrying out innovations to let patients know about the programme, such as placing advertisements on buses.

“We are looking at what works best, whether leaflets, ads or radio campaigns.”

What is gleaned from the use of the new agreement, along with the inclusion of Key Performance Indicators (KPIs), will be fed into the overall contract review process. Sue Gregory, deputy chief dental officer for England, said KPIs would be set according to the local situation of a given area.

Other key factors of the agreement are that it is more specific and thereby could facilitate more effective contract management by the PCT. It is also underpinned by new national data collection arrangements.

The Government’s commitment is that by March 2011, access to an NHS dentist will be available to all who seek it. But the British Dental Association’s General Dental Practice Committee (GDPC) is of the view that providers should seek advice first before entering into any agreement. The GDPC thinks that dental access funding contracts are unnecessarily complex.

The body believes that fundamental new provisions, such as the payment mechanism, the need to comply with new KPIs and the dental care assessment of patients should have been developed and piloted in conjunction with the wider profession through the implementation of the Steele review.

GDPC chairman, John Milne, said: “Although it must be an individual business decision, we advise dentists to think very carefully and seek advice before taking on one of these contracts as the dangers of breach are rife, and the consequences of breach may be very damaging to practices.”

However, initial feedback from providers with whom the template has been discussed, suggests that there will be sufficient providers willing and able to tender for these services.

The, publication of the DH’s Deliver Better Oral Health toolkit last year, has also made an impact on the accessibility of dental health, with significant increases by patients in the use of high-concentration fluoride products.

The draft access agreement, can be viewed on the BDA website, at: www.bda.org.uk
Out with the old?

Chris Hindle asks ‘what impact a Conservative government would have on NHS dentists?’

With a possible change of government looming on the horizon, it is interesting to contemplate potential changes that a Tory government may make to the running of NHS dentistry should Mr Cameron et al achieve power.

Transforming NHS Dentistry, published last year by the Conservatives, received a cautious welcome from BDA General Practice chair John Milne, Mr Milne stated: ‘The dental contract introduced in 2006 has created significant problems for dentists and patients. These problems have been well documented by the BDA, patient groups and the Health Select Committee. In seeking to address those problems, it will be important to afford access to dentists to all and ensure that dentists can provide modern, preventive care’.

Traditional thinking

Much of the proposed policy expressed in the document fits in with traditional Tory philosophy and thinking – such as reducing bureaucracy, less state interference, greater access to information, more patient choice, further opening up of the dental services market and financial incentives for dentists to increase capacity.

One of the lynchpins of the proposals centres around dentists being able and encouraged to offer preventative treatment – can this be paid for through the anticipated cost saving it is hoped will be brought about by an assumed, consequent decrease in curative and restorative activities?

The idea of providing increased statistical data to the public does amounts to more bureaucracy rather than less. Dentists will be concerned to see which of their activities will be measured and how the data is presented.

Patient charges

Dentists may find themselves involved as enforcers to some new, hard-line, money-saving measures – being able to fine patients who miss appointments for example and also, although only a point for consultation at this stage, as to how they can help in preventing patient fraud. There is a belief that dental care funding is losing out as a result of patients wrongly claiming exemptions. A figure of £120m has been quoted as the figure the PCTs lost in income, since the introduction of the new dental contracts, due to patient charges being lower than anticipated.

A welcome change

There is though plenty in the proposals that dentists may welcome – such as dentists having the opportunity to achieve more control over their own destinies. The current target-based contracts system would be phased out when the time-limited contracts expire.

This also raises the worrying prospect of already overburdened PCTs having to take on and run a dual system. The proposals would allow dentists to return to having their own lists of registered patients – and for those practices it would certainly make it easier to define what is meant by practice goodwill; thus meeting a much welcome requirement of dentists to make it easier to buy, sell and fund NHS practices.

Some dentists will welcome proposals to allow a child-only NHS facility at their practices, no doubt helping the envisaged Tory crusade on encouraging prevention rather than cure.

Whether or not the Tory proposals have the substance the profession wants for reform remains to be seen; the Tories certainly seem to have taken note of dentists’ cries for reform. Any changes though will take a lot of time, energy and of course money.
Access over quality = prescribed neglect?

Although high-need patients can be seen for dental treatment, Neel Kothari thinks the jury is out as to whether they are getting the treatment that best meets their needs.

Over the last few days, I witnessed a miraculous cure to my writer’s block when a patient I recently treated brought to my attention some of the issues that can still be seen within NHS dentistry.

This patient is a young lady of around 25 who presented in a great deal of pain from a lower abscessed molar tooth, as well as rampant caries elsewhere. I asked her when she had last seen a dentist and she replied: “Only last week, I booked in to see a dentist under the NHS, but at the end of my session I was told that this was only an emergency visit and they did not have the time to see me for treatment.” She was told to find another dentist and was given a prescription for antibiotics, but still could not sleep or eat.

Funnily enough, this is not the first time this has happened and I am sure that many of you may have encountered something similar. The problem here in my opinion cannot be put down to the new contract, but when any system is based solely on ‘improving NHS patient numbers’ rather than ‘improving quality’, surely the architects of the new contract must accept some culpability for introducing a system that, through a lack of proper piloting, has effectually prescribed neglect across the nation.

The good news for the Department of Health (DH) is that this patient will now probably count twice in the access figures! Leading me to question, just how exactly does the Government collate access figures?

Meeting bottom line While I have some sympathy for dentists having to provide an unlimited mass of dental treatment for a fixed level of remuneration, surely there can be no excuse for kicking out patients in pain and agony while cherry picking those patients who help to better meet the bottom line? Cases like these do raise important questions as to how the profession deals with those patients needing much restorative intervention. When trying to find out what the ‘powers that be’ (various PCTs and dental unions) seem to think, I was not surprisingly bombarded with a myriad of different options ranging from treating all dental disease within one course of treatment, to treating some of the major problems, stabilising the patient and spreading the treatment over multiple courses.

While they all agreed that it was unacceptable to leave a patient in pain, I’m afraid across the nation, many dentists are apparently still working in different ways and it is clear that we still all have different interpretations of exactly how the new dental contract should be implemented. One problem still remains: when one dentist chooses to cherry pick patients, this leaves others to unfairly pick up the pieces.

Disastrous consequences Ten years ago, in September 1999, Tony Blair told the Labour Party Conference: “Everyone will have access to an NHS dentist within two years.” Ten years later the drive to (still) try and achieve this has clearly had disastrous consequences. Rather than improve quality, access and patient satisfaction with the service, the reality of the situation is that in real terms we have gone backwards.

The promises made at the recent Labour Party Conference should really be measured up against Labour’s own record. This in fact shows loss of access. After the introduction of the new contract, the number of people accessing NHS dentistry fell by one million. Some 2.5 million people are not going to an NHS dentist, because it is hard to find one. Fewer children are accessing NHS dentistry – more than 100,000 fewer than before the new dental contract and dental caries is now the third most common reason for children’s admission to hospital.

A key driver? Regardless of how the Government dresses up various new schemes and initiatives to improve NHS dentistry, it does not take long to realise that ‘improving access’ tends to be the key driver. But how sensible is this aim? Of course everyone who needs a dentist should be able to get one, especially as it’s called a National Health Service, but exactly what are they getting?

In Hampshire and the Isle of Wight, access figures are clearly well below average. Regardless of how much investment into dentistry has been made here in recent years, according to prospective Parliamentary candidate Terry Scurr, thousands of people across the New Forest still have no access to an NHS dentist.

One of the problems here is that any new practice commissioned by the PCT would be subjected to a massive number of patients, many of whom may require treatment for years of dental neglect. That’s great, you may say? Surely that’s exactly what a new dental practice needs, isn’t it? Well, yes and no; we hear a lot about NHS efficiency savings and getting more for less, but there comes a point where less is definitely less and if PCTs choose to fund new services based around improving access rather than quality, just exactly who are they accountable to? And at what point does this transgress from governing to influencing clinical decisions?

Of course since the inception of the NHS, dentistry has always been used as a political football where successive governments have incentivised clinical choices they deem favourable. However in incentivising access over quality, while high-need patients are able to be seen for dental treatment (according the DH), for me the jury is out as to whether they are getting the treatment that best meets their needs.

About the author

Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at UCLs Eastman Dental Institute, and regularly attends postgraduate courses to keep up to date with current best practice. Immediately post graduation, he was asked to be the chair of the seniority team and see the changes brought about through the introduction of the new NHS system. Like many other dentists, he has concerns for what the future holds within the NHS and as an NHS dentist, appreciates some of the difficulties in providing dental healthcare within this widely criticised system.

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