High standards

In part one of this two-part exclusive interview, Neel Kohthari talks to Chief Dental Officer Dr Barry Cockcroft to find out how well he thinks the NHS system of dentistry is working and what standards it should be aiming for.

NK: Since Labour has come into power, funding for the NHS has almost doubled. In your opinion how well is NHS dentistry currently doing?

CDO: The way we describe it at the moment is that it’s turning the corner. It’s certainly been a very turbulent period over the last three years and it’s obviously a very high priority for government and ministers. What we know now is that the amount of NHS dentistry being commissioned, being purchased from dentists, is now above the level it was in April 2006 and that’s continuing to rise. We increased spending by 11 per cent in 2008/9 and we will increase it overall by 8.5 per cent next year, which is a massive level of investment. According to Information Centre data the number of dentists providing treatments is up, and the NHS is already commissioning more dentistry than it was prior to the introduction of the new contractual arrangements in 2006, but the access data which has stubbornly so far gone in the wrong direction we are absolutely confident will begin to move in the right direction.

NK: When do you feel this will happen?

CDO: Very soon, we know it’s retrospective data, so the data we publish towards the end of February will indicate what happened in the two years ending last August. In our view, it’s already turned around, but isn’t reflected in the retrospective data yet.

NK: Has the increase in NHS dentistry spending gone towards commissioning new services or has this been lopped up by a deficit in PCTs’ budgets from a reduced patient charge revenue (PCR)?

CDO: No, not at all, the two things are not connected. The reduction in PCR I wouldn’t say is insignificant, it was there in the first year of the contract, but is certainly getting better. But the 11 per cent is certainly being used by PCTs to commission new services which you can see all over the place.

NK: But that’s not really the case everywhere. After all, PCTs also have to make ends meet.

CDO: Now they have made a commitment to grow services, as you can see in our response to the HSC, they have got more money to grow services, and that’s what it’s about. The overall difference in PCR pales into insignificance compared to the money they now have to grow.

NK: What I mean by that is, as you are well aware, dentists and PCTs have to budget themselves within a certain level…

NK: What do you feel about this?

NK: So should dentists on the NHS be providing a basic, core service and how does this compare to what’s available within private dentistry?

CDO: It sets out in the regulations that dentists are being paid in advance to provide treatment that is clinically and cost effective. We are providing them with extra money, dentists’ income has gone up. I think the comparison between the NHS and private sector is not something I want to go into. I think there are things that the patient may want which are not clinically effective and it’s right that the NHS doesn’t pay for that. At the same time, if someone’s got a developmental defect and has hypoplasia for example, it’s quite right that the NHS pays for cosmetic treatment in that situation.

NK: But an anecdotal report from another practice where a patient had been refused endodontic treatment under the NHS and was told she could only have the treatment privately. What do you feel about this?

CDO: Can I give you another anecdote going the other way?

NK: Sure.

CDO: Anthony Halperin from the Patients’ Association took a high needs patient with poor oral health around dentists in north London and publicised this on Sky News. He said that the patient had right missing teeth, an untreated abscess and that the correct treatment plan was a 12-unit bridge and endodontics. Quite frankly, I think a dentist carrying out that particular treatment plan might have been in breach of his contract. So it’s not the NHS’ job to treat absolutely everything at the absolute highest cost, which is what that was and it was totally inappropriate. It’s about clinical and cost effectiveness, and that’s a judgment dentists have to make. If a dentist says something is not available because it’s not clinically appropriate – around molar ends it may be that the crown’s not restorable or the tooth might be mobile, or it might be an upper wisdom tooth which is of no clinical significance at all – it’s completely appropriate to say that’s not available, that’s not clinically effective. But if something is needed and necessary and if a dentist deems it on the basis of cost, then that’s completely inappropriate and is a breach of contract.

NK: If NHS dentistry is aiming to provide more then a basic service, has the government fairly allocated funding for complex treatments?

CDO: We think of first of all the funding for individual contracts, but the commissioning of clinical spending, so if dentists did treat under the old system, they are funded for doing it now. The incidence of complex and routine treatment is going down and we completely accept that. If it’s inappropriate then that’s fine, but remember the old system completely incentivised intervention. If you go from a system where the incentives are going in the opposite direction, you are going to see some reductions in treatment, which we’ve seen. And we have seen that in PDS pilots since 1988. The research done on PDS pilots, which showed the reduction in intervention in both complex and routine treatments, it had no negative impact on oral health. However, if the reductions in treatment are inappropriate, this then becomes a quality issue which needs to be addressed.

NK: The recent HSC review into NHS dentistry highlighted a range of complaints by dentists and patients and has concluded that the contract is in fact so far failing to improve dental services measured by any of the criteria set by the DCS. Do you agree with this assessment?

CDO: Most of the evidence was given in March 2008 and most of the evidence was created much before that and as we all know, it takes time for systems to reform to start to show a benefit. Many of the things the HSC reported from the evidence they’d been given have...
not actually come true. There is no shortage of vocational train-
ers, there is no evidence of a mass exodus of dentists. There is significant increase in the amount of preventative treat-
ment going on. The amount of NHS dentistry commissioned has gone up, the number of den-
tists working in the NHS has gone up. One thing that has not turned round yet is the retro-
spective access data and if we are right, we expect that to turn around; then we will have evi-
dence that everything we said would happen would have actu-
ally happened.

NK: In 2009, the three-year term for the current contract expires, what changes can dentists expect to the current system?

CDO: Current contracts do not expire. This is a complete misunderstanding about what will happen after April 2009. Nothing changes, other than the gross income guarantee. So everything else remains the same, GDS contracts are open-
ended and can only be termi-
nated if there is a breach of contract.

NK: So dentists can expect no changes to the current UDA system, not even an increase in the number of bands as ad-
voctated by the HSC?

CDO: No, nothing like that. We would need to consult on any of that, and in the statement of fi-
nancial entitlement which we consulted on widely recently we made the point that contract val-
ues, if nothing happens, will for next year remain the same, just up-rated. The only thing that changes is the gross income guarantee. The PCT does not have the power to change a con-
tract unilaterally. But if somebody had a contract value for £200,000 and for the last three years has only delivered £100,000 worth of contract, then the PCT now has the opportunity to say you have underperformed for three years and we propose that your con-
tract value be reduced.

NK: Nationwide PCTs have provided a mixed service, have the PCT staff received ade-
quate training with com-
missioning or is more needing to be done?

CDO: We completely accept that the quality of PCTs’ com-
misioning has been variable, as has the engagement of clini-
cians. What we’re now able to say is that 50 per cent of PCTs have already increased access since the new arrangements, but others have not, and that’s why we announced in the HSC that Mike Warburton, who helped implement the equitable access for GPs last year, is going to help the PCTs that are having the most difficulty. In our final response to the HSC, the strate-
gic health authorities (SHAs) have said: ‘We will work with our Primary Care Trusts to make sure that all our PCTs’ commis-
ioning plans enable us to de-
liver health dental services to anybody who seeks them by April 2011’, at the latest. I think this puts together a nice little package to help support our PCTs. But it’s been very difficult over the past two to three years getting clinical engagement. But things are clearly moving in the right direction now.

In part two to be published in a later issue, Neel Kothari talks to Barry Cockcroft about how the sys-

tem has affected the balance be-
tween performers and providers.

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 UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up to date with current best practice. Immediately post graduation, he was able to work in the older NHS system and see the changes brought about through the introduction of the new NHS sys-
tem. Like many other dentists, he has concerns for what the future holds within the NHS and as an NHS dentist, appreciates some of the difficul-
ties in providing dental healthcare within this widely criticised system.

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