Knocking opportunities

Since the revised dental contract in 2006, some dentists have gone private, but others are running successful NHS dental practices. But how well are they really doing? Yvonne Gordon investigates

Principal dentist, Dr Gurpreet Singh Lidder opened his first practice in Dunstable in 2004 - the year of the new contract’s test-scheme – and a second practice in Leighton Buzzard this August.

He says his success is because of regular communication with the PCT. Dr Lidder acknowledges the practice is doing fewer complex procedures, but thinks an advantage of the new contract is increased flexibility to use both NHS and private treatment. He says: ‘Previously, dentists were either NHS or private, but the new system encourages mixing. A patient can have an NHS filling or crown for some teeth and private treatment for others. Dr Lidder says this compensates for financial losses from NHS treatments. A dentist can charge privately for restoring a root-filled tooth, with the root-canal treatment on the NHS. Therefore a patient can have more aesthetic and durable restoration as an amalgam alternative. ‘Once we explain to patients why we offer an additional private treatment option, most readily accept it,’ he adds.

However, he thinks one of the new system’s disadvantages is there is no longer patient registration, which opens the floodgates for criticism. He says: ‘Lack of registration opens the door to give the Government flack that NHS patient figures are now hidden; under the old system, it was clear how many were registered.’ He thinks if patients were registered, surgeries with more NHS patients could be financially rewarded and patients could ask for their own dentist, rather than any available.

Although much of the motivation for the new system was simplification, Dr Lidder thinks it has become oversimplified. This can encourage some dentists to opt for tooth removal rather than longer treatment, because payment is the same. He says: ‘As an incentive, financial rewards should be given to dentists for more complex procedures.’

But he adds that technological advances like implants offer a very successful treatment outcome – an alternative to tooth removal and to other complex and statistically less successful procedures.

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Trust…
He says the new system makes it easier to budget, because income is predictable. Beforehand, income was dependent on how much work a dentist undertook, so investment was riskier.

All in all, Dr Lidder sees a bright future for dentistry. He says: ‘In Bedfordshire, the PCTs are doing very well. With the Leighton Buzzard practice, there is hardly anywhere with lack of NHS access. But I would suggest bringing back registration and rewarding those NHS practices with more NHS patients.’

And to any new dentist thinking of starting their own NHS practice, Dr Lidder advises: ‘Start small with something you can control and then expand after several years. Don’t go for big tenders, leave them to the corporates. Take a small tender with feasible UDA targets and build up slowly.’

Crude UDAs

General Dental practitioner, Shiv Pabary, is the principal of a large practice in Newcastle, running five other dental practices, two of which opened since the new contract. He is also part-time honorary clinical lecturer at Newcastle Dental School. He has always worked in the NHS, having his first practice in 1987. Alotted one of the original Personal Dental Service (PDS) contracts, he isn’t keen on Units of Dental Activity (UDAs). He says: ‘I am not a lover of UDAs, which are a crude, financial measure.’

It is not just about delivering UDAs, but the need to develop quality initiatives, such as preventative dental health.

However, the new contract offers many opportunities, depending on how good the PCT is.

The key to local commissioning is the relationship with PCTs, which are both very fair here. They need to ensure they engage with dental practitioners before they commission and analyse surveys on patients’ needs.

‘We have found the PCT very helpful in providing funding for equipment. But it would be worrying if they stopped such non-recurrent funding.’

Dr Pabary says the surgeries, which see up to 20 patients per day per dentist, have enough capacity to treat all NHS patients. For him, a downside of the new contract is the length of treatment for high-needs’ patients and the danger of running out of money if one expands, although it is possible to negotiate for more UDAs. Other gripes are treatments, such as individual crowns, which have risen. A patient, who has three crowns at once, will pay the same as a patient who just has one. Dr Pabary has not changed his overall philosophy, - to cater for the needs of individual patients - but he does understand how some dentists could veer towards doing tooth extractions rather than conservation treatment, because payment is the same.

He says: ‘The average UDA for our practices is £22 with the same UDAs for a filling taking 10 minutes or a root-canal treatment, taking several hours.’

He says UDAs claim to incorporate prevention, but dentists would have very little time if this were done for everyone, so a hygienist and an oral health educator help out. He thinks there should be more emphasis on prevention. ‘There will always be jobs for dentists, because of advances in technology, with areas such as titanium implants becoming huge.’

Dr Pabary has always offered private treatment to give patients all options. Under the new contract, NHS treatment must be a clinical necessity, so cosmetic crowns or bridges do not usually fall into this category.

As for the future, he thinks it bodes well for large practices. He said: ‘Practices of a certain size will survive, because it is easier for PCTs to commission with a large set-up. The single practitioner will become isolated.’

PCTs need to look at what quality means to patients, in terms of access, ease of ap-
pointments and explanation of options.

‘We are working well with the PCTs and doing a good job, but part of the problem is lack of continuity. In Gateshead, two women lost their PCT positions, with whom we had built a relationship. So trust was built up and then lost. PCTs should have a dedicated dental lead person to maintain ongoing dialogue with dentists.’

‘Whether local commissioning works will become clear when PDS ends in 2011.’

Challenging contracts
Meanwhile, Shalin Mehra is MD of a 21-practice dental corporative, with practices across several PCTs in Northamptonshire, Derbyshire, South Staffordshire, Gloucestershire, Leicestershire County and Rutland, Oxfordshire and Bucks.

He feels the new contract has some very definite advantages, while acknowledging initial problems. He says: ‘Every new contract is challenging and one must be adaptable to change. One advantage is that, as a provider, it is easier because an accurate prediction can be made regarding annual income. This helps with business planning and is a big positive.’

He thinks the new contract is a great opportunity for PCTs to take control of local dental provision.

‘If an NHS dentist decides to only offer private treatment, the local PCT can re-invest the money clawed back, which is good for patients.’

Mr Mehra takes on board comments from the Health Select Committee about fewer patients and decreased access, but thinks these issues are being resolved.

‘We can work with the PCT to change and address local needs. I think that figures quoted about less patients having NHS dental access, are historic and that access is improving overall. The new contract is not perfect, but again I am hopeful that concerns aired by the profession are being taken on board.’

The handing system needs to be refined and targets are hard to achieve in areas of high need.

‘But most of all, one needs an open, honest and transparent relationship with the PCT, which is currently commissioning a lot more dental activity.’

He adds there is an ethical duty to give patients the choice of fit-for-purpose NHS treatment or cosmetic treatment which is a luxury. ‘The range of options now is far wider and patients can mix and match NHS and private treatment.

‘It is early days, but I am sure things will gradually stabilise under the new contract, with a greater emphasis on prevention in the future.’

Listening up
Dave Pulford, principal dentist of a 25-year-old practice in Nuneaton, is local dental committee (LDA) chairman of Warwickshire PCT. He says there has always been good dialogue with his PCT, which carried over his PDS contract to the new GDS contract. ‘The PCT has listened since day one. I think PDS was a better system, because there was more emphasis on preventative dentistry.

‘Before UDAs we were given a monthly sum so there was more clinical freedom. Now the monthly sum is tied into the number of UDAs on the three hands of examination, fillings and laboratory work.’

Mr Pulford says the most common treatments at his surgery are check-ups and advice, less crown and bridge work is being done. The practice also offers cosmetic dentistry. He thinks that overall the new contract is working well in Warwickshire.

But as for dentistry’s future, he sounds a warning note: ‘The Government has what it wanted – to fix the cost of dental treatment. If that continues, there will still be an NHS. But what one gets for it, may well be diminished.’

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