NHS Dentistry: your questions answered

Practice Plan's **NIGEL JONES** looks for answers to the questions you're asking.

"What is the impact of the prototype blends on those practices involved?"

SINCE April 2016 two different blends of remuneration have been tested out by practices (a total of 80 are currently involved) as part of the contract reform process. The difference lies in the proportion of care that is covered by capitation and activity.

To get more insight into the real impact of these blends on a practice, here, we have asked a dentist from a blend B practice about their experience. We will also be asking a dentist from a blend A practice for their insight in a future column.

Remuneration in prototype blend A practices is covered by 60 per cent capitation, with band one activity included, and the rest of the bands covered by activity. Whereas for prototype blend B practices it is 83 per cent capitation, including band one and two activity, with band three covered by activity. While that is the fundamental difference between the prototypes, this has an impact on the way those practices operate. We asked Ben Atkins, Clinical Director of a prototype B practice, to share his experience:

"I welcomed the new dental contract, in its prototype form, as its aim is to support patients on a lifelong preventative pathway to maintaining good oral health. In my view, this is a most welcome shift from the UDA focus of the old contract.

Prototype blend A and blend B practices were nominated to trial the system. The two blends are very similar in approach and in clinical terms, with the differences being in the areas of capitation and remuneration.

My practice has been prototyping blend B, and it has been an interesting journey so far, from many different perspectives.

The change is fundamental. It goes against all the things I love in dentistry, or did love before my further journey into Minimal Invasive (MI) healing dentistry. I actually enjoy restoring, drilling, filling and endodontics! So, to change the emphasis in such a large way to prevention, is still a challenge.

I must, begrudgingly, recognise that at approximately £45 per preventative intervention, I'm not cost-effective compared to a dental nurse/extended duties dental nurse at £0.48 per intervention. In addition, they are likely to be far better than a GDP in delivering the preventative elements and stages of the patient's care pathway.

So, this means thinking about the composition of staff in my practices and how to pay for them. We do now have an EDDN delivering two full clinics, weekly. This cost was covered by a reduction in laboratory bills in the early days. But these costs may just prove to be deferred rather than removed. This is because, the GDPs now focus back on band three UDAs, as required by the prototype structure, whilst not having been a part of the earlier pilot project.

To make the new structure work effectively, we will need the NHS to support the preventative side of dentistry (the latest disclosing gels, behavioural change products for patients, etc.) as well.

Our experience confirms that patient education is a crucial part of success. As a practice, we have had to invest considerably in this area. There is a big mindset change going on for the profession, but the change is no less profound for patients, who are used to a regular routine of dentist and hygienist visits. Also, they will never have been held as accountable for their own oral healthcare, as they are now. It is the right message to give, but the first time you explain to a patient that they must improve their own oral healthcare before a course of treatment can commence, is a challenge.

For non-GDP support staff, the workload has increased and they are being taken outside their comfort zones and into areas that they are not necessarily fully trained for. As the prototype project becomes reality (as I'm sure it will) then a change in support staff training, across the industry, may be a consequence of ensuring that we get delivery and implementation correct. In my own practices, we have had to deliver regular additional training to stay on track.

"Let's get proper goalposts in place – clear, simple targets, up-to-the-minute comparative statistics"

The biggest challenge I have, is the movement away from restorative work, to a culture of minimal intervention and prevention. It is a significant and countercultural mind shift for dentists. Because of this change, I've seen a drop in morale across the team. This new way of working is challenging and to many, is complex.

In truth, it has not been helped by the fact that, despite us reporting our findings as required, feedback coming the other way has been slow and as a result, counterproductive. Trying to deliver significant change is hampered if you are not promptly told how you are doing, nor given prototype-wide data to benchmark against.

I can't delay paying my team until three-month old data arrives for me to accurately assess the position. As the business owner, therefore, I always take the financial hit.

We have had to introduce new systems and processes because of the prototype. For example, we now operate a daily lapse list, to ensure we don't lose patients, which would affect us under the blend B capitation structure.

And, as I've mentioned, we now have UDA targets, as well as prototype blend B targets, and DQUOF hasn't gone away either!

But this prototype must work; it has to, for the good of public health; the NHS and our profession. So, let's get proper goalposts in place – clear, simple targets; software that helps; regular and up-to-the-minute comparative statistics. And removing DQUOF would also help.

Better, centrally produced, patient-education tools could be created and distributed and the BDA/NHS reintroducing the funding of local support groups would help us to move forward, further and faster; setting the standard and the template for when the new contract eventually rolls out nationwide."

Thanks Ben for sharing your experience and providing more detail of life in a prototype blend B practice. I'm sure many of us working in dentistry are looking forward to the findings of the review and evaluation of all the prototypes that was due to be conducted 2017/18. In the meantime, we hope to soon share similar insight from a prototype blend A practice in this column to help provide further insight to the profession. ■

Ben Atkins

Ben Atkins is clinical director at Revive Dental Care in Salford, a prototype blend B practice. He qualified from Sheffield University in 1998 and now specialises in restorative work. Ben is a spokesperson for the Oral Health Foundation, is on the Board of Trustees of the OHF, and Chairman of the Salford Local Dental Committee. He has also been a member of the Young Dentists Commission and Press and Parliamentary Representative for the British Dental Association.

Your questions answered!

Nigel Jones, Sales & Marketing Director at Practice Plan, has been helping dentists convert from the NHS to private care for 27 years. In this new, regular column he is offering YOU the chance to ask any questions you may have about the ongoing uncertainty surrounding NHS dentistry and the framework of the proposed dental contract going forwards. Simply email hello@practiceplan.co.uk with your question alongside your job title and location, and let Practice Plan do the rest!