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NHS contract reform: what if?

Denplan gave a panel of dental practitioners and key opinion leaders the opportunity to voice their fears, concerns and hopes for the incoming NHS dental contract. In the second of a two-part account, Sophie Bracken reports on the key points raised during this important debate

In the December 2016 issue of *Dentistry*, we brought you part one of the key points raised in Denplan's 'If' roundtable discussion, held in central London in November. The concept behind the panel debate was to hash out key issues and uncertainties related to the new NHS dental contract.

Although said contract is scheduled to roll out next year, details of its contents have been frustratingly scarce. An emphasis on prevention, increased access and improving children's oral health have been cited as a focus for the new contract, yet the government has remained tight-lipped on important elements such as activity measurement, capitation and contract re-tendering.

That's why the UK's largest and longest-established dental plan provider brought together a varied mix of professionals to discuss issues facing NHS dentistry contract reform in England, and to put forward fresh – and sometimes groundbreaking – ideas on how to make the looming NHS contract work for patients and practitioners.

Part one of this article covered discussions on the implications of the potential introduction of time-limited contracts, the falling NHS dental budget, and confusion surrounding mixing private and NHS treatments.

One change

We pick up the debate at a highly anticipated point in the discussion. Chair of the event, Dr Martin Fallowfield, posed the following question in turn to the panel: 'If you could make one change to the NHS contract, what would it be?'

Eyes turned first to Dr Henrik Overgaard-Nielsen, chair of the General Dental Practice Committee of the British Dental Association (BDA), who first offered an answer on behalf of BDA members: 'Many of our members would like to get rid of UDAs' he said directly. On a personal note though, he commented: 'I would like to get rid of the power that the area teams have got. Getting rid of their power would help any qualified provider, including giving newly qualified dentists a career pathway.'

Panel member Chris Groombridge of Teeth Team in Hull, said he would like to see GDPs linked to local schools and nurseries, while GDP Dr Josephine Jones was also in favour of abolishing the UDA system. GDP Dr Ben Atkins, however, took a different stance, asking to see better contract monitoring. 'I'd like to find out where we are as a team compared to everyone else. All dental practices are a silo at the moment'.

Dr Mick Horton, dean of the Faculty of General Dental Practitioners, said he would like to see a change in the way dental health is monitored as a whole: 'For as long as we reward professionals for restoring and extracting teeth, we will always fail. We need to monitor outcomes and improvements in health.'

'I would get on with rolling out the new contract, but I would remove the contracted value', offered GDP Dr Nick Forster. 'I'd base it purely on capitated numbers of patients, with an element of activity. Let's go back to a pre-2006 model with capitation and remove the restrictions so you can grow your practice if you want to. We'd balance out the corporate element of dentistry, you'd have more control and you could still be entrepreneurial.'

Dr Eddie Coyle, head of clinical services and commissioning at Oasis Dental Care, said he would like to see a return to focus on quality care, and the long-term improvement of oral health, with clear messages from government. 'We have to get to the situation where we know exactly what is expected of us', he said.

The panel all agreed that a focus on prevention of dental disease and long-term maintenance of oral health should be the overarching theme of any new contract. Julian English, editor of *Dentistry*, concluded this section of the debate by proposing a system of remuneration for dentists that deliver long-term improvement in patients' oral health.

Amalgam versus composites

Given that numerous dental schools in the UK and Europe are phasing out the teaching of the placement of amalgam fillings – due in part to a worldwide phase-down of the use of mercury-containing products – the next topic up for discussion was, what if composite becomes the restorative material of choice in the future?

'I think that the argument that amalgam is a quicker to use and longer lasting material [than composite] is no longer valid', began Martin, before asking the panel to comment on whether they thought that amalgam is the most expedient way forwards all the time.

Firstly, Nick raised the point that certain composite materials that contain microsphere plastic may be banned before dental amalgam. While there was suggestion around the table that a phase-down of dental amalgam would be likely, Ben highlighted the merits of the material:

'I love amalgam, because I work in a high needs area where I'm lucky if my patients brush their teeth once a day. We get a lot of patients who come from other countries where composite is the first-choice material, and I'm replacing those with amalgam, because we're getting so much failure on composites that are placed incorrectly.

'It's not the material, it's the dentist. I can make amalgam last for 20 or 30 years. I prefer amalgam [for high-needs patients] because I can monitor that really simply.

'But it's not just about simple fillings', continued Ben. 'We've got to get the preventive service running properly, and enable our teams to do this. I'm getting back into prevention; I've done the full circle now in my career, and I'm loving teaching patients to brush their teeth.'

Nick confirmed, from his experience running a prototype practice, that the new contract is heavily prevention focused: 'We're doing the dentistry we were taught at dental school all those years ago, and it's fantastic. The prototype stuff is what every dentist should be doing. It's completely obvious: if you prevent dental disease, the patient experience is better, the dentist's experience is better because you're making a difference, and you're placing fewer restorations. It's win-win.'

Nick went on to explain how the prototype contract is working so far for his practice. Whilst, he said, many prototype practices had seen a decrease in their patient numbers and are experiencing difficulty meeting activity targets, his practice in Winchester was overachieving on patient numbers and activity.

'But that's an educated, informed, dentally healthy patient base', he clairifed. Nick reiterated that the prototype contract gives scope for dental practitioners to practise 'the sort of dentistry we should all be doing'. 'The nuts and bolts of how we should be in it, how much the capitated value of the patient should be – I'm not sure that's quite right yet', he conceded, 'but I would say 100% it's really good dentistry. You go to work and you feel like you're making a difference.'

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Mick was less than satisfied with the prototype contract, given that, like the current NHS contract, it still has a large focus on 'activity'. 'It keeps going back to being rewarded for an intervention, or measuring an intervention', he said. 'We take care of a populous, and we improve the health of that populous. That's the reward and that's what dentists should be paid for. In spite of a contract that supposedly is preventive, the measure is still on an intervention, and that's a flaw.'

The future of NHS dentistry

The roundtable discussion concluded with a look towards the future, and the panel were asked what they thought NHS dentistry in England would look like in 10 years' time, and what they hoped to see. Some interesting ideas came to light.

Martin started off the discussion by stating that he would hope to see a desire for the concept of a partnership with patients, to empower them to take ownership of their dental health. Julian believed the future profession would see a dominance of corporate dentistry, similar to the pharmacy and optometry sectors, while Nick hoped to see the roll out of the prototype contract. Mick predicted the evolution of two distinct types of practice: emergency drop-in clinics and practices focused on prevention and monitoring, and hoped to see a greater emphasis on patient education.

Ben predicted an increase in patient responsibility, calling the dental profession a 'leader in the medical world' in terms of disease prevention. But Ben also foresaw a risk to associates' salaries and their standing within dentistry: 'I can see [associates'] wages coming down as well as the number of jobs available to them'.

Chris was a vocal advocate of the use of skill mix, and predicted a future for 'value for money private dentistry'. The final word, however, went to Eddie of Oasis Dental Care, who captured the apprehensive but hopeful feeling around the table:

'If we continue as we are, then nothing changes, or we could see a reduction in quality. We've all agreed that the decreased funding as we go forward will be a challenge; I think both of those things would be due to [the government] monitoring the wrong areas of dentistry – we're being driven in the wrong way.

'That's down to treatment delivery, but also a contract manager who has no knowledge of dentistry telling you you're seeing patients too often, or not enough. And if everyone's doing sort of the wrong thing, then you become an outlier for doing the right thing. Let's move forward and change to a new system based on prevention.

'I also think there will be consolidation of practices; increasingly we [at Oasis] see that people don't want the day-to-day burden of regulation. If we get a new system, the quality of dentistry is going to go up and people can do what they are trained to do. Because let's face it, dentistry is a vocation.

'Regarding the skill mix and model of delivery, I could see us moving towards more utilisation of the team's skill sets – but then, when I worked in practice in Glasgow 20 years ago, we played to the skill set of the people in the practice, so is this new, or is the wheel just gently turning?' D

Meet the 'If' roundtable panel

Panel chair Dr Martin Fallowfield, head of professional relations at Denplan

Dr Ben Atkins, GDP, Revive Dental Care, Manchester

Dr Eddie Coyle, head of clinical services and commissioning at Oasis Dental Care

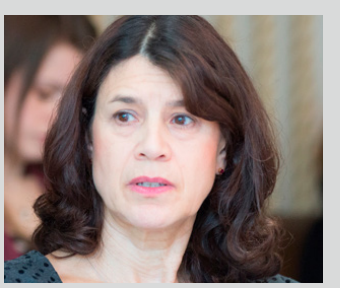
Julian English, editor of *Dentistry* and editorial director at FMC

Dr Nick Forster, GDP, St James and Chesil Dental Practices, Winchester

Chris Groombridge, chair of Teeth Team, Hull

Dr Mick Horton, dean of the Faculty of General Dental Practitioners

Jolian Howell, head of marketing at Denplan



Dr Josephine Jones, GDP, Avenue Road Dental Practice, Wallington

Dr Henrik Overgaard-Nielsen, chair of the General Dental Practice Committee, British Dental Association