High standards

In part one of this two-part exclusive interview, Neel Kohari 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 levels 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.

(NC data published in February showed access increased by 109,000 in the two year period ending August 2008.)

NK: But even if you take a simple procedure like a small composite filling, there are numerous ways in which this can be provided. Surely in a budgeted system, the onus on the dentist is to provide it in the most cost-effective way. This doesn’t always mean the best way, does it?

CDO: Part of quality is about messaging to patients. If you’re giving poor quality messages to patients, such as ‘we can’t provide you with a scale and polish under the NHS if needed’, but ‘we can provide you with this privately’, then that’s wrong. The NHS is aiming to provide a quality service, not a quality service, then the PCT needs to sort it out. The treatment of choice for a very small single surface cavity, according to Pickard, is a composite restoration and that should be the starting point for the NHS. It is not just “cost” but clinical effectiveness as well. Access is starting to improve now and PCTs are very also need to be focussed on quality of care. Dentists need to work within their PCTs, and we can see up and down the country dentists are working much better with their PCTs, but it’s a big cultural change and I accept that.

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

CDO: Well I think first of all the funding for individual contracts, buy out, by the patient, high 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 you’re properly incentivised 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’ve got an incentive to stop the treatment, which we’ve seen. And we have seen that in PDS pilots since 1998, 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 Department, 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

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

CDO: Well the whole health service has to do that. I think the point is that the ring-fenced budget for dentistry has vastly increased now.

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.

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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 untreatable 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 is not clinically appropriate – around molar end 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: Have you given dentists any guidance to help them decide what is clinically and cost effective? Because it seems that across the board there is wide range of opinion on what is cost effective.

CDO: It’s certainly been a turbulent time. Under the old system they had an SDR. But dentists are highly trained professionals who have spent five years at university. If they can’t work out professionally what is clinically and cost effective, then it’s a pretty raw deal really.

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

CDO: No, not at all, the things are not connected. The reduction in PCR I wouldn’t say is significant, it was there in the first year of the contract, but is certainly getting better. But I 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. This doesn’t always mean the best way, does it?
not actually come true. There is no shortage of vocational trainers, there is no evidence of a mass exodus of dentists. There is significant increase in the amount of preventative treatment going on. The amount of NHS dentistry commissioned has gone up, the number of dentists working in the NHS has gone up. One thing that has not turned round yet is the retrospective access data and if we are right, we expect that to turn around; then we will have evidence that everything we said would happen would have actually 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 terminated 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 advocated by the HSC?

CDO: No, nothing like that. We would need to consult on any of that, and in the statement of financial entitlement which we consulted on widely recently we made the point that contract values, 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 contract 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 contract value be reduced.

NK: Nationwide PCTs have provided a mixed service, have the PCT staff received adequate training with commissioning or is more needing to be done?

CDO: We completely accept that the quality of PCTs’ commissioning has been variable, as has the engagement of clinicians. 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 strategic health authorities (SHAs) have said: ‘We will work with our Primary Care Trusts to make sure that all our PCTs’ commissioning plans enable us to deliver 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 system has affected the balance between 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 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.