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NHS contract reform: what if?

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

With the new NHS dental contract scheduled for roll out in 2018, details of its contents have been frustratingly scarce. Although an emphasis on prevention, increased access and improving children's oral health have been cited as a focus for the new contract, the government has remained tight-lipped on important elements such as activity measurement, capitation and contract re-tendering.

What if you had the opportunity to have your say on the ins and outs of the new contract? That's exactly what happened at the 'If' roundtable panel discussion hosted by Denplan in central London last month.

The UK's largest and longest-established dental plan provider brought together a varied mix of key opinion leaders and dental professionals to hash out the 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.

Time-limited contracts

The debate kicked off with a focus on one of the most contentious issues surrounding the new NHS contact – the possibility that contract holders may be forced to re-tender their contract every five years. Chair of the event, Dr Martin Fallowfield, posed the question to the panel that if five-year re-tendering were mandatory, how would dentists' long-term business plans be affected?

The view from the panel was unanimously sceptical about the logistics of time-limited contracts. As GDP Dr Ben Atkins emphasised, the 'depth of tendering' is a long process that can be stressful for dentists, which potentially takes dental professionals out of clinical practice for two to three weeks to work through the administration of the procedure.

The main thrust of the anxiety concerning the idea of five-year contract re-tendering centred on the potential effect to independent businesses. As Chris Groombridge of Teeth Team in Hull pointed out: 'What bank or financer is going to lend a dentist money against a contract of that short a time period?'

Dr Henrik Overgaard-Nielsen of the British Dental Association, however, assuaged some fears, when he revealed: 'The Department of Health say [time-limited contracts] are not a priority for them. The Department said that they have to happen because of European legislation. But following the UK's vote to leave the EU in June this year, the time-limited element may not be a necessary component of the new contract by the time it is rolled out in 2018'.

The perceived advantage held by corporate dental groups in tendering contracts was also mentioned, due to corporates' economies of scale, purchasing power, and ability to procure sites more rapidly and easily than independent practitioners.

Dentistry's editor, Julian English, however, set the record straight on the latter point, informing the panel: 'I don't think, in the conversations that I've had [with Sara Hurley, the chief dental officer for NHS England] that it's possible for the government to commission from a provider that does not have premises or any experience in dentistry.'

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Dr Eddie Coyle, on behalf of Oasis Dental Care, confirmed this from his own experience: 'If you submit a bid where you don't have premises identified, your chances of being strong on that bid are reduced. So it's always advisable to have an initial site or a landlord in place.'

Martin closed this opening session of the debate by summarising the panel's findings: 'Perhaps as Henrik pointed out, there isn't the urgency now from the EU to actually comply with the five-year contract, so maybe the rolling contract will be with us for quite a bit longer.

'You made the point between you that it's very important for individual practices to be aware of contracting. It's not something that is taught at dental school, nor is there time for a foundation dentist to learn the ins and outs of contracting. There's no doubt that corporates have an advantage, but maybe it's not as great an advantage as we thought.'

Budget constraints

The panel moved their attention next to the politically-charged issue of the NHS dental budget, as Martin asked: 'If the NHS budget fell over the next five years, how would that affect the dental contract value?

'I think we all know that the NHS dental budget is falling', continued Martin. 'It's been disappearing in various directions and it's not being ring-fenced. So, what's going to be the impact of that on NHS practices?'

'It's true that in real terms the spend on NHS dentistry has gone down dramatically', answered Henrik. 'We also know that practitioners have seen a substantial cut in income over the past 10 years – by around 30-35%'. He explained that cuts to NHS contracts generally come about through government failure to recommission certain elements of contracts, or through clawback.

'There is a certain amount of guarantee to your contract as long as you complete your UDAs, which as we all know is becoming more and more difficult', continued Henrik. 'But if there are fewer dentists around – and there are several ways we can end up with fewer dentists, such as difficulty in attracting dentists from overseas [post-Brexit] – will that mean that the money [for contracts] will have to go up? From my position, I would hope that, but I don't know.'

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Martin followed on by stating that a flaw in the current system arises when practices are satisfied with their contracted UDA targets. 'If practices are meeting their UDA targets they're simply not interested in seeing new patients', he said. A solution to this came from Chris, who suggested that dental practitioners in an area share their patients lists, allowing practices that have the capacity, to accommodate patients from practices that do not have the means to take on new patients.

'In our area we have a list that's put together every three months and all the GDPs are contacted – who's taking patients, who isn't, and that list is then fed down the line, so everyone is singing off the same song sheet to ensure access'.

With the pay uplift for NHS healthcare staff capped at 1% in 2017 and the costs of running a practice increasing year on year, Martin speculated that the yearly decrease in real income that has hit dentists in recent years can, sadly, only continue.

The mixing mystery

The practice of mixing NHS and private treatments was next on the agenda. The panel chair referred to mixing as an area of the profession that could make dentists 'very vulnerable' to criticism from the public', alluding to public lack of awareness of precisely which treatments are available on the NHS and which are not. If public understanding were to change, the profession could face backlash, he said.

Martin particularly mentioned confusion surrounding the availability of composite restorations in posterior teeth as an NHS treatment as opposed to the use of amalgam, and the clinical merits of scale and polish. An impassioned discussion resulted.

'I've got a problem with this one', ventured Henrik, regarding scale and polish as clinical treatments. 'The Cochrane review said that there is absolutely no proof of any health benefit from scale and polish, and we all got it in the neck from politicians that we were overcharging the NHS for scale and polishes that weren't necessary.

'Somehow, the Department of Health changed their tune in 2006 when scale and polish was included as an NHS treatment, and I have a problem with that. Obviously perio treatment is absolutely necessary and is done on the NHS. But in my personal opinion, and according to the Cochrane review, there's no health benefit from a scale and polish; it's a cosmetic treatment.'

The debate became more contentious when the use of composite fillings in posterior teeth was discussed, as Martin explained: 'Lots of practices are saying you can't have white fillings in back teeth, that you can only do this privately. They are therefore upping practice incomes by doing private treatments on patients.

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'In theory there's nothing in the contract that says patients can't have white fillings in back teeth. But patients are hearing it all the time. At some point this could be very damaging for the profession.'

Henrik countered: 'Patients are entitled to anything that is clinically necessary. If I do an amalgam filling on a back tooth, the patient has received what is clinically necessary. It takes longer to place composite fillings than it does amalgam fillings. If the government wants that, they should pay for it'.

'Lots of dentists are confused about what you can provide [on the NHS]', added Nick. 'Pre-2006 we had a statement on remuneration that laid out clearly what treatments you could and couldn't provide on the NHS. From 2006 we were told to do what is clinically necessary, and that can be white fillings on posterior teeth, or posterior white crowns; there are even codes for whitening. So lots of dentists are very confused about this issue now. We would like a statement of what's available on the NHS and what isn't.'

Julian chipped in with some 'good news' from his discussions with the CDO on the subject of mixing treatments. 'The government understands and accept that mixing treatments is going to go on in this new contract', he said. 'The government is hoping that mixing NHS and private treatments will help fund, or take pressure off, the NHS budget. They totally accept that now, which they haven't done for a while. Going forward, I think there's going to be less pressure from the government on practices that mix.'

Also looking towards the future, Dr Mick Horton from the Faculty of General Dental Practitioners, stated that he believes the way forward for NHS dentistry is to provide the most clinically appropriate treatment. New research, he said, suggests that in a number of cases, the argument should focus on whether a restoration is needed at all.

'Ten years down the line this argument may be absolutely moot as to whether you put amalgam or composite in there', he said. 'You may be asking, "why did we ever put anything in there in the first place?" I think we need to be careful about how strongly we argue about things that may not be relevant in the future.

'There will be even more significant issues [in the near future], like replacing the heavy metal brigade and trying to maintain them later in life, which will actually have a greater impact on the treatment that we provide and the complexities of those treatments within the next 10-15 years than we have ever had before.'

A break in the proceedings came at the right time, giving panel members the opportunity to digest all that had been discussed so far. Topics up for discussion post-interval included proposed changes to the current NHS contract, analysis of how prototype practices are faring so far, and a look forward to the state of play for the profession 10 years from now.

Read all about it in the January issue of *Dentistry*. 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