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Dear Eric,

Please find my personal response to both the Stirling meeting and the "Modernising Dental Services Document"

I left the Stirling meeting feeling slightly depressed as it seemed to me that all that was wanted was an increase in the fees and for the existing system to remain as it is. The reason for my depression is that I had hoped that a new system might be found or at least discussed that would allow me to carry out treatment in a manner that would have measurable benefits for patients dental health but would also allow me to practice in an environment where I would be able to give a quality service carrying out practical clinical governance for a level of earnings that would still mean my business would be viable. I believe in the ethos of a national health service and in an ideal world this would mean for me delivering the best evidence based treatment for patients irrespective of their financial situation and being able to earn an income which would reflect my skills and abilities. This may be a difficult figure to arrive at but in my opinion is not less than consultant level, depending on qualifications and experience, and if we are to be responsible for owning and running a business at the same time would also have to take into account the financial outlay in buying and investing in the practice.

I felt that in an effort to be seen as impartial the Executive left the canvas too blank. Certain points required to be made which I think would have stimulated discussion. Many of the practitioners present have made considerable financial investment in their practices, in my own case probably something like £300,000 if I include buying the business and equipping it, I have also made substantial contributions to the NHS superannuation scheme and am I hope a reasonable employer to some 16 members of staff.

Unlike the discussions south of the border where it was stated that there would be no loss of income over the first three years of the contract we were given no such information , no mention of how or whether superannuation would be dealt with. If a base line calculation was required to say average gross income, would this figure include practice improvement money and commitment payments as these have probably kept fees artificially low over the past few years.

It should be no surprise that no meaningful changes were discussed. I am aware of the talks around purchaser/provider or block contract arrangements mentioned for England but don't really have any sure ideas on how to prepare a bid for this situation and I'm certain that the vast majority of practitioners feel likewise, it is no wonder that they are reluctant to go down this route. I wonder if local PCT's have anyone who understands dentistry well enough to negotiate with dentists it strikes me that they would also have a steep learning curve to undergo. We read in the newspapers that many Primary Care Trusts are unable to bring their budgets in on target, but they then make their case to the

Executive who will bail them out. No such luxury for us practice owners, I'm afraid it is the bank manager who we have to deal with. If a PCT with all of their accountants can't manage the books what hope have we dentists. I am fortunately not old enough to remember what happened in 1948, but it did not take long for HMG to realise that it could not afford the system it had put in place and cut fees .I would need some guarantees that history would not repeat itself.

I have set the scene for some of the difficulties I see, however, that does not mean that I wish the present system to continue – far from it.

I think that the SDR must go, it is outdated and is a method of payment which bears no relation to modern dentistry. It is a system of payment and has very little to do with dentistry .Albeit it is probably easier to administrate. There is no system of payment for preventive treatment or allowance for treating patients who are anxious or have complicated medical histories. One only has to look at the guidelines for general anaesthetic referral to see how impossible it is to introduce children to local anaesthesia if they are nervous before you are supposed to refer, all for no fee if the child won't comply. Periodontal treatment is impossible for the fees offered it is often said that periodontal disease is not being diagnosed, I believe it is being diagnosed it just cannot be treated for the fee offered .Endodontic treatment is uneconomic if carried out as it is currently taught, it is not possible to carry out treatment conforming to the guidelines set out by expert groups and if all aspects of clinical governance have to be embraced then the situation gets even worse. Probably cases are being referred to secondary care that could be carried out in the primary care setting but are uneconomic to treat e.g. TMJ cases or wisdom teeth removal. We are shortly to have to have National Standards for Dental Services, whilst most practices should be able to comply with these, treatment times must be lengthened in order to give the required explanations and obtain informed consent and carry out clinical treatment to a high standard.

I have no doubt that if a system along the lines of block payments could be worked out I would consider that as part of the payment package. One other important thing we were not told is whether the Executive sees NHS dentistry as encompassing all forms of treatment, by this I mean all current best practice would be allowed under NHS terms. If not then I feel that the politicians must come out and say that the NHS is not inclusive and tell patients what exactly they can and can't get under the NHS.If there were to be exclusions then practitioners would have to be allowed a private element to their contract similar to what medical consultants have at the moment. Would we be free to use the laboratory of our choice and how would the difference in cost between laboratories be allowed for. The mixing rule makes life difficult and as long as patients are being informed should go. If the executive cared to buy out practitioners and so become practice owners then they would of course be able to have 100% NHS if they wished, market values would have to be paid. The management of these practices would be best done at a local level either by the existing principles or it may be that young practitioners could take on some management responsibilities without the financial commitment. This may suit some practitioners and might be a way to compensate for those who have devoted their working life to the NHS only to find their practice unsaleable and a large setting up grant given to a new start down the road. The

management costs would need to be factored into the payment as most of this is carried out in the dentists own time unpaid.

I would see greater use of PCD's e.g. Therapists but the method of payment would have to work out better than their present use under SDR arrangements. I'm sure that this would help the workforce problem. I already work with two Hygienists and would see that continuing. I could make greater use of dental health educators which at the moment is unpaid. I could envisage a situation where I might be able to integrate a "specialist" from the CDS in my practice on a sessional basis. I could see a role for the dentist as the leader of a team consisting of dentists, therapists, hygienists, nurses and clinical dental technicians. This of course brings in another problem which would have to be addressed and that is the self employed status of Therapists/Hygienists/Associates and of course Dentists themselves.

If I were to go with this mix/match system of part block payment part private and improved quality service then I'm afraid the manpower problem would get worse overnight because it would be impossible to maintain my present output and increase quality .For me this quality improvement is paramount and any system which did not allow for this would mean looking for another route and I fear this could only mean private dentistry. It is becoming increasingly difficult to carry out quality treatment and clinical governance on the existing fee scale and this is the driving force towards private dentistry.

In England as I have already stated they have guaranteed no drop in income but are looking for roughly the same output. This I feel would not allow for improvements in quality as my wish is to get off the treadmill not exchange one for another and I don't quite see how this is to be achieved.

Now that SVQ for nurses is coming on line it would be nice to be able to do this in house and arrange for proper staff training, this again I would like to see being built into a new arrangement. This could also include Vocational Training and Outreach Schemes but short of working 24 hrs a day would inevitably mean a drop in my clinical output making your manpower problem worse and would have to include an element of non-clinical payment. At the moment the gross earned by Vocational dentists is added to that of their trainer, if there is to be no SDR how do we quantify what they have earned and so recompense the trainer particularly if there is no previous history of VT in the practice. Are we to be given a sum equal to the average earnings of VDP?

CPD for PCD's would somehow have to built into a payment system as once statutory registration for them comes in it is inconceivable that they will not be subject to the same rules as dentists, we would have to pay them for time out of the practice if this was required and pay for a replacement whilst they are on their courses.

The refurbishment of premises or the payment of staff wages ,rates etc could be a help to keep practitioners within the NHS how would this affect a practitioners equity in the practice ,could the NHS become a partner in the practice paying a share of their bills in return for a certain level of commitment. Some practitioners might be prepared to enter this type of arrangement. A difficulty I see and I think it was apparent at Stirling is that dentists have been used to almost complete control over their workplace and it may be difficult for them to relinquish this freedom. It may be that for them they would opt out.
It would be of great benefit to be part of the NHS net and be able to link up with medical practitioners to have some access to patients medical history , obviously there would be

worries about confidentiality here. It may be that we could be linked up to the secondary care system for information about referral or consultation. We have been encouraged to use EDI transmission but at the moment are caught between two systems as the DPB won't accept prior approval by this means and this should be rectified.

One of my worries is that at the moment dentistry is high up the political agenda because politicians are getting flack from the public about access, if this improves how long will their interest remain, will they still be committed to NHS dentistry because I believe this may be a case of the last chance for NHS dentistry if it is not right this time then I think anyone who can get out will. It was apparent the level of mistrust in the system at the meeting and this will be a major hurdle to overcome.

Much of the behind the scenes work for the NHS i.e. committee work seems to be done in practitioners own time sometimes for little or no recompense, this would need to factored into any package.

I could live without collecting patient's contributions and in an inclusive health system should we have to pay fees for it however I feel sure that the patients' contribution would have to be made up somewhere – direct taxation, insurance. The paperwork would be easier if it was direct taxation and maybe this would reduce false claims for exemption and bad debt .It does seem that apart from anything else the patients charges set a limit on the demand for treatment if this was to be removed then I would think that we may be unable to cope with the increased numbers of patients seeking treatment. One thing is for sure that if patient's contribution were removed the payments to practices from CSA would need to be prompt, if we are still to pay our own bills. Any system put in place would have to be flexible enough to cope with change as it takes place e.g. associates leaving midway through a contract or wishing to extend hours whilst in the midst of a contract period. If the payment were to be fixed and output reduces due to less dental staff would a claw back take place?

How could the Executive police this system because I'm sure that they will want above all to get value for money and see a measurable health gain for their money? This could be difficult because we are at the mercy of the patients' compliance with the recommended treatment, if they do not carryout the recommended homecare it may look the treatment failed and would the dentist still be paid. At the moment we are not required to submit any information to the DBP other than that which relates to treatment carried out .If there was no SDR then information could be gathered which is more relevant to the patients dental health e.g. a basic periodontal examination every 6 mnths, a record of soft tissue examination DMF scores and so on .An oral health index could be recorded similar to that proposed by Burke and Wilson, this would be traceable and could also be used to show health gain or not. There are recognised ways of assessing caries risk and some measurement could be made of this, treatment would depend on caries risk and payment made on the basis of the severity of the risk. If carried out properly I can see no reason for objection so long as the tests are evidence based. The FGDP currently assesses patient records for their fellowship examination it might be more relevant if a DRO came into a practice at random and looked at a selection of records. I'm sure that there must be a better way to assess dentists than the current DRO system e.g. much information about a practitioner can be gleaned from the frequency of bite-wing radiographs. The results of this could lead to a mentoring role for DRO's or DPA's rather than imposing punitive measures; this would surely lead to acceptance of this type of

monitoring. Practices could be helped to take part in clinical governance as is being done in Greater Glasgow or encouraged to take part in the BDA Good Practice Scheme this would be a measure of quality monitoring provided it was followed up and help given if improvement was needed.

The out of hour's service which is run in Forth Valley Health Board seems to me work well and actually offers the patients effective treatment; it is however probably more expensive than other schemes. Would out of hours be a separate contract, like the GMP's have or would this be built into our base contract.

Somewhere into this mix I would like to see a career pathway for general dental practitioners, this would allow for those who could demonstrate a commitment to quality and leadership to be rewarded financially for their efforts. This could be on the basis of some demonstrable postgraduate qualification e.g. MFGDP.I would hope that also there would be a place for the practitioner with a special interest , this could cut long waiting lists for specialist referral and reduce costly secondary care but the level of remuneration would have to be higher than at present under the SDR.The so called GPwSI is going to be a reality, some means of remuneration which recompenses them for the cost of their training will have to be found , unless the NHS/ Executive could fund the training costs, if these practitioners want to practice at the highest level it will not be possible at current fee scales ,however, I'm sure this would still be a cheaper option than secondary care. This might also help to satisfy the career aspirations of young dentists.

In essence I need to see what the Executive or maybe that should be the politicians want from me, do they want a comprehensive service or do they just want the access problems to go away. Maybe they would be happy with just a service to relieve pain and produce a level of dental fitness and anything more would have to be funded privately.

In any case I need more information about what is proposed and I'm sure that if the executive want to take dentists with them on this one then it might work. One thing is for sure; to go back to where I started is that the same level of funding won't do if a quality service is to be achieved. If the funding is to stay the same then you will be unable to purchase the same level of treatment, it could purchase different treatment for the same money, this could be preventive treatment and some of the restorative treatment may have to be provided privately. It may be that the interval between examinations could be made more patient sensitive and I believe that NICE will be publishing guidelines on this soon. This will not result in a saving but may allow the money to be directed to some other dental treatment. The current spending is not adequate and to think that savings could be made from things like changing the exam interval and taken away from the dental budget would only drive dentists further down the private route.

Once the consultation is past I hope that you will be able to answer some of my questions and then it might be possible to see a way forward that could include dental services under the NHS.Of course those who have already gone down the private route may find that they have no desire to return.

Information is beginning to filter out about the proposed "Base Contract" for England and Wales and this is going to have an effect on responses as most people will assume that similar ideas will come north of the border.

These are some ideas which would be desirable for me, do I think they will happen. I just don't see how it will be possible to fund increased quality which will

inevitablely lead to reduced output. One thing is for sure the politicians must be honest for a change and tell the public what they can afford, maybe if all the parties thought about what might be good for the nation's health instead of the ballot box something useful could be achieved. The BDA Scottish secretary asked us at Stirling for a wish list the above are some things I would like to see happen and I think it was yourself who said that the Executive had set no limit as yet to the amount of money they were prepared to spend. I like to take an optimistic outlook on things but am expecting to be disappointed.

Yours sincerely,

Charles Ormond GDP