

DIAMOND & DIAMOND
EASTERHOUSE HEALTH CENTRE
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EASTERHOUSE
GLASGOW G34 9HQ

Mrs Isabel Diamond BDS
9th March 2004

Dear Hamish,

I would like to take this opportunity to make a personal response to the document, 'modernising NHS dental services in Scotland'.

As you know there is no such thing as an average dental practice and I certainly do not work in one! I am a partner with my husband in a Health Centre surgery in a Deprat 7 area, not an area which has a throughput of patients from other areas. The problems of working in this area are compounded by the lack of Community Dental support. In the Eastern LHCC we have 0.5 CDO for a population of 170,000.

Even within the profession there is not much understanding of why we have any more problems than other NHS practices.

Ten years ago I was critical of my colleagues (and friends) who rejected the NHS and turned partially or wholly towards private practice. More recently, I have had to apologise to them as our income has fallen and we had to make changes to avoid bankruptcy!

Over the last few years I have become a Lead GDP on our OHAT, member of the LDC and representative on the OHPIG Glasgow. I have given serious thought as to how we can improve NHS dentistry for dentists, staff and patients in our area.

High Deprat Problems

a) Medical: A high percentage of our patients have complex medical histories that require liason with their GMP and The Royal Infirmary before treatment can commence. Many patients do not know the name of medication they are on, or even

sometimes what it is for.

We have patients on warfarin, chemotherapy, recovering from kidney transplant and bypass surgery. There is a high level of confused elderly, often brought by confused carers from the local nursing home! Those with mental health problems in other age groups also require extra time as do the adults with learning difficulties.

Many Methadone users also attend - when they decide to keep their appointment. Hepatitis B and C carriers are more prevalent in this area. Asthma levels are high in the children we treat. Medical problems that do not directly influence treatment affect the patients ability to attend for treatment leading to cancellation, or more likely a broken appointment.

b)Dental: We all know of the high dental disease rates and of the 'pain only' attendance in this type of area. NHS fee scales are not set so that a business can be run on this type of attendance. Due to modern cross infection control, gone are the days when we can see everyone who turns up at the door.

Some in the profession think that we do multiple crowns all day on our patients, as they do not pay! Patients whose mouths merit that kind of treatment are few and far between and we often extract and provide acrylic dentures i.e. the less profitable type of treatment. I believe that crowns and bridges are essential for oral health, but not for every patient.

There is plenty of treatment required, but persuading patients to keep appointments is difficult. 'Life' problems are more prevalent and dental treatment is not high on the list of priorities.

Those patients who do attend, tend to be more nervous than in other areas and therefore require more time to complete even the most simplest of procedures. It is not unusual for patients to fail to complete a course of treatment.

c)Social: We do have some patients who pay for their treatment, they do not tend to have much money to spend on their teeth, and I feel that this group opt for a less expensive or only partial course of treatment and are not well served by the NHS. Due to

their lifestyle many of our patients cannot keep regular appointments and would be better served with a drop-in type of service, this also extends to the problem of unregistered children who could be treated by the re-introduction of mobile dental units.

d)Dental 'Business': I am sure other responses will illustrate the problem of running a business with an income capped at 3.25% increase, and spiralling outgoing costs. Over the past few years we have had to 'let go' a hygienist and two nurses, both qualified and having worked with us for 4 and 12 years since leaving school. We could not afford to keep increasing their wages at the rate one is now earning at the Dental Hospital and the other in private practice.

As a practice we keep up to date and institute relevant Clinical Governance guidelines, but increasingly we are requested to do things without any funding so this directly has to come from our income!

Possible Solution

I have considered leaving this area and working as an associate in another area, but am holding out at the moment as I do not want to give up on the people I have been treating for 12 years, and my partner has treated for over 20 years. It would be ridiculous to let all that experience go to waste.

I look to the general medical practitioners and see that they are given special payments for working in deprived areas, are reimbursed for staff wages and for premises, and hope that something can be worked out along those lines.

In the last two years surgeries have closed down in this and other deprived areas of Glasgow, thus increasing health inequalities. Underfunding leads to cornercutting and bad practice.

If this was to be piloted we would be happy to volunteer as something has to be done before it is too late!

Yours sincerely,

Isabel Diamond BDS

