Risk management from Dental Protection

Dental Protection

Riskwise UK 36

Taking steps

Whilst the political turmoil surrounding the new primary care dental contract in England and Wales continues, dental practitioners are facing the reality of the system which is coming up to its third anniversary

Although many problems have been identified, one of the most significant issues facing NHS practitioners is the management of the patient with complex clinical needs. With only a fixed number of units of dental activity allocated for each course of treatment, irrespective of how much treatment the patient might require, new patients attending practices over the past three years have found themselves increasingly unwelcome.

This article aims to identify the parts of the NHS contract which have created the problem and to offer some solutions.

Type of contract

Most dentists working in primary care dentistry as a performer will have a mandatory services contract. Clause 74:

The Contractor must provide to its patients, all proper and necessary dental care and treatment which includes —

74.1 the care which a dental practitioner usually undertakes for a patient and which the patient is willing to undergo;

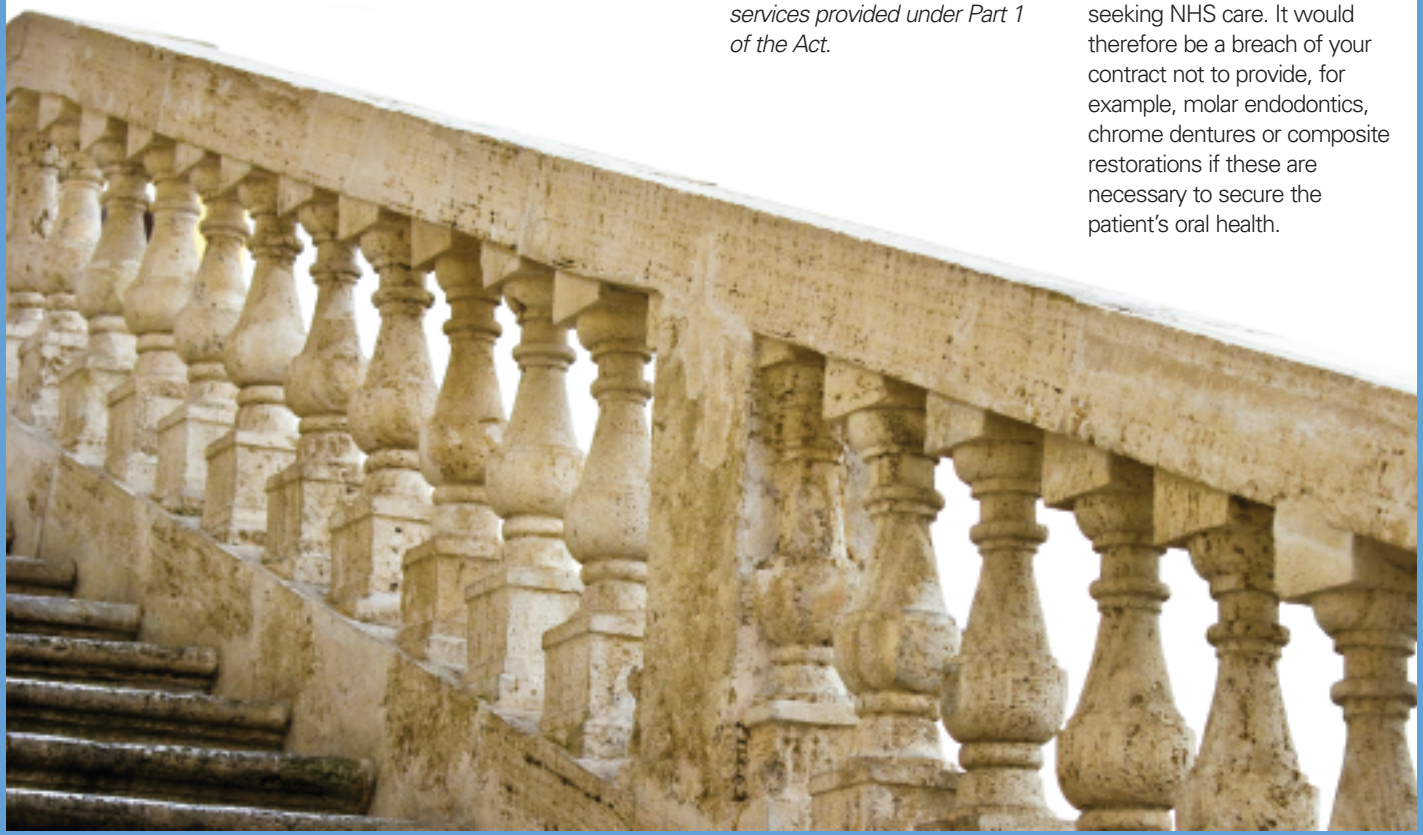
74.2 treatment, including urgent treatment; and

74.3 where appropriate, the referral of the patient for advanced mandatory services, domiciliary services, sedation services or other relevant services provided under Part 1 of the Act.

Mandatory services include

- Examination
- Diagnosis
- Advice and planning of treatment
- Preventative care and treatment
- Periodontal treatment
- Conservative treatment
- Surgical treatment
- Supply and repair of dental appliances
- The taking of radiographs
- Supply of listed drugs and listed appliances
- Issue of prescriptions

In other words the normal range of general practitioner services should be available to patients seeking NHS care. It would therefore be a breach of your contract not to provide, for example, molar endodontics, chrome dentures or composite restorations if these are necessary to secure the patient's oral health.



When deciding whether or not to accept a patient who wants NHS treatment it is necessary to consider the parameters set described in clause 28 of the Standard NHS Contract:
The Contractor shall only refuse to provide services under this Contract to a person if it has reasonable grounds for doing so which do not relate to - a person's race, gender, social class, age, religion, sexual orientation, appearance, disability, medical or dental condition; or a person's decision or intended decision to accept private services in respect of himself or a family member.

The important phrase in this context is 'dental condition'; meaning that it is not possible to decline to treat a patient on the NHS on the grounds that they require a large amount of treatment.

Financial interests
Clause 243:
In making a decision as to what services to recommend or provide to a patient who has sought services under the Contract or to refer a patient for other services by another contractor, hospital or other relevant service provider - the contractor shall do so without regard to its own financial interests.

It is a breach of the contract to suggest to a patient that it is not worth your while treating them because you will be losing money. You may think this, and it may well be true, but you certainly cannot cite it as reason for refusing to treat them.

The real challenge when treating high needs patients is not just the NHS system but the patient themselves. For many patients the Government's injection of money into the NHS has genuinely improved their access to NHS services and so for many people this may be the first time in many years that they are attending for dental treatment. The reasons driving them could be pain, appearance, and loss of function or any combination of them.

One factor they will usually have in common is a chronic active disease and the consequences of it – not least the damage caused by caries and periodontal disease. It is not possible for a clinician to simply put these patients back together in one course of treatment and reverse the behaviours and attitudes and lack of dental health education that got them there in the first place. A sequential approach to a healthy outcome is one that has groundings in all dental school education programmes and one to which NHS practices need to return.

The stepwise approach
The first stage may well be urgent treatment[1] to relieve pain and other symptoms - if that has prompted the patient to seek dental care.

The next stage provides stabilisation of any progressive disease[2] or conditions which may become acute (eg. temporarily restore very carious teeth, remove necrotic pulps or extract teeth even if they are symptomless at the time).

After this has been completed there is an opportunity to asses the cause(s) of the dental disease and begin initial preventive measures.

The patient's response to these measures will then need to be assessed over a suitable interval in order to decide the broad outline of the future plan based on the patient's motivation, their response to the initial treatment and preventive measures and any cost considerations. The provisional nature of the treatment plan at this stage precludes speculation as to the eventual outcomes until a definitive treatment plan is developed at a later review.

The initial stages of any definitive treatment may require further preventive measures, periodontal treatment, orthodontic treatment, extractions or other surgical treatment. Subsequent reassessment to evaluate the success of the first stage of definitive treatment provides an opportunity to revise the treatment plan as necessary before starting the final stages of the definitive treatment, such as crowns and dentures. It would then be necessary to determine the most appropriate sequence of future visits for review and maintenance.

The guidance offered by NICE on dental examinations applies to all NHS contracts, but does not prevent the clinician from examining patients more frequently if their particular clinical condition so dictates.

It follows that the clinical records must be sufficient to show why more frequent monitoring was required.

Consent
Patients, particularly those who are paying for their treatment, need to be fully aware of what you are aiming to achieve, and also to understand that their treatment will not be provided as a single event. There is a danger in this age of the makeover television programme that patients will assume that they could be starring in their own show and that at the end of sixty minutes they will walk out of your surgery and into a new life.

In explaining the staged approach to their treatment – and obtaining the patient's consent to treatment on that basis - it is important for the clinician to establish that their intention is not to create arbitrary episodes of treatment for the patient in order to claim more UDAs but to provide a course of treatment which is based on a recognised preventive approach in order to maximise the long-term health gain for those patients for whom dental treatment had not always been a priority, or where access to such treatment on the NHS had been less readily available.

References

[1] Urgent treatment has specific definition [under the relevant regulations]: Urgent treatment' means a *course of treatment* that consists of one or more of the treatments (urgent treatment under Band 1 charge) that are provided to a person in circumstances where— a prompt course of treatment is provided because, in the opinion of the contractor, that person's oral health is likely to deteriorate significantly, or the person is in severe pain by reason of his oral condition, and treatment is provided only to the extent that is necessary to prevent that significant deterioration or address that severe pain.

[2] Kidd EAM,Smith BGN,Watson TF Pickards ,Manual of Operative Dentistry 8th Edn Oxford University Press 2003

A matter of principle

As from April 2009, responsibility for the handling of NHS complaints in England and Wales passes from the Healthcare Commission to the Parliamentary and Health Service Ombudsman (PHSO).

It is particularly encouraging, therefore, that the digest of case summaries published by PHSO in December 2008 (*Improving Public Service: a matter of principle*) www.ombudsman.org.uk should have included a report of a case in which the PHSO acknowledged deficiencies in the Healthcare Commission's investigation of a complaint against a Dental Protection member. The PHSO agreed with the representations made on the member's behalf by Dental Protection that the Commission's investigation had been flawed, and concluded that the Commission's response to the representations we made had been '*cursory and superficial*'. Advice given to the Commission by one of its Dental Advisers had been factually incorrect in terms of the NHS Regulations in force at the time, and the PHSO acknowledged this fact by upholding the appeal which Dental Protection made on behalf of this member.

On the recommendation of the PHSO, the Commission apologised to the dentist who had been the subject of the original patient-initiated complaint and agreed to reconsider the complaint and review its recommendations. Although the Healthcare Commission had on this occasion failed to follow many of the very principles of good administration and complaints handling that it expected of others, at least the PHSO was meticulous in its adherence to these principles. The even-handed approach shown by PHSO on this occasion bodes well for the future.