BIRMINGHAM LDC NEWSLETTER

COMPILED BY VIJAY SUDRA & EDDIE CROUCH

Birmingham Dentists Give nGDS the Boot

Barry Cockcroft left 'The Way Forward?' evening complaining that the reception from Birmingham dentists was hostile. He openly criticised Birmingham and Sandwell dentists at the LDC Officials day in London three days after his visit to Birmingham. Anyone who was present at the Way Forward? meeting must agree that apart from one incident , the whole meeting was as well mannered as can be expected considering the high feelings of anxiety amongst the profession towards the new contract.

Barry should expect no less, and if anything had a very easy ride. He is seen as a face behind the contract. In this newsletter, we summarise events of that evening and highlight changes which will occur should nGDS go live next April. I have reported events from the Way Forward? meeting as accurately as possible, making clear the difference between actual comments passed by attendees, and expressing opinions that should be thought provoking.

VS

The "Way Forward?" meeting on Tuesday 29th November was unprecedented in the history of dentistry locally. We had a large audience of colleagues exceeding the 300 capacity for the venue, with standing room only for late comers. The whole event and associated matters were taken up locally by TV, radio and the press. We had prime time TV slots during evening bulletins highlighting our concerns, headlining both Midlands Today and Central News. Public awareness of the impending crisis in NHS dentistry is now a hot issue. Following a well mannered debate, the profession locally have voted unanimously to adopt a policy of non-cooperation with the PCTs. Colleagues took to the dais to vent anger and concern over the new contract. The policy adopted is not a snub to the PCTs, but to the government. The reasons for the non-cooperation policy stem from the fact that there has been no dialogue between the government and the profession, especially at grassroots level (the government doing whatever it likes), the fact that we feel our practices are being taken over, the fact that future growth/expansion plans can only take place after the PCTs' blessing (and if there's money for this, which will be unlikely), the fact that our patients are no longer registered with us. The list goes on.

The debate was started by Mark Nicholls who had himself arranged for local colleagues in Harborne and Edgbaston to get together and discuss how to deal with this contract. He explained they all found the exercise most useful. Arranging similar groups in our localities highly recommended, speak to your colleagues!

What was interesting, perhaps almost surprising, was the number of colleagues who have simply had enough and are not only planning, but are now actively converting to the private sector. Speeches from the rostrum advised us to convert fee payers to the private sector, others have adopted policies where all patients, *including* children and exempt groups will be charged privately for treatment. All cases were very persuasive, we all felt that the government are treating the profession with contempt. Others made a clear case for staying in the NHS, one speaker in particular was passionate about the need for treating poorer patients, the feeling of a moral obligation. Some colleagues expressed their concerns that conversion to the private sector was highly dependant upon the location of our practices, others questioned this explaining that they run highly successful private concerns from less than super affluent locations. Some speakers commented on the inevitable lack of cohesion between such a large group of dentists, all with different concerns. Achieving a consensus was going to be difficult.

We will all individually do what we feel is best for our patients, staff and of course ourselves. The aim of the policy of non-cooperation is to make clear to the government we're not happy with what's on offer. We need now to be precise exactly what it is we want changing, Steve Clements made this point clear at the meeting. Gilly Cottam suggested, for starters maintain

NEXT LDC MEETING

TUESDAY13th DEC 6.30 pm

@ BIRMINGHAM CHAMBER OF COMMERCE

If you would like to attend as an observer, please contact Eddie Crouch

Contact Numbers

Chairman
Clive Harris
0121 475 2666

Vice Chairman
Dave Cottam
0121 428 2824

LDC Secretary
Eddie Crouch
07779 331 132

Newsletter Secretary
Vijay Sudra
0121 747 8227
Email:vijaysudra@tiscali.co.uk

Inside this issue:

Way Forward?	1-2
Barry Cockcroft	2-3
DDRB	4
Update nGDS	5
Redraft nGDS	6
BEDS	6
Associate Worries	7

(Continued from page 1)

patient registration, maintain our autonomy, redress the patient charges issue, make clear what exactly treatments will not be available on the NHS. You will have received, or are about to, receive a communication from Clive who will make clear the adopted policy and request that you complete the accompanying pro-forma expressing what part of the contract it is that **YOU** have concerns about. The profession have made a stance, we need now to be precise about **EXACTLY WHAT** we want addressing. Please return your completed forms asap.

Make sure that the posters you were issued with at the meeting are on display in your waiting rooms, and you're dishing out those cards. The ONLY way we can get the government to rethink there position is to get public opinion, our patients, on side. Once there is a groundswell of public opinion, then the whole contract may be jeopardised. Blair has enough difficult issues to ponder before he steps down. If this contract kills the provision of NHS dentistry for all, then the irony of it will be that it was a Labour administration, the 'guardians' of the NHS who were responsible. But of course, you know who'll get the blame, us. VS

Barry Cockroft's Presentation & The Following Q&As

The acting CDO's definition of 'Cash Limited Budget' with relation to dentistry is different to mine, and most probably yours too. He explained that it means funding that is protected specifically, for provision of NHS dentistry, commenting that, "Crucially, money not spent (*in the present GDS*), goes back to the Treasury". So this obviously means that extra monies that you and I will be having zero access to next year, (as they won't exist), will no longer go back to the Treasury, simple really!

Much was said about the 'unprecedented investment in NHS dentistry', the £330m per annum figure was frequently quoted. He did have to stress that 1/3rd of this came from increased patients charges, so it's hardly fair to say the government are themselves rewarding NHS dentistry with the extra £330m.

Apparently, according to Barry, we have over 1,100 more (Whole Time Equivalent) dentists, claiming that there are now that many new contracts issued by the DPB to reflect this increase in numbers of WTE dentists. Big deal, some of us have more than one contract, possibly for work at satellite practices. (I know for a fact that my PCT does not know exactly how many dentists actually work on their patch, they know how many contract holders there are, but not how many of them work full/part time, what their NHS commitment levels are, and indeed what services they offer).

The workforce issued was laboured, there being the additional funding (£29m) to take on an extra 189 undergraduates per year, this figure leading to 850 extra graduates in 5 years from now. What BC failed to explain was where these dentists will go once they graduate. It's clear there is no more money to expand practices. This problem is now facing medical graduates who have increased in numbers due to government initiatives to increase numbers of doctors, but somebody forgot to tell them that they would need to increase junior house job opportunities too. It is not unheard of for young doctors having to apply for over 100 house jobs before they get even to be interviewed for a position!

Barry stressed that the DoH are giving us a guarantee that for the next three years (from April 2006), if you maintain your NHS commitment, then you are guaranteed your income for that period. No mention was made of a 'rolling' contract as in PDS, and NOTHING has been said about what will happen after March 2009.

He stressed how important it is for, "A written Ministerial comment to be correct". Does this apply to Rosie Winterton, who has time and again told the Commons that we have worked with the DoH in formulating this contract? The acting CDO also explained if we go back to anything that the DoH have said in the past three years, it is all accurate.

Patient charges: the new system of charges must bring in the same amount of revenue, "If more monies are collected, the Minister will be embarrassed". What if less monies are collected Barry? I doubt Rosie will award the shortfall to the profession.

Despite coming to talk to us about nGDS, Barry Cockcroft kept making references to PDS. PDS examples show that in addition to the 5% drop in courses allowed, of the actual courses carried out, there is evidence of a 20% drop in treatment. We were told what was presently wrong with PDS. Presently, they are only pilots, and until the Secretary of State signs them off to the control of PCTs, they will not be substantive. Monitoring of PDS practices was described as being haphazard. (Not out fault or problem, matey. This newsletter has voiced a common feeling that PDS was iniquitous and that mass implementation of such a contract had serious workability issues). Barry continued that apparently, "60% in Devon are now PDS, and they are 'Really enjoying it'".(?!) (No mention was made of what incentives they had to convert to PDS).

Regarding the thorny issue of mixing, Cockroft said that nothing has changed on the DoH websites, qualifying that, "We've been saying right from day one, that you can mix private and NHS treatments". Maybe I just can't read then.

Child only lists would under the anti-age discrimination laws be illegal, but Barry said that these would now be allowable under the redrafted contract which allows a practitioner to "Prioritise any group of patients, by agreement with PCTs". He further added that PCTs will not want to see child patients being 'deregistered', and so the inference was that PCTs will not prevent you from having such

(Continued from page 2)

lists.

The NHS Superannuation scheme was praised and noted as another reason for not leaving the NHS. He also explained that 80% of our premises are inadequate, poor relatives of the, "Palatial PCT developments", up and down the land. Barry continued that there was a need to provide investment for these, and that, "This is my job".

Dentistry is second only to MRSA on the government's agenda for the NHS.

Barry also commented on the patient being able to make an informed decision on whether (s)he has NHS or private treatment. Analogies were drawn between the USA and UK. Yes Barry we hear you, and yes, (according to your figures) dmf figures for 12 year olds nationally have gone down from 6 (in 1973) to 0.6 today. Who's been responsible for that? Us the profession off course and if that's not 'preventative care', I don't what is.

Q&A

When asked about whether he felt that the vision held at the time the Modernisation Agency was set up, set by Options For Change had been met, the acting CDO replied, after much waffling, "Yes": nGDS would mean no item of service, improved quality, treatment centred around preventative care.

An excellent question was put forward by Alan White regarding matters of goodwill, sale of practices and no extra funding (for additional surgery hours etc). The response regarding goodwill was breathtaking. "Goodwill is YOUR property now". I'm sorry Bazza, but it was ALWAYS ours!! Our medical colleagues had their goodwill bought of them by the DoH in 1948 when they 'joined' the NHS. Regarding the second question, PCTs would only be prevented from allowing the sale of a practice if the purchaser had previously been struck off, or whose track-record was questionable. The third question was not answered.

The next question generated the first round of applause from the audience. Peter Wintermoore asked that he remain the Captain of his ship, and was concerned about the fact that he, for personal reasons, had had to take much time off work last year (thus affecting his ACV), that he was concerned about the fact that his VDP finishes in July three months after implementation of the new contract and the fact that as a 'paper form' practice, he had no way of verifying his UDAs. Barry said that the VDP would be paid as normal, coupled with much waffle about service value, trainer value and salary value. Regarding the other matters, we were all advised to speak to our PCTs and discuss these concerns immediately. (This makes me think about the 'dialogue' that many of us were involved in with our PCTs regarding PDS. It was clear that the ultimate responsibility for contract approval came from the DoH, and most in Birmingham who were pursuing a PDS contract were left disappointed. We've got very little time left for individual concerns to be addressed by the PCTs). Cockroft added further that, "All PCTs will get some growth". If practices left the NHS, then neighbouring ones could challenge for those lost monies.

Eddie Crouch questioned the verification of UDA totals. BC was adamant that (for those who are computerised), software companies will be able to help with this. My enquires with my supplier (Dentsys) and similar queries from colleagues to SOE and Kodak would prove Barry (unsurprisingly) wrong. What about those of us who are not computerised?

There was (I think) a joke from Barry, UDAs were referred to as 'Air-rotor miles'. "Options for Change has been useful in modelling UDAs and the new patient charges system"

The point was further challenged in that figures relating to PDS contracts varied wildly, accuracy of notional lists was questionable. Barry's reponse was PDS contracts do not end on 31/03/06, and will continue as substantive contracts. Different PDSs are monitored in different ways and therefore data from DPB and PCTs can be a little 'cloudy'. A great politician's answer, completely avoiding the question again.

Questions on how we could expect to do complex treatment for, say band B (3UDAs) were met with, "Some people screw the system now and they will do the same in the new world". This will be a high trust environment, and we will be expected to treat our patients on their needs.

When asked how one can justify the band charges, the response was that clarity is what our patients want. Prescription charges were cited as the analogy to compare. Again with this response came a load of superfluous waffle on PDS.

Recognition of periodontal treatment came in that periodontal treatment will now be rewarded 2 UDAs, whoopee.

Much of the presentation lacked coherence, much talk centred on PDS. However, Barry said something towards the end of the Q&A session which may be the only important message to take away. For the first time, we now know what a UDA is 'worth'. According to Barry, an average contract value is made up of an average number of UDA, whereby 1 UDA is equivalent to 20minutes clinical time, so 1 hour of chairside time= 3UDA. The give-away sentence buried in the presentation was this, "**April 1st is the beginning of change, we're committed to developing the system**". THIS SHOULD SEND ALARM BELLS RINGING!

When asked, "Why, we're not offered the NHS escalator?" The response was, "Because we are now" (!!???!) He further continued that , "Money is not capped"(!!?!).

When asked on where all this money's gone (because lets face it, we haven't seen it!), Barry said that monies had been spent in the provision of NHS dentistry in places like Shrewsbury, Oswestry and the Isle of Wight (and not access centre either, apparently)

Gilly Cottam asked questions relating to provision of Specialist orthodontic services. The responses from the acting CDO were pitiful. "GDS is open ended; the PCT can only terminate if breach of contract". Regarding the PDS orthodontic contract, "Try and negotiate a rolling PDS contract." Very helpful that, Barry.

Top Academic Questions Wisdom of New GDS

Prof Trevor Burke has written an interesting editorial in the current *Dental Update*. He questions the wisdom of replacing the current GDS with PDS/new GDS. It is heart warming to hear such a respected academic value the contribution of NHS dentists to the dental well being of the nation. Prof Burke states (quite rightly) that we wish to be remunerated at a rate which reflects our talent, qualifications and experience. He also comments on how efficiently we run our practices.

Previous to 1991, no data was available to demonstrate the effectiveness of the GDS dentist. The search for this 'evidence based' data was carried out by the DPB. The treatments of 80,000 adult patients involving over 0.5m courses of treatment, between 01/1991 to 12/2002, were examined and assessed. This was the largest data base for research into longevity of restorative treatments. The results show that the current GDS is extremely good value for both patients and for the government. "***Outcome and cost-effectiveness results makes GDS envy of the world***."

The editorial also confirms that there is no evidence of systematic abuse of NHS dentistry, further adding, so why change the system when it works?

Come 01/04/06, the collection of this data will be lost. With the loss of the precise breakdown of the nature of courses of treatment, we will be denied accurate prescribing profiles. Prof Burke suggests that those of us who are computerised seek from our software suppliers, the possibility of storing accurate information, to help audit our performance. This is an important part of Clinical Governance (a cornerstone of modern healthcare, remember(!!)). We will lose abilty to check the effectivness of treatments carried out.

Prof Burke also makes comment that the National Audit Office will want to know how the government will audit the nGDS, now that we will have to submit a very simplified claim forms ('X' boxes for band 1,2 or 3)?

Vijay Sudra

Dept of Health Continue to Offer Pittance for Untested Contract

The BDA and DOH were miles apart in their value of NHS Dentists when it came to submitting evidence to the Doctors and Dentists Review Body.

The BDA are requesting a fee rise of at least 5.8% but the Department of Health are asking for 2.5%. This is less than in the previous three years, which mysteriously amounted to near the 10% three year deal rejected by the Profession , only for the Review Body to award almost exactly that in their three year ?? INDEPENDENT ?? recommendations.

As the BDA puts it "the rejected deal has in fact been delivered by the Review Body".

It is hard to see how practitioners can have faith in the Department when they say "the new way of working will produce a fall in practice expenses, as a result of intended shift towards fewer interventions on average, within the typical course of treatment", then later say "this will enable dentists to see more NHS patients" !!!

In the untried new world of UDA's, who can be sure how practice expenses will alter, but the DOH state "initial analysis of the latest expenses data suggest that dental expenses have fallen".

The BDA's evidence is thoughtfully put; highlighting how the initial hopes had been sacrificed to access, indeed in the DOH evidence, access to NHS dentistry is continually and repeatedly mentioned.

The BDA estimate the under supply of Whole Time Equivalent Dentists to be around 4000, and quote a study by the University of Bath that says the NHS need to recruit 5,200 dentists, even the DOH acknowledge that of the supposed recruited 1000 they were still short of dentists by about 850. Which ever figure you look at, the manpower situation is likely to remain an issue for sometime to come. Interestingly the BDA say the salary packages offered to overseas recruits are around £50,000, and many are unhappy about getting less than the colleagues around them, risking losing them to the private market.

Going back to expenses the BDA produce figures showing a 22.4% rise since 1999-2004, averaging at 5.6% per annum compared to fee scale rises of 3.5% per annum. . They say the increases in disposables, waste management costs, insurance and cross infection control have driven up dental inflation. Staffing costs have also risen say the BDA, with many practices having to pay significant pay rises to recruit or retain staff. Finally they call for the introduction of practice allowance valued at 6% of the contract value to allow Dentists to employ staff to undertake the running of a practice freeing up clinical time to see patients.

So to summarise we may get a contract we are unhappy about and receive a derisory pay award to implement it. Just gets better doesn't it.

Eddie Crouch

Update on the nGDS

According to the BDA, 20% (~2,000) of practices see children/exempt groups only on the NHS. Many PCTs may be happy for this to continue, others will re-engineer this so that fee payers are given greater access to NHS services. Where the PCT takes the later action, if practices do not comply (ie. dentist has the capacity to see a patient, but refuses to do so), the PCT will be in a position to terminate the contract. It remains to be seen how the PCTs in Birmingham will play this one.

Once UDA targets have been reached, unless more funding is offered, the PCTs cannot ask you to do any more unless more funding is offered. Perhaps the skiers amongst us will have more time on the piste next Winter!

Mixing private and NHS remains a grey area. The redrafting of the contract indicates that rules on mixing remain unchanged except that the 'same tooth' rule has been removed as have the exclusion of treatments such as PBCs on molar teeth and the use of posterior composites. (I find the BDA's recommendation that we refer to a standard undergraduate text, to cite where it may be appropriate to offer a posterior composite on the NHS most patronising). As commented on in the last newsletter, we must not mislead patients over quality of NHS care.

The bulk of orthodontic treatments will be offered under PDS arrangements, with rationing according to IOTN. Clinical scoring will be undertaken by the orthodontist of 10% or 50 cases (whichever is smaller). There will be no reduction in UOA to reflect the fact that orthodontists will be treating more complex cases. Where a case falls outside of the IOTN requirements, treatments can be offered privately.

Practice owners ('Providers') will be set practice targets to deliver and thereby put performance targets and controls on their associates ('performers') to fulfil the practice obligations to the PCT. So much for getting off the treadmill.

Tax status of performers has been assessed by the BDA. The BDA does feel that there is no immediate rush for the government to remove the self employed status of performers (a status, which the BDA admit, may prove difficult to justify under the new arrangements). If performers do lose their SE status, then providers will want to ensure that the additional costs of employing performers are met by a reflective increase in their contract values, funding for which the Treasury will be reluctant to release. The Inland Revenue may, however, wish to hasten the whole process.

BDA has calculated that there will be a significant increase in management and administration time needed as a result of the nGDS contract. More bureaucracy then, so much for wanting to simplify the system!

BDA highlights risks for single handed practitioners, time off due to ill health etc will make meeting UDA targets difficult, the new contract making no provision to help such practitioners, especially in view of the expected increase in non-clinical demands.

Is a dental practice is sold, the PCT is not obliged to offer a GDS contract to the purchaser, or even to the successor of an associate with his/her own personal contract, who may decide to leave a practice. The later point illustrates that despite associates having the option to have their own personal contracts, the likelihood of this in reality is very low, the PDS model proving my point. The first point here is most alarming. If we are forced into signing up for the new contract (which seems inevitable now), we will be giving up ultimate control of our practices , accepting fully that with a solid list of registered patients, our practices were worth a fair sum of money for their goodwill.

This worth may be nullified overnight, as the practice will only be worth what the PCT feel is appropriate, related strongly, to their need for an NHS practice in your locality. Most practice owners will have accounted for the sale of their practice to supplement their retirement aspirations. If the PCT feels your practice is surplus to their requirement, you'll not be able to sell the business as the PCT will refuse to commission to the new owner. This is a serious slap in the face for the profession, especially those who have given their working lives to the GDS. Disgraceful.

As I type this, I hear on the radio that the National Audit Office have reported to the Daily Telegraph that before long, 21 PCTS will be running in the red. This fact will not surprise any of us. However, what will concern us is that on the grand scheme of things in the NHS, I fear dentistry will be always be the Cinderella profession, and despite talk of 'ring fencing' monies for dentistry, when push comes to shove we'll have our funding channelled by the PCTs to other, more 'needy' causes. The government have reneged on far too many promises to this profession, and cannot be trusted anymore.

The recent exposure of the PCT in Suffolk denying obese patients hip and knee replacements just highlights the world that we are entering into. We know the world of NHS dentistry will be a cash limited one, lets hope that's all it will be, and not one where we will have to fight for that which is rightly ours, but I fear the PCTs will afford to lose a handful of practices just so that their books balance for the accountants. There is already a crisis in the provision of dentistry in this country, the PCTs may simply view the whole matter as one that can get no worse.

Vijay Sudra

A fable for out times !

Three dentists were having dinner one evening. A private dentist, a GDS dentist and a PDS dentist.

They noticed the very attractive young waitress had a missing upper central.

'Good heavens, She needs an implant' said the private dentist'.

' She needs an acrylic spoon denture' said the GDS dentist,

'I rather like her as she is' said the PDS dentist

DoH Redraft the nGDS Contract

1. Core Hours

"Core Hours" redrafted to be referred to 'normal surgery hours'. Opening hours will be for local agreement.

2. Electronic Forms

All forms apart from prescriptions (receipts etc) will be allowable in the electronic form.

3. Corporate Bodies

A new corporate body must be registered with the GDC prior to entering a contract.

4. 'Advice and Planning'

The Dept of Health have now clarified that apart from the 'same tooth rule', the mixing of rules are substantially the same in the new arrangements as currently.

5. UDA tolerance

2% tolerance of UDA requirement extended to 4%, but still to be made within no fewer than 60 days.

6. Mid-year review for in-year starts

This additional text to cober reviews for contracts commencing mid-year, where a rigid six-months would be inappropriate. The review would happen at a time agreed with the PCT.

7. Completion of treatment

In original draft, all courses of treatment were required to be completed within 90 days. This has been changed to 'a reasonable time'.

8. Termination of course of treatment- 'irrevocable breakdown'

There is the addition of 'irrevocable breakdown in the patient-dentist relationship' as legitimate grounds for the contractor to terminate a course of treatment. This will require prior notice to patient and for the PCT to be informed.

9. UDA for incomplete treatment

Change to reflect charges for incomplete treatment. This would cover, for example, a patient who has a crown made but was never fitted. The dentist receives the full UDAs but the patient only pays a band 2.

10. UOAs

Redrafting to allow for UOAs for case assessment and start of treatment and to allow for inceptive orthodontics for children under 10 years.

11. Children and exempt-only contracts

Redrafting to allow a contractor, WITH SPECIFIC AGREEMENT of PCT, to restrict services to specific groups only (eg children and exempt groups only).

12. Violent patients

As for current regulations, such patients can be refused to be treated.

13. Care and treatment summary

If your patient requests, then you will have to supply a 'care and treatment summary'.

14. Repairs and replacements generating

You will now get UDA credit for treatments redone as 'free under 12/12 guarantee'

15. Qualifications of DCPs and employment

Eventual GDC registration of DCPs will be recognised by the new contract.

16. Training of DCPs

Restriction on training requirements to DCPs via clarification that this paragraph applies to GDPs and DCPs only.

17. Patient Records

Addition of PR form and lab docket to definition of record.

18. Property rights

Amendment to the text clarifying that the contractor owns the patients' notes

19. Notification of courses of treatment

Redrafting to clarify all circumstances under which a case start should be notified and to add clarity linking UOAs to case completion.

20. Death of contractor- termination

Redrafted to extend timelines to 7 days, with an additional 3/12 and then 6/12 (ie total of 9 months). The right of 7-day termination is retained (to be used in exceptional circumstances). (Previously this was 7+28 days).

21. 18-month notice from PCT

This is revised entirely to state that , "The PCT may only terminate the contract in accordance with the provisions in" the contract ie. breach of contract, not 18/12 notice.

22. Point of treatment checks

Requirements to establish a patients' exemption status (previously omitted)

The DoH have made 22 amendments to the draft contract. These are listed here, with points 1,4,5,9 & 11 being especially important.

VS

*BEDS** Important News*

BEDS will continue to run until 31st March 2006 when the PCT's will take responsibility for out of hours cover.

Ray Greening, Chair of BEDS says this valuable service that covers emergency cover for weekends and Bank Holidays can be accessed by participating Dentists for a final subscription of £65 to cover the final period.

BEDS this year will operate from the evening of Friday 23rd December to morning of Monday 2nd January.

Further information is available from BEDS Manager Yvette Cox on 07901 702307.

Any concerns or queries with BEDS will be handled by Yvette. EC

Promised Dreams

Many of you will have registered an interest in this charity, at the 'Way Forward?' evening.

If anyone would like further information on this charity or would like to take part in future events, please contact Steve Dourass on 07980 526 667.

Need more Posters (re nGDS) for your Surgeries, or Postcards to give to your patients? If so, please contact Eddie, and he will post you some.

Eddie Crouch Looks at Contract Implications Of nGDS For Associates

From feedback forms we have received (from the 'Way Forward Evening?) and from conversations with colleagues, many Associates are unclear and equally worried about new GDS. The BDA has been bombarded with Associates seeking guidance, with stories that Principles are talking of changing terms and conditions, and what is certain is that the days of the old Associate agreements with 50:50 schedule splits are numbered.

It is clear that in certain parts of the country Principals are insisting that the new contract is **practice based**, despite the regulations saying Associates can hold individual contracts. The benefit to the Principle is that should an Associate leave, the contract value (if contract has been granted to the Associate) will not go back to the PCT. It would seem that if Associates disagree with Principals on such a stance, they are also being told take it or leave it.

The BDA's advice is to seek their help, for members, and to use the new Associate contracts they have been working on. So start talking to your Principals now.

The new Contract is output driven and should Associates not perform claw back will happen to Principals and Associates alike, whether it is the PCT or Principal that claws back the money. Performance targets are here for us all.

Performance Monitoring will be part of the new way and Principals if they are to keep their budgets will have to monitor Associates and their UDA activity .Also in the regulations is that Principles will be responsible for the quality of care in the practice, and poor work by an Associate will affect the Principle (as the later will be directly responsible).

The LDC opposed this part of the contract in PDS but it is present in nGDS, and although an Associate must continue to have indemnity for malpractice, Principles should contact their own Indemnity Companies to ensure they are adequately protected against action by the PCT.

Associates in the new system will have to be given time for CPD and Clinical Governance, and agreements will need to be made within the practice of what happens to the monthly contract payments if Associates are ill, on holiday and all other ramifications of work. Sharing of UDA's may be the way forward.

There should be practice policies in place so that the service provided within the practice is consistent, and that consistent treatment policies are in place on what service is provided, patients may complain to the PCT's if they perceive different service from different dentists.

Access and acceptance polices of patients should also be discussed, so that uniformity is across the practice. With the loss of UDA's with DNA's and the lack of ability to charge for missed appointments, it may be that Associates with high DNA's will be penalised as well as Principles.

The new contract allows Patients to request to see anyone in the practice and policies should be in place for how this will work, included in the regulations is compulsion that patients are informed of this right.

Whilst we are now working in a budget economy, cutting bills and reducing lab costs although beneficial in the short term to principles, such a trend will lead the DoH to present evidence to the Doctors and Dentists review body that dental costs are falling. If this happens the poor pay uplifts we already get, will be reduced further. Also worryingly there is nothing in the contract that protects Practices from inflation and if this rises no guarantee that budgets will follow.

PCT's will carry out a mid year review and at least 30% of your UDA target must be reached by the 1st October. They will also have many new powers; they will have access to premises, patient and business records, appointment books, basically anything that is reasonable in connection with the contract.

New powers will also allow Public scrutiny by Patient's Forums, Healthcare Commission and Local Authority Scrutiny Committees. Remember also that patients will no longer be registered and you must provide care for any patients subject to capacity and agreed limits.

Contractors must keep records for 2 years including the treatment plans that MUST be provided and signed for Bands 2 and 3, with Private treatment also included and signed for. Practices must also appoint a Cauldicott Guardian (refers to patient confidentiality).

The new way may certainly provide greater areas of dispute within a practice, and the PCT will expect the practice to deal with Human Resources within their practice, this also has wider implications. It would seem only a matter of time that Self Employed status of Associates goes, and this raises the spectre of employment tribunals.

Principle must check the qualifications of any new Associate, and that they are on a performers list, notify the PCT of changes and the superannuable pay of Associates. Two references are needed when employing an Associate, a register of gifts from patients must be kept, and PCT's have to be notified of any serious untoward incident.

In this untested new market of Patient's charges, attendance patterns of patients may change significantly as they begin to realise regular attendance will be penalised and that better value for money for them, is to accumulate work into one hit. So much prevention orientated!!! This will also hit your UDA output.

So there you have it, a complete mine field of new aspects of working that we will all have to get our heads round very quickly, and all this for the same money you got last year.

It's no wonder we all voted on 29th November to reject the contract in its present form.

Eddie Crouch

LDC MEMBERS

Clive Harris (Chairman)	0121 475 2666	Dave Cottam (Vice Chairman)	0121 428 2824
Eddie Crouch (Secretary)	07779 331 132	Russ Steward (Treasurer)	0121 706 0863
Steve Clements (Ass Treasr.)	0121 776 6757	Ashok Takhar (GDPC Rep)	0121354 3579
Peter Lowndes	0121 454 0023	Ashok Solanki	0121 440 1668
Vijay Sudra	0121 747 8227	Jon Taylor	0121 773 8294
Alan White	0121 476 0976	Phil Mason	0121 456 2199
Jan Skrybant	0121 743 2669	Greg Fickert	0121 414 1551
Gill Cottam	0121 708 2994	Philip Davenport (GDPC Rep)	0121 779 2112
Louise Mackenzie	0121 472 3001	William Murphy	01564 772 184
David Payne	0121 472 3001	Chris Gattas	0121 420 2323

New LDC website now up and running Visit **www.BirminghamLDC.com**

Oral Cancer Week

The max-facs dept at University Hospital recently arranged two evenings for general practitioners to visit and view patients during Oral Cancer Awareness Week.

The take-home message was clear. Refer if a white patch shows sudden change, high density, redness or speckling, or ulceration.

Persistent ulcers (>3/52 duration) with a granular base are worrying. Induration or a rolled margin may also be due to secondary infection, if not, refer. High risk locations are floor of mouth, retro-molar fossae & ventral surface of tongue.

Referrals can be made to 'BDH RapidClinic', held every Monday morning.

(This information was supplied to Newsletter by Gilly Cottam)

As this newsletter goes to print, we have all received our UDA allocations (late, not surprisingly). Judging by the conversations I've had, it is clear that many are not happy with their allocations. There were always going to be winners and losers in such an iniquitous system.

Something brought to my attention today may affect some of you. A colleague told me that at his practice, he has a high DNA rate. This meant that his patient's forms were often terminated as 'incomplete treatments' (to receive prompt payment). A new form would be transmitted if and when the patient returned for further treatment. This has now stung him as his actions have contributed to an increased number of UDAs for little extra funding!

If you as a contract holder in Birmingham would like to attend future LDC meetings, then you are more than welcome to do so. The next meeting will be on Tuesday 13th December 2005. If you are interested, then please feel free to contact LDC Secretary Eddie Crouch so that he can make appropriate arrangements.

MERRY CHRISTMAS TO ALL COLLEAGUES AND YOUR FAMILIES.

MAY 2006 BRING MUCH HAPPINESS, PEACE AND PROSPERITY!

BIRMINGHAM LDC

☺ Any comments, criticisms , contributions to this newsletter are welcome.

Please contact Vijay Sudra ☺