BIRMINGHAM LDC NEWSLETTER

COMPILED BY VIJAY SUDRA & EDDIE CROUCH

GDS RISES FROM THE ASHES

The powers that be at the DoH must clearly live on another planet. With the release of the draft GDS contract 2006, the press communication stated, along with the usual twaddle relating to the miracle of local commissioning, "***that we ourselves, had asked***" for these new contractual arrangements!! Where do they get this sort of stuff from? Perhaps the roses are doing very well in DoH garden this year, there's plenty surplus 'food' for them.

PDS conversion has now finished, and despite the Dept of Health's certitude, my personal view has not changed: policy on PDS has failed. After all the enticing, less than 1/3rd (considerably fewer in Birmingham) of the profession have gone PDS (and the figure of 1/3rd also includes the old CDS clinics too, remember). Good luck to those who have converted. My conversations with colleagues and friends up and down the land who have 'gone early', indicate that many are not happy with their lot despite some having had incentives, many missing the old GDS. And it is still early days, remember. It seems probable that those PDS contracts grossly different from the new GDS model will be brought into line come next April. Certainly all PDS pilots will terminate from 1st April 2006. It remains unclear whether the existing terms for the remaining PDS agreements will be adjusted or totally aborted and new contracts formulated.

The refuseniks, have now got new GDS. What's offered is certainly more than the previous meaningless 'frameworks'. There is now meat on the skeleton, and you must decide what you make of what's on offer.

In this newsletter, I first highlight the key elements of the draft GDS Regulations (2006). Here, I have been as objective as possible, representing the facts as they are delivered by the DoH. Later on, I have expressed opinions and hope these are thought provoking.

Also, brief comment is passed on the PAC's findings in the summer with a basic summary of Harry Cayton's (long overdue) patient charges report.

In the previous newsletter, comment was made on the DoH's need for yet more changes to the infrastructure of the NHS (to save money). This is now evident in Birmingham with the amalgamation of North and East Birmingham PCTs as of 1st April 2006, which will coincide nicely with the implementation date of our new contract. It is just shocking how much money is wasted in the NHS because of these changes, we all know it's only a question of time before we revert back to one Health Authority, so why don't they just get on with it?! In the meantime, these changes will cause anguish and distress to those working for the authorities and also unease for us who will be commissioned to work for them. With the amalgamation of North and Eastern Birmingham PCTs, we have lost a two dental commissioners in EBPCT. One, Tony Ruffell was passionate about his charge and although there were obvious differences between what he felt was feasible and we as an LDC knew to be unworkable, he remained a stalwart campaigner for his PCT always attending all LDC meetings (the only dental commissioner to do so). The other had only joined the PCT a couple of months ago from the DBP. Dawn Jenner came to the PCT with a wealth of knowledge on matters relating to NHS dentistry. It beggars belief that she has been moved onto other non-dental work. How can such changes in personnel instil confidence in an already sceptical profession? Also, this situation proves that any promises made by the PCTs regarding your contract need to be written as those giving you verbal guarantees may be sidelined before your alginate sets.

This newsletter has time and again commented on the strongly held view that there is a need for liaison between the (presently) four PCTs to save money and time. Just before the demise of PDS, we had four separate PDS SLAs. The legal opinion was that there should have been just the one PDS contract pan-Birmingham, and so the four PCTs then abandoned their separate contracts to embrace this new version just as the plug was pulled on PDS! Why didn't they just work on a common SLA from the outset? Again, such actions demonstrate why there is unease from the profession about the whole concept of local commissioning. VS

NEXT LDC MEETING

TUESDAY 13th SEPT 6.30 pm

@ BIRMINGHAM CHAMBER OF COMMERCE

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

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GDS 2006

New GDS Regulations published o1.o8.o5 will be finalised by Christmas 2005 and are planned to come into effect Jan 06. This will leave us 3 months to resolve contracts with PCTs, before the new contract goes live on o1.o4.o6.

Little has changed from what the 'base contract' back in late Spring 2004, and from which the BDA's GDPC later terminated dialogue with the DoH .

INTRODUCTION to GDS 2006 and the world of UDAs

The new GDS Contract will accommodate for the provision of:

(1)**MANDATORY SERVICES** (full range of dental services), **and**, can incorporate

(2)**ADVANCED MANDATORY SERVICES** (full treatment as mandatory services, but carried out *on referral*, **and/or**

(3)**ADDITIONAL SERVICES** (defined as advanced mandatory services, dental public health, domiciliary, orthodontic and sedation services)

The contractor will provide a number of units of dental activity (UDAs), and if applicable, units of orthodontic activity (UOAs)).

A formula will be used to determine how many UDAs each GDP or practice should provide, based on numbers of courses of treatment they undertook during the period October 2004 to September 2005 **MINUS 5%**. This 5% represents ½ of the 10% drop in activity the DoH expect.

You will be seen to be in **breach of your terms of service if,** once the new GDS goes live, your **UDA falls by 2% in the year**. The PCTs can only take action if the activity of the dentist is not increased to address the problem, by a period of a minimum of two months.

So what do you have to do for your UDAs?

For those treatments exempt of patient charges UDA values:

FEE BAND	UDA
1 (except urgent)	1.0
1 (urgent)	1.2
2	3.0
3	12.0

See'ORTHODONTICS' for **UOA**s. (*We do not know if the 'monetary value' of a single UDA is equivalent to that of a single UOA*).

Rx only 0.75, Repair denture 1.0, Repair Bridge 1.2, Removal of Sutures 1.0, Arrest of Bleeding 1.2

Free replacement items (eg. #ed filling within 12/12) will not (as present) award remuneration (or UDA, as the case will be). The treatment will still be free for the patient.

You will not be allowed to practice treating only children/ exempt groups under the new GDS. (*See 'Opinion' for further clarification on this*).

Entitlement to a contract, subject to terms & conditions, and their gross earnings will be protected for 3years.

There is **no definite list of treatment** and **no treatments are excluded**.

Treatment must be completed within 90 days of treatment planning the patient. If not, then a new treatment plan needs to begin.

CALCULATING THE ACV & UDA

Annual UDA for the first year of the new arrangements will be calculated by the DPB, analysing care and treatment provided by GDS practitioner for 01/10/04 to 30/09/05.

The minimum ACV (mACV) is based on the historic gross earnings for the agreed level of UDAs and will be determined according to the GDPs performance from 01/10/04 to 30/09/05, uplifted by DDRB increases.

The mACV will include:

- Fees earned
- Commitment payments
- CPD allowances
- Clinical Audit allowances

To calculate the mACV for 01.04.06 →31.03.06, the PCT will increase the total remuneration to compensate for the time lag effect inherent in the GDS payment system and apply a percentage increase to the figure obtained as a result of this calculation to reflect the percentage increase as a result of the DDRB recommendations for April 2006.

The mACV is only applicable to those dentists who are entitled to a GDS contract because they were providing General Dental Services before 01.04.06

Those GDPs who earned >£1,000 from recalled attendances will have to agree with their PCTs how they will offer to redeploy additional capacity. Otherwise, this will affect the mACV.

Gross contract value will be paid net of the patient's charges due. *(NB There is no explanation as to how we will be protected against patient charge shortfalls, whether as a result of changes in the charging regime or 'new ways of working')*.

PCTs and practitioners will be sent details of their proposed contract value by the end of November 2005.

DEFINITIONS

mACV = minimum annual contract value

aACV = actual annual contract value, this can be > or < than the mACV

nACV = negotiated annual contract value

aAVC>mACV where the contractor offers to do additional services eg. OOH, dental public health.

aACV may be >or < in circumstances like where a practitioner has had maternity leave.

For those who are not entitled to a mACV, the PCT and contractor will come to an arrangement as to what the nACV will be for ‘x’ no. UDA/units of ortho activity.

ADDITIONAL PAYMENTS

For those who want to offer domiciliary/sedation services, under the new contract, it is intended that the contract and number of courses of treatment that it provides which involve the provision of domiciliary/sedation services, in ADDITION to the aACV.

MONTHLY PAYMENTS

From 1st April 2006, you will be paid your aACV in 12 equal monthly instalments, LESS patient charges, due monthly. This will be the monthly contract payment (MCP).

ie. $MCP = \frac{aACV}{12} - \text{patient monthly charges}$

Like presently, MCP will be paid the beginning of the following month.

Under the new GDS regulations (& PDS agreement), the contractor must submit data to the BSA (new name for DPB), within a specified period of time, about the course of treatment or orthodontic course of treatment it has provided and the patient to whom it was provided, including information about whether an NHS charge was payable. Using this data, the BSA will calculate the amount of NHS charges that have been collected by the contractor in the relevant period. The total amount will then be deducted from the MCP before it is paid to the contractor.

MONTHLY SCHEDULES

Will include:

-the aACV, MCP prior to any deductions

-amount of NHS charges that the PCT has calculated that should have been collected and any other deductions (eg. Overpayment of a previous MCP), together with a reason for any deduction

-the amount of the MCP following these deductions

-plus any other payments

-net superannuable pay in respect of each performer as notified to the BSA by the contractor, and

-UDA or orthodontic activity to be achieved for the year and has so far provided on the data submitted , and has left to provide during the financial year.

ORTHODONTIC CARE

This is unclear. It appears that practices limited to orthodontics will have PDS agreements, and unlikely to partake in the GDS contract.

Will be limited to treatment cases with dental component on the IOTN scale to grades 4 or 5, or 3 if the aesthetic component is 6.

UOA values:

Case Assessment = 1.0 Unit of Ortho activity

For actual treatment <18yr = 20.00 UOA

For actual treatment ≥18yr = 22.00 UOA

For repairing an appliance not fitted by yourself = 0.8 UOA

OUT OF HOURS COMMITTMENTS

OOH care will be the responsibility of the PCT. However, during core hours of 8.00am to 6.30pm (Mon to Fri, excluding Bank Holidays, Good Friday and Christmas Day), we will be responsible for all emergencies. If you want to do these OOH emergencies, then you will able to offer your services to your PCT. Information relating to the gross fees for recalled attendance will be included in the data that you will receive in relation to your proposed mACV for 2006/07 (November 2005).

SENIORITY PAYMENTS (10% enhancement of gross fees)

Preserved for 2 years, both for those who already qualify (55 years of age), and those who will within the first two years of the new GDS. After 2008, seniority payments will be replaced by a, “framework that rewards the dentists’ skills, competence and expertise in the provision of oral healthcare”.

DPB

To be replaced by a new Special Health Authority (SHA), to be called “**NHS Business Services Authority (BSA)**”. BSA will be established from 01.10.05, but take over from the DPB 01.04.06.

NON-DOMESTIC BUSINESS RATES

Reimbursement will continue as present.

PATIENT CHARGES

A new data collection system for the verification of patient charges will be used throughout the service. The new patient fee scale will apply to GDS and PDS, and indeed where the PCT is providing the service itself.

No practice 'joining up' fee will be allowed and DNA fees will also be banned.

CONTRACT TERMINATION

Contractor gives 3/12 notice, the PCT 18/12 (with no need to give explanation)

REVIEWS

PCT will undertake an annual review and produce an annual report, by 30th June following end of financial year. This review will show aACV from the previous financial year and the total amount of deductions made to MCPs paid to the contractor during the financial year, and the total amount of any other deductions made under the contract including the net superannuable pay for each performer.

Also, will be a mid-year assessment of UDA (there is no mention of patient charges). If at mid year (30th September) <30% have been provided, the PCT can contact the contractor and arrange mid year review. Contractor will be allowed to provide written evidence for reasons as to why there has been a decrease in the UDA. Alternatively the PCT can withhold monies which are payable after the end of the contract year providing the UDA requirements have been met within 2%.

The contract can be varied by mutual consent. VS

CAYTON DELIVERS

The long awaited and much delayed new patient charges report has now been published. There is a public consultation period running 'til the end of September 2005. The profession's views are sought by the BDA at www.bdaconsultation@bda.org. It is most probable that following the process nothing will change and the proposals will be implemented next April.

Summary of new Patient Charge Bands

BAND 1 **(£15.00)**

Diagnosis, treatment planning and maintenance

Covering all 'reversible' treatments, including examination, radiographs, S&P, OHI etc.

BAND 1 URGENT **(£15.00)**

To include examination, radiographs, dressings, re-cementing crowns, up to two extractions, and one filling.

BAND 2 **(£41.00)**

Treatment not involving laboratory work (excluding denture additions)

Including all plastic restorations, RCTs, XLAs (including surgical procedures), denture additions.

BAND 3 **(£183.00)**

Complex treatment involving laboratory work

Crowns, bridges dentures, irrespective of size/number of prostheses.

The charges are not cumulative. In the opinion article, I question how difficult it may be to mix NHS/Private work without falling foul of the regulations. The BDA's advice is less defensive, arguing that you will be able to advise a patient to have a treatment done for less than the patient charge, by having it done 'privately', without being in breach of your terms of service, in the name of "patient choice". So a small partial denture could be offered to the patient for less than £183.00, but you'll lose 12 UDAs for helping the patient out, your choice.

VS

OPINION

So what concerns should we have with the GDS Regulations 2006 (draft)? It must be stressed that what the Government have presented to us is the original base contract, brought back from it's moribund state. We as a profession voted against this in the BDA survey (then titled the "Base contract framework"). The BDA's GDPC stopped dialogue with the DoH when no progress was being made on the same contract.

Below, I list some immediate concerns that come to mind when I look at what's on offer. You may disagree with my observations, but this is what the Government are offering, and unfortunately it appears to be the only show in town. April 2006 is only 8 months away.

Patient Registration

There is no mention anywhere in the draft statutory contract of the notion of patient registrations. For those of us who qualified post 1990, this is quite frankly absurd, having grown up with the concept of 'complete' patient care. This leaves me thinking we'll be used as drop in centres, forced to see whomever walks into our surgeries. The vast majority of us already have more patients on our books than we can readily see. It will be most unfair if non registered patients are seen as priorities over those that have been loyal for years if not decades. I foresee our already stressed out reception staff having a job explaining this to disgruntled patients who previously were registered and had the luxury of seeing 'their' dentist at short notice. For years, we've bashed home the message to our patients of 15 month registration periods, that will no longer be the case.

If nobody is registered with an NHS dentist, then the access problem disappears overnight, great news for the Government.

Mixed Practice

Many of you will be in mixed practice environments. Here things will get very awkward. In the new GDS, there is no definite list of treatment options and no treatments are excluded. This means that if a patient demands a posterior composite, and there is an indication for it, then you must provide it on the NHS, otherwise you will be seen to be in breach of your terms of service. The GDS (2006) regulations are presently in draft form only, but although the statement makes clear that we can still mix private and NHS treatments, it states in PART 6 schedule (3) part (2), paragraph 9(2), that **"A contractor shall not, with a view to obtaining the agreement of a patient to undergo services privately- (a) advise a patient that the services which are necessary in his case are not available from the contractor ; or (b) seek to mislead the patient about the quality of the services available under the contract."**

The contract currency is the UDA and not registration or fixed pool of patients. The regulations seem to suggest that you will not be able to see children and exempt adults only as NHS patients. However, the DoH's legal department are unsure exactly where they stand on this. It may take a test case brought by an exempt patient on grounds of income discrimination to settle this matter. The Dept do go on to say that anti-age discrimination laws will preclude children only contracts.

Collectively, this will all point to the demise of mixed practice. Those in such practices will have to seriously look at the viability of complete conversion to the private sector.

Associate contracts

Dept of Health papers can be quite difficult to read and deciphering the content can be consuming. The draft report fails *miserably* to explain where associates will fit into this debacle. My understanding is this, practice owners/partners/dental corporate will be "Contractors" (and if also treating patients, a 'performer' too). A "Performer" will also be the term used to describe associates. No guidance is given on how the contractor/performer relationship should run. Any help on this matter would be much appreciated!

No guarantees for future growth

If 2% less output of UDA confers a 'breach in terms of service', what will happen if your UDA is 2% up on the previous year? There are no guarantees of increased funding, access to 'growth funding' in PCT parlance. Make no doubt about it, this will be a ***strictly cash limited service***. Like under the PDS proposals (and precisely why PDS was so unpopular), the PCT will still have control of the 'destiny' of your practice. Future expansion programs, setting up branch practices, getting in a VT/new associate will all have to be blessed (if 'affordable' to them) by the PCT commissioners. It inflames me, and most of our profession I'm sure, that the PCTs can take charge of our commercial interests overnight with no previous input. When the medical profession came into the NHS at it's inception, the Government bought them out by paying GPs handsomely for practice goodwill. We get nothing.

Patient Charges

Regarding the fee bands, there are anomalies, for example does a denture ease fall into band 2, as such work is 'irreversible' (ie. £41.00 charge!)? (continued..)

Another concern is if a patient has previously not been to see a dentist for a long time and presents with acute toothache as an ‘emergency’ patient. (S)he can leave having had a couple of molar endos. with associated pinned amalgams, radiographs and leave the surgery out of pain for £41.00. This makes my 90 minutes of professional time with this patient cheap in the eyes of the public. Of course the reality is going to be different: we’ll all remove the offending teeth. (So much for ‘preventative dentistry’). But this is a crying shame as years of training and then even more spent honing our technical skills will be lost because we will be using them less and less. Also, which dentist will want to spend £1,000s on higher training courses if you’re feeling undervalued and more a “bob-a-job” dentist. We are professional healthcare providers who deserve more respect from the government, otherwise it’ll be audieu to NHS dentistry, forever.

Orthodontics

Only certain cases of malocclusion will be treated on the NHS (IOTN 4, 5 or 3 (if aesthetic component 6). This will prove highly contentious. Many of us will have treated less severe malocclusions and these courses of treatment will contribute to the overall UOA. As more select cases only, will be treated under the new GDS, it will be very difficult to meet your UOAs, unless you have a surplus of patients and can still get the numbers up.

Promises Promises

At the beginning of this whole fracas, so many promises were made, we would be off the treadmill, we were to work in an environment of ‘high trust’, we would have more time with our patients, and best of all, we would have access to the NHS escalator meaning we would have a slice of the massive increases in NHS spending.

Not a single promise has been honoured. And perhaps it is here that there is a chink of light (hope?) in that repeated procrastination by the DoH on this matter has led us going from one mess to another with recurring delays, with poor evidence of, or even no, long term planning. Things have not gone to plan on this whole matter for three years now. If we, as a profession, have helped scupper the Dept’s plans, by not playing ball, then that’s not our problem. The rules of this game are too one sided. This is not a modernisation programme for NHS dentistry, but a recipe for disaster, it may kill NHS dentistry once and for all. One lives in hope that the Government sees this before it is too late, or perhaps they know this already?

VS

CLINICAL WASTE REMOVAL – NEW LEGISLATION

There appears to be conflicting and confusing information regarding the need for dental practices to sign up for the new Environment Agency registration. Your clinical waste disposer will be keen for you to register (at considerably more than the £18.00 if you register yourself at www.enviroment-agency.co.uk). You only need to register if you feel your practice is producing more than 200kg/year of hazardous waste. The BDA’s advice is that they do not feel that under current guidance, dental clinical waste is sufficiently infectious to be deemed as hazardous, and that this waste should not be included in your calculations when deciding if you exceed the 200kg limit. The BDA also feels that as most practices will not exceed the 200kg limit, there is no need to register for the exemption code either. It is likely that there will be developments on this matter, the newsletter will keep you updated.

VS

PUBLIC ACCOUNTS COMMITTEE

This report was published 14th July 2005 and highlights many of the concerns previously exposed by the National Audit Office Report relating to the present state of NHS dentistry and moreover, what the government proposes. Quotes include:

DoH seen as being ambitious to attempt implementation of such a reform programme. The PAC is, ‘***extremely concerned*** *that the PCTs lack of necessary skills and resources to undertake their commissioning responsibilities effectively*.’

Regarding the new charges system, there are fears that, ‘*it must avoid creating incentives to offer private treatment to registered NHS patients at a lower cost than the NHS charge, leading to fall in the costs recovered by the NHS from patient charges. The PAC is concerned that the time needed for the consultation and ministerial debate will leave little time for convincing dentists to agree to the new charges by April 2006. The DoH will need to manage the risks inherent in this to prevent an exodus from the NHS at the 11th hour*.’

The report in can be read in it’s entirety at www.parliament.uk/parliamentary_committees and will be titled as the 30th report of the PAC.

VS

OTHER NEWS Eddie Crouch

PDS Not for all time!!!

The recent new GDS proposals also contained information relating to existing PDS contracts and obvious contracts yet to go live but awaiting final approval. Some practitioners have already budgeted based on these signed contract values, in some case sales of practices have gone through based on these figures. It transpires that come April 2006 these PDS contracts will have to be renegotiated to include the UDA's (Units of Dental Activity). So a contract signed for a three year period may last less than 6 months in some cases.

The stopping of new PDS applications has also affected some practices being sold, as sales were depending on the proposed PDS contract, and if the application had not reached the Department of Health it is now being shelved for new GDS.

I would be interested in hearing of any other similar issues where new regulation proposals are causing such problems.

LDC Election

Following the recent By-Election Dr David Payne and Dr Chris Gattas have been duly elected.

New Dental Hospital

An update will appear in future newsletters on the progress of the new build.

Domiciliary Visits

Practitioners are reminded to check with their Defence Unions if carrying out Domiciliary Visits, regarding emergency drug provision and transportation of Clinical Waste.

Computerisation

There is still an opportunity for practitioners who do not transmit forms to the DPB electronically to apply for the Grant of £950 to enable them to start this may not be around for much longer.

Future Meetings

Following on from the Choices meeting held at the Novotel in April, the LDC is planning another large Pan Birmingham Meeting for the autumn regarding the new proposals. If you have specific requirements for what issue this meeting should address, please let me know quickly, so that appropriate speakers can be arranged, it is important that we as an LDC know the concerns of Birmingham Dentists; it has been disappointing to date that relatively few are contacting LDC Committee Members.

Eddie Crouch

LDC Secretary

Lobby Your LDC Members!

Further to Eddie's comments above about a future pan Birmingham meeting, I would like to bring to the attention of all colleagues the need to discuss with your LDC members about how you feel with regards to our local position now. As predicted, the government are willing, without the approval of the profession, to steam roller in the biggest changes to the provision of NHS dentistry, even having the guile to tell the media that we have asked for these changes. I hope there is plenty of food for thought in this newsletter. Are you happy with the current situation? Are we happy to lie back and take whatever the government throws at us, or is it time to become more militant in our actions? What should such actions be? This LDC is a body representing (and funded by) over 400 colleagues in Birmingham. We act on your behalf, and this is a two way process. Please lobby your LDC members, tell us what you feel should be our response to the government's latest proposals. We can only act along with the consensus of opinion. A personal view is that one of the government's ploys with PDS was to divide and rule , they needed (wanted/ hoped for) 50% to convert to PDS, they failed in their estimations, especially here in Birmingham. They may fail again. However, reading the PAC report, what is inevitable, is the fact that there will be a change come April 2006. The government feels it has to act, if for no other reason, than simply to save face.

VS

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☺ Any comments, criticisms , contributions to this newsletter are welcome. Please contact Vijay Sudra ☺