Response to LDC Conference motions 2007

Executive Summary

On 1 February 2008, GDPC considered its response to LDC Conference motions. This is the finalised response based on that discussion.

Final Response to LDC Motions

1. **Surrey LDC: "This conference demands the re-instatement of the right of general dental practitioners to charge patients for wasted surgery time or to receive a UDA allowance for it."**

The General Dental Practice Committee (GDPC) agrees with this motion; indeed it has been an aim of the GDPC since the new contract proposals were first published. Failure to attend charges are not permitted within primary legislation and despite lobbying from the GDPC, the Department of Health has no plans to amend this.

But missed appointments are a waste of NHS resources. It is GDPC advice that practitioners institute a 'two strikes and you're out' rule i.e. making it clear to patients that if they miss appointments without giving prior notice they are liable to be refused any further treatment.

In addition, high incidences of missed appointments should be reported to the Primary Care Trust/Local Health Board (PCT/LHB) so that this may be taken into account at the end of year contract monitoring stage, perhaps by a reduced UDA target.

2. **Bro Taf LDC: "This conference demands that in order to improve the oral health of children, the NHS dental contract must increase the rewards for the prevention of dental disease."**

GDPC agrees with this suggestion and regrets the lack of incentive for preventive care in the current contract. GDPC has made strenuous representation on many occasions for a positive reward for prevention as part of the NHS contract but without DH agreement. We shall continue to pursue this cause. A prevention-based system could be delivered if the NHS contract used a range of quality-based performance indicators

rather than sole reliance on a single, flawed output measure. Instead, dentists are facing financial penalties derived from untested targets.

3. **Rotherham LDC: "This conference deplores that the new dental contract discourages the care and treatment of patients with high dental needs; and consequently the contract is likely to increase inequality in health and healthcare access."**

GDPC agrees that the current UDA-based, target driven contract does not encourage care of high needs patients. Dentists are working to a contract that places value only on meeting UDA targets, where there is as much recognition for simple procedures as for more complex ones. This arrangement is only likely to exacerbate existing inequalities. This point of view has been expressed by GDPC, including jointly with patient representatives at the Implementation Review Group, but the DH does not agree. However, Conference can be assured this will not be allowed to rest.

4. **Bexley and Greenwich LDC: "This conference calls upon the Department of Health to address urgently the need for additional funding resources to enable dentists to carry out root canal therapy under the NHS."**

As below.

5. **Oxfordshire LDC: "This conference believes that practitioners should not be expected to absorb the additional costs of centrally imposed changes in clinical practice from within existing contract values."**

GDPC agrees with these two motions, which were carried by LDC Conference shortly after the DH published revised guidance on the single use of endodontic reamers and files. A consequence of this new guidance was an increase in costs to NHS practitioners above and beyond that included within their contract values. Whilst the DH advised PCTs/LHBs to consider this with their local practitioners, there was no guarantee that these additional costs would be reimbursed. The Chair of GDPC made representation when the DH published its guidance but no central funding was made available.

This requirement is just one example of changing costs, but several other challenges, such as dental nurse registration, other cross infection control requirements and clinical governance guidelines are combining to threaten the financial viability of NHS practice. In December 2007 the DH announced an eleven per cent increase to the dental budget for the coming year; it is important that this money be used to compensate practitioners for these and other additional costs.

6. **Devon LDC: "This conference is disappointed by the lack of continuity of funding provided by PCTs for VDPs on completion of their training."**

GDPC agrees with this motion and will continue to press DH for continuity of employment for new dentists. Because of the change in funding arrangements, many new dentists are unable to work in their training practices. In 2006/7 the British Dental Association Research Unit conducted a survey to assess the impact that the reforms to NHS dentistry has had on the ability for vocational trainees to find and secure employment. Almost two-thirds (63 per cent) of vocational dental practitioners in 2007 wanted to stay on at their training practice; however, only one third (33 per cent – or half of those expressing that preference) reported that they would actually be staying on at their training practice. The corresponding figures for 2006 were similar.

There was a clear message that finding jobs has been a relatively difficult process, with 30 per cent of vocational dental practitioners stating that their experience of job-hunting had been more difficult than expected; the figure for the year before was 46 per cent. Just under a third (30 per cent) did, however, find job-hunting easier than expected - a similar percentage as in 2006.

Only just over a third (37 per cent) of the vocational dental practitioners felt that they had managed to pursue their post training career plans; this is down on the 48 per cent reported in 2006.

7. **Avon LDC: "This conference calls for the DH to ensure all new UK graduates have a fully and centrally funded VT placement and to remove the link between UDA targets and their ongoing placement in the GDS."**

GDPC agrees that appropriate VT placements are of crucial importance. They help to ensure that young dentists are provided with continuity of training, which is of benefit to the NHS, to the dentists themselves and to patients. The GDPC deplores the implied link whereby UDA targets form part of the contractual values attached to vocational training. We believe that the provision of modern quality dental care within a properly monitored educational setting should take precedence above the attainment of NHS targets.

8. **Suffolk LDC: "This conference calls upon the DH to censure any primary care trust that does not spend its entire floor-funded dental budget on direct patient care."**

This motion was passed in the context of PCTs using capital and other funding to offset deficits in patient charge revenue and other financial shortfall. GDPC agrees that funding from the dental budget should be used for dental services only. The DH allowed the use of unallocated funding to support shortfalls in patient charge revenue, which effectively took those funds away from front-line patient care. This was done despite strenuous representations to the Department of Health from the GDPC Executive.

Since 2002/03 when a five-year period of sustained funding for the NHS began, the proportion of NHS budget spent on dentistry in England has fallen and is now lower than it was in 2002/03. In the light of this it is more crucial than ever that the maximum amount of funding be allocated to improve patient care.

9. **Bromley LDC: "This conference believes that one year should be the maximum recall for any dentate patient."**

GDPC agrees with the sentiment behind this motion i.e. that the new contract fails to promote a continuing care relationship between dentists and patients, which would encourage a preventive approach to care. Instead, the reforms attempt to address the access gap by spreading the same amount of NHS dental services increasingly thinly.

The precise time interval between routine examinations is for agreement between the dentist and patient, as stated within the NICE recall guidelines. The key issue for GDPC is to call on the Government to create an environment in which NHS dentists are able to spend the time they need with their patients, in terms of frequency of recall for examinations and length of appointments. GDPC has made this point to DH and to the Minister of Health without positive results, but will continue to illustrate the current contract deficiencies.

10. **Northamptonshire LDC: "This conference should chastise itself for its part in allowing the DH and Her Majesty's Government to ride roughshod over the profession."**

GDPC considers this to be a matter for Conference.

11. **South Cheshire LDC: "This conference believes that all PCTs should be given the authority by the DH to deduct a statutory levy from all providers and performers in order that the LDCs can continue to function effectively."**

GDPC agrees that it is vital LDCs are able to raise sufficient funds to cover the costs associated from representing local NHS dentists. It is already the case that GDS providers are automatically represented by LDCs and therefore automatically contribute a levy. Primary legislation does not permit PDS providers (unless they are also performers) to be represented by LDCs. Both GDS and PDS performers must actively sign-up to be represented by their LDC and to therefore contribute a levy. GDPC has made the point that the mechanism for collecting LDC levies seems unnecessarily complex and ill understood by PCTs, LDCs and the NHS Business Services Authority. A simpler system should be instated.

GDPC believes that there are practical steps that PCTs/LHBs should take to facilitate the easy collection of the levy: for example, by assisting LDCs in contacting all local performers and providers. This is one of many ways in which constructive progress can be made if PCTs/LHBs work closely with their LDC.

12. **Bexley and Greenwich LDC: "This conference calls upon the DH to require PCTs to permit a 10 per cent tolerance in over performance and under performance at the end of each accounting period."**

GDPC agrees with this suggestion. Almost half of NHS contracts were short of their UDA target in 2006-7. Only 20% were within 96-100%. In child only contracts 75% missed their targets. So it seems clear that the test year figures were inaccurate.

Under the current chaotic clawback system, there has been a large disparity amongst PCTs reclaiming money for those missed UDA targets. Of those who have missed their UDA target, 40% were subject to clawback; 35% asked to make up the shortfall in the following year; and 20% not penalised at all. This is an iniquitous system and should be scrapped. To reflect the obvious errors in test year prediction, GDPC agrees that there should be significantly more flexibility allowed. The GDPC Chair wrote to DH to request an amnesty on those performers who had struggled to achieve their UDA targets but had made significant efforts. This request was denied.

13. Norfolk LDC: This conference has no confidence in the DH's handling of the introduction of the new dental contract and has grave concerns over its ability to successfully deliver a 'fit for purpose' dental service in the future."

The period in the run-up to the new contract, and the two years since its introduction, has been an enormously destabilising time for general dental practitioners. Whilst any fundamental change of contracting systems was bound to have teething problems, much of this process has been handled poorly by the Department of Health. For example, problems with the payment schedules and the supporting IT systems; with changes to UDA quotients for VDPs; and with different interpretation of the regulations. At the end of the disruptive and difficult first year, BDA research showed that thousands of dentists were subject to financial clawback.

Looking ahead, the BDA is focusing on moving towards local commissioning arrangements which benefit dentists, PCTs/LHBs and patients. There is the potential within the current regulations to implement a more 'fit for purpose' dental service. The BDA and GDPC are working with LDCs and PCTs to facilitate these developments and would encourage LDCs to prioritise this in the run-up to 2009 – and beyond.

14. Norfolk LDC: "This conference moves that the continued increase in dental training places in the UK is a waste of tax payers' money as there is no longer a workforce shortage to address"

Workforce planning is not of concern to the GDPC alone, but we hoped to have input. However, it seems that DH believes an excess of dentists is to their advantage. GDPC believes the Department's focus should be on training sufficient dentists to meet the nation's oral health needs, regardless of their payment method. Many dentists want to provide NHS care and many patients want to receive it. If there is insufficient funding available to meet this demand, the government should make this clear.

15. Birmingham LDC: "This Conference calls on the DH to demand that PCTs not be allowed to reduce the monetary value of UDAs."

GDPC agrees with Conference's regret that, with the introduction of full local commissioning, PCTs/LHBs will be under pressure to reduce UDA values to cut costs. This can only result in pressure towards the lowering of quality standards in NHS dentistry. GDPC believes the DH should encourage PCTs/LHBs to focus instead on criteria of quality of care rather than short term cost as a means of providing NHS dentistry. GDPC has made clear that the reliance on the flawed output measure of UDAs as the sole criterion of performance benefits neither dentists nor patients but merely creates another treadmill.

16. **Birmingham LDC: "This Conference calls for all contractors to be offered rolling contracts with a minimum five year term, thus offering a greater degree of stability to their businesses."**

GDPC agrees with this motion. There are different arrangements for PDS and GDS contracts. Currently, PDS contracts run until an agreed expiry date; GDPC recommends that all PDS contractors seek to extend their contracts on such a rolling basis, and has called on the Department of Health to advise PCTs/LHBs of the benefits to them and to patients of service continuity and stability. GDS contracts are indefinite, unless terminated by breach of contract or by the dentist contractor.

However, GDPC is highly concerned about the ability of PCTs/LHBs to vary the *terms* of GDS and PDS contracts after 2009, a process which has yet to be published by the Department of Health. Whilst GDPC recognises the DH's call for service stability after this time, we will continue to lobby for more safeguards to be put in place to ensure the continued ability to operate NHS businesses and to provide some certainty for practitioners.

17. **Enfield and Haringey LDC: "This conference urges GDPC to press the DH to liberalise the rules governing local commissioning that have rendered the sale and transfer of dental practices virtually impossible in some PCT areas."**

GDPC agrees with Conference that the DH should take steps to make the sale of practices more straightforward. These should include the introduction of longer, fixed term contracts and guarantees that measures other than UDAs will be used to determine quality of service. There should also be efforts to recognise the value of goodwill which dentists have worked hard over a long period to build up, and which is often a crucial component in pension plans. GDPC has voiced significant concern about the ability of PCTs to dictate the terms of the sale of a practice or indeed, whether it can continue to provide NHS services; this includes representation to the DDRB. We shall continue to work at achieving a fair position which will enable practitioners to purchase and sell practices as known entities without PCTs altering existing terms.

As a consequence of the new dental contract, dental practices now face much greater uncertainty about their NHS income. For many, that income has stayed the same or fallen since the introduction of the contract. BDA research from 2007 indicates that, in England and Wales, profits of 64% of 'NHS practices' (defined as having 75% or higher NHS patients) had stayed the same or decreased since 2006. As a result, only a

little over half of NHS practices have managed to maintain their planned two year investment programmes. And the sale of practices has become far harder, in some cases unviable.

Lester Ellman
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