Contract reform and general system improvements: briefing to LDCs

Introduction

1. The GDPC has been discussing its priorities for contract reform and NHS system improvement for a long-time. This briefing summarises the GDPC’s position regarding contract reform and NHS system improvements.

2. The paper was approved by the GDPC in May for wider circulation to LDCs and communication to the profession.

The issues

3. The BDA has many criticisms of the current prototype business model. At present we could not recommend the model to the profession. We believe that improvements can be made that would not justify starting again with testing.

4. Currently there is a growing recruitment problem within NHS dentistry. The reasons are multifactorial but from our research we believe they centre around:

   a. UDA targets that are increasingly difficult to meet because of BSA actions
   b. Below inflation contract value uplifts and the fall in taxable income since 2006
   c. Younger dentists wanting to practise in a way that best uses their skills and not to be put under the great stress that committed NHS GDPs experience
   d. Dentists graduating with much higher levels of debt than were previously experienced, they do not feel the same level of commitment to the NHS that had previously funded more of their studies
   e. Implications of Brexit for EEA qualified dentists
   f. Experienced and highly committed dentists retiring early at 55+
   g. Low UDA values and particularly UDA values below the Band 1 patient charge amount
   h. Corporatisation, with associates within the corporate chains being unhappier than those working within family practices
   i. Continuing performer list problems
   j. Very low morale with morale falling as NHS commitment rises
   k. A feeling that the NHS does not care about its workforce because no support is offered to the profession to improve their working lives.

5. This paper sets out the GDPC’s views on what will improve the situation in relation to contract reform and within the wider dental system.
Contract reform

Access measures

6. If the prototype care pathway is introduced then this will be a fundamentally different approach to NHS patient care. If patients are treated based on risk assessment and prevention more time will be needed which means that numbers of patients seen will fall in the short term. Even adopting NICE recall guidelines, patient habits take time to change and patients with high needs, who need the most time to treat, need to be seen frequently.

7. We can see two alternative ways of creating space for practices to introduce the new arrangements. Both would be helped if a new Government access measure of numbers of unique adults and children seen in the last three years was introduced. We fully understand the Department of Health’s political imperative around access levels, but believe that contract reform presents an opportunity to begin to define access in a different and more appropriate way. This would at the same time deliver a break from previous access measurements, limiting the opportunity for, and value of, historic comparisons.

8. In our view the two options are:
   
   • enable practices to reach their patient numbers targets over three years but with a target of say 90 per cent at the end of year two or
   • if a two-year target period was used, for the first-year patients who would have dropped off the list because they have not returned to the practice should stay on the list.

Rollout

9. As has been agreed by all sides, staggered rollout will help to prevent system destabilisation. If a three-year access target or patient list target is chosen then it seems logical to phase in the pathway over three years. Year one could be children, year two adults up to age 50 and year three all other adults. This would leave the most complex group until last but would still mean the system was introduced fairly rapidly. Software issues would need to be dealt with to enable two systems to be operated.

Weighted capitation

10. If there are individual practice capitation rates for existing patients there needs to be some way of incentivising new patients such as a weighted payment based on age, sex and deprivation or some other form of entry payment. This will recognise that new patients will often have high needs and require more time for prevention and treatment.

Income guarantee

11. We would like some form of income protection for the first few years of new contractual arrangements. There is a great danger that, as might be happening in the current Southern Orthodontic procurement, numerous practices decide to close or move over to private care because of worry over business survival. We can discuss the best model for this which does not damage access figures but there must be something in place to ensure the risk to practices is manageable.
Bandings

12. We would like more granularity within Bands and particularly more UDAs to be earned by the provision of molar endodontics.

System improvements

13. Although contract reform has the potential to go a long way to improve dentists’ appetite for NHS work there are other things that could be done now to improve the situation.

Clinical audit and peer review

14. We are still awaiting more news about NHS England’s quality improvement framework but one thing that seems to have been agreed on is that peer review and clinical audit activities should be re-introduced. These were widespread prior to 2006 and we ask that work is done on these schemes together with protected time for practitioners to carry on this activity.

BSA

15. The BSA is continuing with its 28-day recall programme. We see no justification for it now that the initial outlying contractors have been dealt with and now practitioners only slightly outside the average are being asked to spend time on unjustified audits. This is contributing to a climate of fear with dentists not claiming for things they are entitled to claim for and therefore finding it harder to meet their targets. We think there needs to be a conversation with NHS England about the BSA’s actions and a joint approach to ensuring that contractors are not under-claiming.

Commitment payments

16. In our evidence to the DDRB for this year we asked for NHS commitment payments to be re-introduced. When they were previously available we felt that they helped to retain dentists within the NHS. Not only would this re-establish some goodwill, it would help the current recruitment issues. The £7m funding (2011 prices) should still be available after the cancellation of seniority payments. This could be used to partly fund the scheme or commitment payments to dentists close to retirement.

Contract management

17. The move by NHS England to shift routine contract management to the BSA gives an opportunity to adopt national policies. However, it also means local discretion for local circumstances may be more difficult. We would like to work with NHS England to adopt an approach to contract management that is designed to achieve the very best for patients and practices, which means supporting practices that are in difficulties and taking a pragmatic approach where there are issues. In our experience, Local Offices can be inflexible and often try to achieve the very lowest UDA values when calculating what they deem to be safe levels. We appreciate that the NHS must look for value for money, this approach can be a false economy. We would like to work with NHS England to look at practice cost inflation and for all Local Offices to ensure that no practices have UDA values that are less than the current Band 1 patient charge.
**Dentists’ mental health**

18. Recent BDA research has shown that dentists experience very high levels of stress and reported burnout. The incidence of mental ill health increases with NHS commitment and GDPs are experiencing the highest levels among the different crafts. At present nationally, there is no specific mental health support for dentists and this service is much needed. Our research showed that dentists are less likely to seek professional help for their difficulties because of fear for their careers. London has a mental health service for doctors and dentists provided by NHS England and we believe this should become a national service.

**Consultation and involvement**

19. In recent times NHS England and the Office of the CDO’s willingness to involve the BDA in possible changes has diminished. There are some very good examples of consultation and involvement but in other instances there has been little or none. If meaningful consultation can become the norm then this will help to ensure changes are made that take account of the effect on practitioners.

**Indemnity**

20. Indemnity costs are rising for dentists and if assistance is going to be given to GPs then the same assistance should be given to GDPs. We realise there is the issue of mixed courses of treatment but this can be overcome.

**UDA values**

21. The recent 5 per cent uplift in patient charges has brought the question of low UDA values into sharper focus. We believe that there should be a minimum UDA value of the Band 1 patient charge. That value should be uplifted by the annual contract uplift or the percentage rise in patient charges, whichever is the greater. We know of at least one area where this was done in 2017/18 but this should be a national policy.