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PLANNING FOR ORAL HEALTH IN BRENT

A RESPONSE FROM A GDP

Introduction

The PCT Lead for Dentistry in Brent has presented a draft ‘plan of action’ to review. This comes at an auspicious time, in that PCTs and GDPs are currently coming to terms with the imposed new General Dental Services Contract (nGDS) to commence on 1st April 2006.

Currently it would be appropriate to state that both parties are concerned that this aspect of change occurs as successfully as possible. Both are mistrusting of the Dept of Health to provide timely, accurate advice to enable successful change to occur. Both know that the contract remains under funded and that serious omissions have resulted in no IT provision, no link to the national IT network and no real funding for modernisation of practices. Both are surprised that after 1st April, much work will have to be done to clean up contracts, misinterpretations, DPB software inadequacies, GDP monthly funding and surplus UDA funding.

The BDA has pointed out to Government that there is nothing in the new contract that will improve prevention of oral disease and have expressed their extreme disappointment that negotiation has not been allowed. GDPs have been aggrieved that no local commissioning has occured at this stage and no local variation has occured for the PCTs as this has been denied consistently at DoH level. Both parties feel that the three year period in which centrally released funding to local level puts risk, both financiial and operational, onto the PCT and GDP and consequently the resentment that each party feels is not conducive to a full exploration of a detailed strategy review at this time.

Regretably over the next year there will be an uncomfortable settling in period in which PCT staff, unfamiliar with dentistry, and already burdened with other medical, optical and pharmacy challenges.

September 2006 and April 2007 will be crucial points at which PCTs will have to review performance and reallocate funding as many GDPs will have failed to deliver UDA levels as expected.

GDPs have been urged to consider a reduction on dependence on NHS funding both by the BDA and astute colleagues and it will be this conversion to the private sector that will provide the main concern to PCTs. Within twelve months, the best practices will have shifted the level of their commitment significantly to the private sector with an aim to be non-dependant on the NHS by 2009. In addition the success of Denplan and Practice plan in facilitating the conversion of practices nationally will have some

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impact on Brent with perhaps only Brent South remaining fully committed to the NHS. By 2009 it will be difficult to attract these essential practices back to an NHS remit. The task of the PCT in then implementing a true oral health strategy that is effective in delivering the outcomes detailed in the draft document would be remote.

The strategy would, in my opinion, be doomed unless the PCT is willing to risk considerable local investment to dental services beyond that in the nGDS ring-fenced pool. The Chancellor has in the March 2006 Budget committed funding to Education rather ythan Health whilst at the same time demanding that the £900 m deficit in PCTs nationally be fully addressed. After 2009 it is likely that dental funding may be reduced considerably.

If the Government's real intention is that by 2009, the middle classes are removed from NHS dentistry it is highly likely that GDPs will make this happen, even in Brent. However it will leave a GDP population behind that will be resentful, further dispirited and less able to deal with the challenges.

I put this vision forward as I am now convinced that this is the most likely scenario that the nGDS contract will lead to. I have enormous sympathy with PCTs who have now been mandated with providing dental services at a time when they have not had experience nor asdequate funding to achieve a DoH dogmatic approach to commissioning.

PCTs, not having an opportunity to have any input by way of a local strategy into the contract, are now having to support, implement and manage a three year term when all of us are aware that increased access and the improvement in oral disease will not be achieved.

The last days of March 2006 see the demise of the old NHS contract for dentists. It will, in hindsight, be viewed as an extremely good deal. Risk was entirely that of DOH. A dentist could generate large income by working hard. Whilst the profession was underfunded, income could be considerable and long hours reduced overheads significantly. The new era dawns with extreme sceptism on all sides.

Critical Review of the Current Position – The Good, Bad and Ugly

The document, 'Planning for Oral Health in Brent' is an excellent overview of idealised community delivery of dental services. However it describes a national overview of dental disease and fails to address the practical and local issues that would frustrate the implementation of the model.

The following issues are listed in an attempt to focus the PCT on the extent of infrastructure and funding limitations that need to be considered.

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The Good

- Dentists in GDS represent the most effective group of healthcare workers producing profit exculsively within this sector. One has only to compare GDS with CDS to see how entreprenerial spirit, good business acumen and efficiency places GDPs in an extraordinary position viz-a-viz other peer goups.

- Practices are independent businesses run by independant contractors. Goodwill is the preserve of the GDP still unlike GPs.

- Local complaints against GDPs traditionally form the lowest amongst GPs, pharmacists and opticians.

- CPD is met universally

- GDC registrations are totally effective for GDPs, hygienists, therapists and as of July 2006, dental technicians and dental nurses.

- Specialisms are well developed.

- Emergency treatments have been very effective with the service iin Brent and Harrow being a model for national adoption.

- Clinical Audit and Peer Review was late to develop but produced excellent commitment from GDPs in Brent and Harrow.

- Occupational health programmes have been very effective

The Bad

- Relationships with FHSA, FPC, HA, PCGs and finally PCTs has been consistently poor.

- GDPs are not included in the ‘family community of other professionals’.

- PEC advise has been poor and the Brent PCT has not been alerted to potential problems and GDP concerns

- The Dental Advisor is poorly funded for sessions that are so infrequent that no valid contribution is recognised by either the PCT or GDPs.

- A published Oral Health Strategy appears not to have been published and updated since before 2000.

- Relationships between the PCT and LDC are ineffective and distant.

- The PCT has failed to adequately engage GDPs with regard to the nGDS contract that has caused an already appalling delivery on the part of the DoH to be stalled still further.

- Contracts that should have been signed by 28th February may finally be in place only at 31st March 2006. Delays in funding from the New SHA will challenge cash flow in practices acutely.

The Ugly

- Almost no practice inspection has occured within the last 5-years despite a mandatory demand from the DoH for the PCT to provide this scrutiny.

- GDPs have signed the nGDS contract either in dispute or with grave reservation that the contract will not work.

- PCT staff seem almost as convinced that this will be the case.

- The PCT has not recieved proper or adequate training or funding to enable a local commissioning of dental services to be effective.

- Local specialist provision in the community service has waiting lists that are 12-15 months for consultation in endodontics, periodontics and restoration. Referral to teaching hospitals results in rejection on the grounds that the wating lists have been closed. Local specialist provision need urgent review.

- Full police CBC is not in place for dental practices

- No quality assurance system is in place nor has it been contemplated for GDPs.

- IT provision is non-existant and not funded centrally. GDPs will not be part of the NHS community. Many dentists may consider submitting information to the PCT and SHA via paper rather than EDI link to cause as much difficulty to the PCT for not funding IT adequately.

A plan to implement change and integrate GDPs onto a new platform for dental delivery could be developed should the dental lead consider that the above personal response from a GDP is sufficiently accurate and incisive to warrant commissioning this further work.

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