

LDC OFFICIALS DAY, HOTEL RUSSELL, RUSSELL SQUARE, LONDON. DEC. 4 2009.

The first Friday in December is the now traditional date for the meeting of LDC Officials hosted by the BDA. With so much happening during 2009, Richard Emms the Conference Chairman said it's been a very interesting year, but he wished it hadn't been quite so interesting.

CARE QUALITY COMMISSION (CQC)

By April 2011 all dental practices in England only, will have to be registered with the Care Quality Commission (CQC) stated Alex Bayliss, Provider Registration Manager CQC. Their remit is a single system of registration and a single set of standards throughout Social Care, the NHS and Independent (private) Healthcare backed up by strengthened and extended enforcement powers. All providers, such as dental practices will be registered in their own right, and monitoring standards will be an ongoing process with integrated practice inspections (e.g. dental practice advisor/reference officer/regulatory bodies). Guidance for compliance will be published by the end of 2009, will be outcome based, and every practice/provider will have their own Provider Profile, a risk based responsive system. Frequency of checks on practices could be frequent or very occasional based on this Profile. They will have the power to close a practice immediately in extreme cases, through the PCT or local commissioner of services. Practices will have to apply for registration from around October 2010 to March 2011, and surprise, surprise, there will be a charge. After April 2011 it will be illegal for any NHS, Mixed or fully Private practice to provide services without being registered with the CQC.

UPDATE ON STEELE REPORT, WARBURTON CONTRACT (PDS PLUS) & WORLD CLASS COMMISSIONING

The key themes that have dominated 2009, John Milne from Yorkshire, the new Chairman of the BDA's General Dental Practice Committee listed were

- Steele Report
- Access initiative (Warburton Contract)
- Clinical Leadership with local commissioning
- World Class Commissioning
- Quality
- Funding

He started with the Steele Report, and quoted from the Report that 'NHS dentistry could lead the world in providing an Oral Health Service' and asked if anyone in the room believed it. Apart from the Deputy Chief Dental officer, no hands were raised!! The Department has divided the Report into 5 Workstreams each with a committee to work on various aspects of the Report. The Pilots will be starting soon, but more about these later.

Of more immediate concern is the Department's Dental Access Programme and the now adopted Warburton Contract or PDS Plus Template Agreement. The profession only heard about this Contract about 4 months ago, which has not been piloted. Basically this

is a PDS, hence time limited Contract, where a minimum of 51% of the Contract Value will be activity based (UDAs), the rest of the Contract Value will be made up of Access Payments and up to 27 different Key Performance Indicators (KPIs). Under these arrangements, the practice will have to demonstrate agreed (with PCT) Performance and Access Targets to trigger these payments as well as do the dentistry in the usual form of UDAs.

Theoretically, PCTs will have the option to offer this 'new' Contract, or a more usual PDS/GDS Contract to any Provider tendering for a new Contract, but it is expected that PCTs will be pressured by the Department to use this new PDS Plus Contract for all new bids (tenders). The draft version of this Contract in circulation since October was so onerous that practitioners were strongly advised not to sign it. It has been modified after a minimum of consultation, but is still considered unsuitable, and our advice is to take advice both from a Solicitor and your professional organisation before you commit to this new Contract. It will not apply to existing Contracts, though could be imposed after any Contract variation or short retirement; *Be warned*.

The PDS Plus Template Agreement is very long and complicated, and makes the 2006 Contract look like a walk in the park, but it may be possible to have an existing GDS Contract run alongside a new PDS Plus Contract for practices wishing to expand, and can be varied by the PCT.

The BDA have produced a Working Group Report on Independent Local Commissioning for use by LDCs and hopefully PCT Commissioners to work towards the concept of World Class Commissioning, the Warburton Contract is supposed to be part of this process.

This is a comprehensive guide to commissioning NHS dental services at PCT level.

With the economic situation as it is, the Department have asked the Doctor and Dentists Review Body (DDRB) to recommend no uplift in Contract Values, which coupled with a 1% 'efficiency' saving translates into a 0.6% rise after taking into account rises in expenses. Both the DPA and BDA have asked for far higher uplifts due to large expenses hikes during the year, the DPA reported that Dental Directory had to increase prices of materials by over 21% since March of this year alone.

After questions it was agreed that the most important immediate battle was to 'prevent the Warburton Contract becoming the new Contract for all practices after the Steele Pilots have completed, and for LDCs to resist any attempt to move PDS Plus into the mainstream'.

LOCAL COMMISSIONING

Local commissioning is now the way that NHS dentistry is provided or procured to use the latest jargon. Dentistry has never been a high priority at PCT or even Strategic Health Authority (SHA) level, and there are concerns about future funding due to the economic situation. The World Class Commissioning Framework has been developed to encourage innovation, prevention and quality in healthcare provision.

One of the biggest grumbles with many LDCs, certainly in Dorset, is changes of dental commissioners or leads at the PCT. 3 years is the average time in post for PCT dental leads, with over a quarter lasting less than a year. Many of the dental leads themselves feel that their PCT lacks the resources or expertise to vary national contract guidance, and less than a third of dental leads get any commissioning advice from their SHA.

Most LDC Secretaries/Chairman and PCT dental leads have regular, useful contact, and over 80% of PCTs do have some form of oral health strategy.

The purpose of the BDA's report on local commissioning is to offer step by step practical guidance, tips and ideas on commissioning general dental services for both the profession and commissioners. It contains many references to the World Class Commissioning Competencies and how these can be met, said Susie Sanderson of the BDA. Many commissioners however, are only interested in meeting their access targets, and also do not take the significant number of private patients into account.

STEELE REPORT

The Chief Dental Officer (CDO), Barry Cockcroft had another meeting to go to, more important than one of the only 2 meetings of his profession's representatives in a year; and sent his Deputy CDO Sue Gregory along instead to explain the work surrounding the Steele Report and the setting up of the pilot schemes to enable implementation. She outlined the main priorities of the Report from the Department's view

- Improving oral health, access and quality
- PCTs requirement to demonstrate good organisation, strong leadership, clinical engagement with dentists, and liaising with motivated SHAs.
- Transition from activity/treatment to oral health
- New patients to have oral health assessments
- Existing patients to have evidence based prevention and advice
- Training and CPD for the dental team.
- Clinical information and measurement of outcomes (monitoring)
- Learn from the mistakes of Options for Change (for new practitioners this died in 2004, may it rest in peace)
- Fairer allocation of funding
- Research and Development for primary dental care
- Rapid progress with proper pilot studies

She then went on to give further detail about the 5 workstreams mentioned before namely Finance, the Implementation Group, Stakeholder Group, Pilot Schemes and Communications etc. She stated that dental access was up by nearly a million over the last 5 quarters, but neglected to mention that access still hadn't reached pre-April 2006 levels. This will be helped by the PDS Plus (Warburton) Contract and emphasised the extra monitoring and quality checks by the CQC mentioned earlier, and help with modification to existing Software Systems to provide this extra monitoring.

STEELE PILOTS

The pilot studies for Steele will be carried out in existing practices, and groups of practices or corporates, and arrangements for the launching and monitoring of the pilots has already started. Pilots will be based on

- Appropriate access
- Provision of emergency or casual treatment
- New patient assessments
- Continuing care of regular patients (nice to see the return of this old favourite)
- Care pathways
- Patient registration numbers, floors and ceilings (another blast from the 90s)

- Key Performance Indicators (KPIs)
- Variations in the current UDA banding system, moving to 5,7 or 9 bandings
- Monitoring of quality standards
- Patient charges

Many Steele pilots will be Steele Affiliates only testing 1 or 2 aspects of the Steele recommendations.

Evaluation of the pilots will be based on the assessment of

- Financial considerations
- Benefits to patients
- Improvement to quality standards
- Efficient use of new process measures
- Risks and uncertainties

The LDC representatives present made clear to the Deputy CDO that they feared and would strongly oppose, any move that the Steele Report proposals would be incorporated into the Warburton Contract as the key performance indicators (KPIs) at the end of the pilot schemes, and this would be rolled out as the replacement to the 2006 Contract.

QUALITY & OUTCOME FRAMEWORK (QoF)

Richard Denton, Secretary of Doncaster LDC explained this initiative where new money was introduced by the PCT and given to dentists who achieved certain quality and outcome indicators on a point basis system. Each point is worth £90 based on an average FTE Contract of 10,000 UDAs. 50% of this new money is paid up front, and the rest after a QoF visit by the PCT and LDC dentists at the end of the year. The points are earned by going beyond basic contractual dentistry with indicators such as fluoride varnish, preventative clinics, smoking cessation, use of rubber dam in endodontics and post graduate events. The speaker, was also an LDC assessor, which was also rewarding. He said 'QoF has been successful in bringing about a more quality driven, preventative focused contract to Doncaster'. Dentists have a choice over which indicators they use, the scheme is voluntary and the money is over and above the UDA Contract Value. Not surprisingly, all practices in Doncaster are in the scheme. Never even heard of this in Dorset, it's always Northern areas that get this type of extra funding.

After a reasonable lunch, the delegates split up into separate groups, the first one I went to was 'Communicating with your members'. It is not good enough to push out information to your members, they must understand the purpose, goals and value of the LDC. One of the biggest problem which was highlighted by myself, and many others present was how to engage foreign dentists in the work of the LDC. (This is also the case at the BDA and DPA). Associates/Performers are also poorly represented on most LDCs, certainly true in Dorset.

'Relations with the PCT' was the next 'breakout session' (don't you love the jargon). The current issues that concern PCT/LDC relations are

- PCTs have to meet World Class Commissioning standards
- Clawback and breach notices
- Action on re-attendance rates

- Population percentage access targets set by the SHA
- Tenders for new services for which a new guidance for PCTs is due out soon, no doubt including the Warburton Contract.

It was emphasised that regular meetings with the PCT leads works best (but take the Minutes yourself), get agreements in writing, and try to engage performers in these meetings. As we know in Dorset, a lot depends on who is in post at your PCTs, the financial situation, the financial situation and the financial situation. You should pick your battles carefully, maintain the relationship, listen to the PCT's priorities and check the Agenda beforehand to agree your united strategy which everyone must stick to.

DECONTAMINATION GUIDANCE HTM01-05

Next up was someone better known to Dorset LDC, namely Martin Fulford, Practice Advisor for Somerset. By the time you read this, all practices should have received the guidance against HealthCare Associated Infections (HCAI). This is divided into 2 sets of requirements for dental practices.

1. Essential quality standards that must be in place within 1 year
2. Best practice

Essential standards are

- Named Infection Control Lead for the practice
- All appropriate policies and protocols available
- A documented training programme
- All instruments must be free of visible contamination
- Validated method of decontamination (Manual or Ultrasonic)
- Instruments to be sterile at the end of the cycle
- Safe storage with a stock control system (used within 21 days unwrapped or 60 days wrapped)
- A properly costed and timetabled plan to move to best practice standards
- Compliance within 12 months

Best practice standards are all of the above plus

- Cleaning with a validated washer-disinfector
- Separate room (preferably 2 rooms) for decontamination

There is an audit tool that accompanies the guidance which details all aspects of implementation, from blood borne viruses to waste disposal, nearly 200 points are listed. There will be a National Decontamination Survey conducted via PCTs, similar to the Scottish survey.

If you haven't got the space in your practice for separate clean and dirty rooms, the minimum acceptable will be a hand washing sink and 2 decontamination sinks, which can be a double bowl sink.

The next topic was NHS Complaints Procedures in England, which we have dealt with elsewhere on the website and have been in force since last April. It is important to remember that the patient can now complain to the practice or direct to the PCT within 1 year of the complaint. If the complaint is not settled at a local level, then it has to go

to an independent investigation by the Health Service Ombudsman. As ever with patient complaints always contact your Defence Organisation, unless it is a verbal complaint that can be settled in 24 hours over the phone.

Dick Birkin is the Head of Regional Services for the BDA, and currently these are available in the North West, and East & West Midlands but not yet the Dorset area. The idea is to support LDCs and Practitioners at a more local level.

All Health Budgets will be squeezed in the current economic climate, regardless of any possible change in Government. A public sector pay freeze is a strong probability over the next 2-3 years, and reductions in funding (possibly dressed up as 'efficiency' savings) will have a marked effect on dental commissioning at PCT level. Also highlighted was the difference in average incomes with practice owners earning around 90% more than associate/performers, due partly to the 2006 Contract and partly to the influx of foreign dentists.

The meeting ended with short presentations by the British Dental Guild, and the fine work done by the Dental Health Support Trust (formerly Sick Dentist Scheme) and the Benevolent Fund.

One thing I have learnt in over 30 years of being involved in NHS 'dental politics', is that it doesn't get any better, in fact it just gets worse, and however ridiculous something seems, there's always something even more ridiculous round the corner!

Brian P. Levy
Secretary of Dorset LDC