LDC Officials Day – Friday 2nd December 2016

Dear All,

Please see the notes below from the LDC Officials Day on Friday 2nd December 2017. These are notes not minutes and if there are any errors they are mine alone. Please also note comments in brackets are mine no one else.

Best wishes,

Chris.

Eddie Crouch – Vice Chair of the BDA Principle Executive Committee (PEC)

Problems in the NHS – Eddie states the BDA has taken senior council advice regarding how Patient Charge Revenue (PCR) is interpreted when claims are disallowed.

Eddie asks members to step forward / get in touch with examples so the BDA can take these forward.

Henrik Overgaard-Nielsen – Chair of the General Dental Practice Committee (GDPC) - Response to LDC Conference motions & update from the GDPC

BDA to resist any move by NHSE towards time limited contracts – waste of taxpayer's money & NHSE does not have the resources / capacity to handle so many tenders - All capital expenditure would need to be in 5 years so as you recoup a GDP or investor's money which then would be reflected in the rate of borrowing (high).

Breaches notices – time limited to 3 years was what was agreed with David Geddes and Carol Reece but after they have spoken to the lawyers – regulations need changing!

Henrik hopes NHSE will drop the 2 month rule & will not reject claims when people cannot be attached to a contract due to Capita.

LDCs – recognised as a formal key independent stakeholder – guaranteed a practice for each LDC on an LDN.

Henrik states the prototypes are aimed at two things- Hit a target number of patients and hit a target number of UDAs. A substantial number of prototype practices about too fail and so it is not possible to have a national roll out. 10% claw back for some prototype – 10% is bankruptcy for a lot of dental practices.

Department of Health says not the final version?

Something must change before a final roll out.

Henrik was asked what percentages of prototypes are failing at this time? Henrik says they are expecting data soon – The person who asked the question stated 8 out of 81 practices on target.

Az Hyder challenged that there is no data on the prototypes (Az has two prototypes). The failings of the prototypes where presented at the one to one meetings between the prototype sites and the Dental Contract reform Team from the Department of Health (DoH).

Az again states there is data available to demonstrate that prototype practices are underperforming and getting worse. There is known data Department of Health data on the prototypes shared in one to one meetings with the prototypes (the document is 13 pages).

Henrik stated the GDPC is waiting for data to analyse prototypes. Henrik stated there is Department of Health data at this time but the BDA need to see this data (this is meant to be in January 2017).

Jill Matthews – Managing Director – Intensive Expert Management Team - Primary Care Support England (PCSE)

Capita performance has been extremely poor causing chaos for dentists, dental practices and NHSE. Jill Matthews stated the PCSE is nowhere near where it needs to be working with Capita (!!!)

Standardising of performer lists

Grace period for FD's extended to 31/1/17

There will be an online application process which will be intuitive (Walk first then run springs to mind!)

Customer Support Centre – less than friendly – enhanced tracking of calls and issues introduced – calls tracked but emails not yet but will be.

Additional staff hired

Providing updated bulletins

Supplies – orders tracked online – delivered weekly or fortnightly

Priority – fix everything - performers list & change performer's status

Alison Lockyer (for Oxfordshire LDC) demanded an apology from PCSE for Capita's failings including the awarding of such a cheap bid with its possible known outcomes as a result.

Question around how come it takes so long to merely include a dentists on the NHSE Performer's list? (!!!)

Kevin Holton – Head of Patients Experience, NHS England - Managing complaints in a dentistry setting

Kevin Holton detailed the regulations under pinning complaint handling.

Annual return – KO416 annual return

85% of all complaints go directly to the provider

Dental complaints are about 10% of all complaints made to NHSE about Primary Care Services.

Regional complaints teams set up within one framework. Peer review process.

Usual reasons for complaints – Price list not displayed, unhelpful staff, lack of empathy, lack of clarity on the cost, lack of emergency appointments, response time to complaint / slow in responding, how the complaint itself is handled, not learning from the complaint.

A practice requires a clear complaints process for patients, commissioners and regulators.

Be responsive to complaints - publish the complaints process in the practice – e.g. practice brochure, website. Respect the patient's right to be able to complain. Respond promptly, learn from the experience and feedback.

Kevin Holton expanded on the NHSE processes on complaints; it does seem to complicate the process – links to the Care Quality Commission (CQC).

Working to deliver free workshops – so far 700 dentists attended to improve compliant handling.

John Milne highlighted with his GDPC hat on about the joint statement from the care Quality Commission (CQC), NHSE and the Department of Health about advice to patients for finding local resolution for complaints.

NHS Choices – Anonymous complaints on NHS Choice (not really appropriate – complain where appropriate absolutely but not anonymously – leads to false statements, complain with accountability by all parties)

Matthew Hill- Director of strategy at the General Dental Council (GDC) – Rebalancing regulation

Rebalancing regulation and regulatory reform - ideas being put out for public debate in early 2017. Need consent of the profession. Opportunity to learn before instead of after.

GDC has not worked well with other regulators

A good regulator focus on prevention, little on enforcement – unfortunately the GDC is the reverse – 75% of funding goes on Fitness to Practice (FTP) – the balance is the opposite of where the GDC needs to be.

He senses dentists moral is very low. Had enough of managing the fallout from external agency incompetence.

Average cost of Fitness to Practice (FTP) is £60,000 to £80,000 per case compared to the Dental Complaints Service (DCS) cost at £210.

FTP of limited benefit or protection to patients and costs a lot.

FTP should be for only the genuine serious cases. From the FTP an education element needs to be developed to develop standards, communicate with the profession and provide CPD.

More support, less stick, embeds standards. Have the profession own the standards.

CPD – Change it – currently simply a set number of hours within a fixed time period, quantity not necessarily quality. Peer review, appraisal and career development plans needed moving forward.

Complaint handling – better in practice, less at the GDC. Encourage practices in feedback so they can learn from it.

Expand mediation services through DCS

Work well with NHSE, CQC and Healthwatch

Focus on public confidence and public safety

Matthew Hill does not accept that the GDC's hands are tied as much as they use to be. There is commitment to local resolution.

Matthew Hill was asked about reducing multiple jeopardy in dental practice regulation; he responded they are trying to reduce this, moving slowly.

Summary – Harm – 1st tier resolution – working with partners – Refocus FTP

Currently have 9 regulators – PSA thinks there should be only 1 regulator – Ministers 3/ 4 regulators.

Sara Hurley (Chief Dental Officer – CDO), Eric Rooney & Janet Clarke (Joint Deputy Chief Dental Officers) – Updates from the office of the Chief Dental Officer –

Sara Hurley explained the background to NHS 111 & Good Morning Britain. Asks practices to keep their NHS Choices profiles up to date regarding access i.e. whether they are or are not taking patients. Focus on practices making sure this was done in time for Christmas.

More collaborative working required – BDA, DoH, NHSE, GDC etc. Move to working with not against.

CDO independent of NHSE – their critical friend

LDNs – empowered in all clinical decision making

Need to learn from the prototypes – practices should not be sacrificed to prove a point.

CDO committed to a 7 year national programme – Smile 4 Life, starting with children. Prevention is key to modern healthcare, major shift required.

Moved onto the Five Year Forward and the Sustainability and Transformation Plans (STPs) – aim is to transform how healthcare is planned and delivered. Joined up / holistic care e.g. digital dental services e.g. e-referrals, e-prescribing, e-portfolios – also link into obesity, diabetes, child health – linking into Smile 4 Life.

Slide on NHSE commissioning – slide itself blurred and hard to understand - over complicated.

Hygienists and therapists – use in care homes with DCPs.

Prescription of antibiotics

Unscheduled care

Need for more sedation.

Eric Rooney – Talks about commissioning service in the North West of England.

National drivers – how to position dentistry & oral health – Development of LDNs and MCNs.

Five Year Forward (published 2014) - driving NHS forward – integrate services – health & social care – NHS – prevention – aging population – resources drain.

Contract reform – Commissioning Guides – linked into breaking down barriers – join up secondary and primary care – MCNs – clinical pathway – care transferred to the individual – one size does not fit all.

Second year planning round financially 2017 – 2019. Sustainability & transformation plans – place based round population needs – 44 STPs.

Touched on devolution – Manchester – elected mayors.

CCGs commission locally – LDNs (set up 2013) – MCNs – great consistency, greater clinical engagement – LDNs actions linked to the Five Year Forward – set up MCNs – pathway approach & linked to Commissioning Guides – local quality assurance – provide clinical / professional leadership with LDCs.

LDN - National Assemblies

LDNs need funding – direct & indirect costs by NHSE, partners e.g. PHE and HEE.

Janet Clarke – Dental Regulation – Quality

CQC- NHSE – HEE – GDC – DoH – BSA – Healthwatch - Share data – risk of duplication – Need roles and responsibilities

Hamid Butt (Head of Dental & Eye care Finance and Financial Policy Lead for Dental Contract Reform Programme, Department of Health) – Paul Worskett (Prototype Provider, Amlecote Dental Care) – Contract Reform –

The population's oral health needs are changing – UDA treadmill (So why UDAs in the prototype...treatment still required yes but also more treadmill?) –

Remuneration system to support

Focus on prevention (that is why the focus is on access and cutting NHS Dental funding via NHS clawback / dentists fees via focusing on by patient's targets where the actual patient figures cannot converge with the targets? Prototype sites been asked to cut the oral health needs assessment to 10 / 15 minutes – sounds like a UDA treadmill)

Pilots started 2011 – Prototypes March 2016.

Prototypes to test patient pathways

DQOF - not up and running yet

2 blends – A &B (B looks very similar to a type 3 pilot) – both have a majority of capitation

A – All band 1 activity in capitation (60%) – bands 2 & 3 activity

B – All bands 1 & 2 in capitation (85%) - band 3 activity

Band 1 emergency – covered under activity for both blends A & B.

According to Hamid the data not robust enough to pay against

Hamid Butt said from 2018 to 2019 it may be possible to begin a national roll out – very unlikely the auditorium burst into laughter on this suggestion.

No big bang roll out.

Now 79 Prototypes –

40 blend A – of these 11 new prototypes from UDAs - 39 blend B – of these 10 new prototypes from UDAs.

CDS have 3 prototypes

21 sites are new sites from UDAs

Eric Rooney leading the evaluation & learning group – BDA & CQC (John Milne) part of this group.

According to Hamid the key items are –

Quality & appropriate care

Improve oral health

Access & Accessibility

Value for money (VFM)

Sustainability on roll out

(The clinical philosophy is excellent – shame about the business/ fiscal model - it does not stack up – How many years has this been highlighted? If something looks like a cow, moos like a cow and walks like a cow, generally, it is a cow)

Paul Worskett – 5 surgery practice – pilot sit since July 2011.

GDP 28 years

April 2012 – joined the National Steering Group

Has a blend B Prototype

4 DCPs as oral health educators crucial – top slice their salaries from the contract value

GDP coordinates the treatment care and complex care

Therapist now nearly full time – Perio, and simple restorations

DCPs with extended duties working hours have risen - Carry out delivering better oral health (DBOH), Fluoride Varnish (F/V), Diet Analysis and Plaque scores

Need to use a DoH monitoring tool – basically a spreadsheet – to predict where you are

Keep taking new patients is KEY.

Associates paid on patient list size and hours worked – so aligning with practice targets (capitation and activity)

Patient list size gone up 12% -

Capitation 88% - Band 1 &2

Activity 12% - Band 3 (a band 3 in this case carrying 9 UDAs not 12 UDAs)

DCPs now top sliced from Associates

Associates paid on 12% activity/ delivery – 88% patient list size

1 associate has left – replaced with a therapist & DCP.

15% increase in clinical time, all from DCPs. List size now dropped to 104% of target but activity 66% of target. Must take on new patients to deliver this.

Care pathways work well. On average each patient needs 30 minutes per year (9,000 patients - 4,500 hours. High needs patients need significantly more time.

Prototype contract is like a rugby team turning up at a football pitch, being told to play football with a rugby (UDA) ball.

Henrik highlights prototype practices that had never under performed in the past under UDAs or pilots must not face 10% cut due to the prototype / system errors.

What works well – Care pathways – patients like them – staff like them - focus on good service - DCPs feel valued – preventative dentistry – patients responding positively to improving their oral health

What does not work well – Appointment congestion – software problems – getting use to Oral health Education & therapists for patients – GDPs not use to team work (partly addressed through link to pay) – DoH dental contract reform team slow to give answers.

Funding and remuneration – Still using UDAs & bands – rules and goals changed but still UDAs.

Suggestions – more 1st year in capitation – tapering off later on over a period of years. Capitation based on RAG score as high needs patients take much more time (and this is focused to an extend on high needs patients – the 30% of the population – also Patient list sizes too high).

High needs patients a registration fee

Treatment on an item of service basis based on treatment time – Patient pays the laboratory bill

Patient charges – should be proportionate to the care the patients receive – if a patient costs more in their care- they pay more (or if part of the 30% the NHS pays for this or subsidises this?)

RAG – Green cheaper – red more expensive – focus patient's minds

RCT – charge for this

By patients having a stake in their oral health / care they will appreciate it more and be more responsible

Can it work? And we fix it ? Bob the builder! Prototypes are not the finished article - Need to align objectives with incentives – be flexible not one size fits all – funding & remuneration is critical must be correct – work for everyone NHSE, DoH, patients, GDPs, practices...

Questions -

Question from Ian Gordon to Paul Worskett regarding funding – Paul says his associates like it but the funding is not there. Not fit for roll out.

Eddie Crouch – asks about evaluation – what has been learned?

Henrik – Needs to work for all, does not but wants to try to make it work.

Comment from in the auditorium - that if practices are reluctant to leave UDAs due to what is on offer that is bad.

10,400 patients just too high – list sizes are wrong - 10% claw back – GDPS saying they can deliver UDAs!

Transition process – 1 year? 2 years? 3 years?

CDO says to Hamid Butt that he needs to revise the mathematics

A need for pragmatism on the transition.

Onkar Dhanoya – entered the process in 2011 – type 3 pilot – now a blend A Prototype. Clogged up appointment books with high needs patients – list up – waiting times 4 months – UDAs down – Patients seen down. Onkar asked the dental contract reform team at pilot practices to prototypes more? The former pilot sites which are now prototype have been told if they are below 90% they will be removed from the programme.

Hamid – difference between pilots and former UDA practices (!) Tested in real environment – was 2% now 10% at risk (10% at risk will send a lot of practices under if not delivered).

Practices that hit UDA target pre 2011 now not enough time – more returning to UDA contracts.

Henrik said 10% puts practices at risk. Practices that delivered UDAs now cannot deliver on the prototypes facing claw back. This is due to the system they are working in.

Eric touched on LDNs and MCNs – no central funding – to support super structure – Pressure on LDCs to pay – Goodwill pushed. Some Area teams put in business cases to fund LDNs from claw back.

CDO stated in the last two years 51% of adults have seen a dentist, 69% of children in the last 12 months, 15% of patient irregular attenders, 15% private

Focus on areas of high social deprivation – where oral health is poorest e.g. Dewsbury, Huddersfield, Dewsbury (Hull, Wakefield....)

Local action – access – quantity – nationally quality – UDAs do not deliver health or prevention

Richard Emms commented on the variability of the prototypes – claw back and the investment practices have had to make to make the prototypes work – out of the bottom line / profit which affects the viability of a dental practice

Paul Worskett said Expenses do rise

Az Hyder - has two prototypes – Blend A - his associates want to leave the prototypes. Huge waiting list, associates 20% behind – more high needs patients – care pathway taking for ever – not enough time to treat patients. Remuneration not right.

CDO said – Bigger CDO team in 2017. Not got the door open but a foot in the door. Comment that some believe her vision is ambitious. CDO stated she does not own commissioning – there to advise/ influence do not have the hands on the levers.

Claw back is not going back into dentistry.

Sara says dental leads waiting for direction -finance director's blocking – need to prove return on investment e.g. Prevention in Children e.g. PHE October Return on Investment document and one page graphic. Gt GAs down