LDC conference 9-10 June 2016

Day 1, 1.30-5.30

The health minister, Alistair Burt had pulled out of coming to speak to conference at the last minute, the importance he attaches to dentistry might be inferred from that.

Update from Henrik Overgaard-Nielson chair GDPC
Henrik gave a verbal reply to GDPC responses/action to 2015 conference motions.
The responses can be accessed in the LDC conference papers. (attached)
Update on contract reform
There are now 82 prototypes in either blend A or B.
Blend A capitation payments cover band 1, activity bands 2and 3.
Blend B capitation payments cover band 1and 2, activity band 3.
Payment for capitation and activity will be 90% of contract value.
DQOF payment remaining 10% (at risk if not achieved)
10% of capitation/activity payment at risk if not achieved.
Over delivery of capitation will be allowed to compensate for under delivery of activity, but not vice versa.
GDPC have fought hard to get a 20% reduction in target for band 2, and 30% for band 3, as prevention takes time to deliver.
Why capitation?
Prevention
Fewer tick boxes and targets
Improve access
Professionalism
As caries rates decline there will be less activity, we will all be chasing decreasing work load if paid on activity.
DoH will not accept 100% capitation.
Patient weighting must be right- high needs patients should be financially viable to treat.
Proper monitoring- DROs again
What do we want?
Activity measure not in UDAs, ?item of service?
Minimum Practice Income Guarantee- there will be considerable difficulties for practices with high UDA values as activity payments are levelled out. This could destabilise practices into bankruptcy. MPIG was given to GP practices during contract reform, but DoH do not like it.
Remove the cap on the dental budget
Remove the restrictions on new practices opening to generate further competition in the market and open up possibilities for younger dentists. Of course this would reduce practice values but these are becoming out of reach to individuals, leading to more corporate purchases.
Recognition that prevention is an activity, takes time, costs money.

The first 15 motions can be accessed in the conference papers and were debated over 2 sessions.
7,12 and 13 were not passed, the others were.

Update on PCSE (Capita)- Tony Grime

Aims:
Consistent national services replacing diversity of local arrangements
Efficiency
Improved customer service
Online portal for ordering (charges are for information only)
Weekly delivery service
Customer support centre
From May 2017 they will handle the Performer List applications, ID checks that have to be face to face will be done by local officers.
There were many critical comments and questions from the floor, clearly the system is not delivering on its objectives at the present.

Day 2 9.15-12.30

Presentation from Sara Hurley, CDO

She is now 10 months into her role and has completed a grand tour of the regions consulting with as many stakeholders as possible. (She was here in April).
There is great variability in both problems and solutions and in the way that commissioners work.
She believes that LDCs should be involved with the development of commissioning strategy to increase the amount of clinical input. (On a day to day basis we may fail to see how we are affected by commissioning strategy but this will actually dictate what services are available and how local money is spent).
LDCs are good at pastoral support of members and enabling the cascade of information which she has been shocked to find is difficult and poor. This can lead to knowledge gaps.
We are the ones working with and in our own communities and have far more useful input than we may realise.

She commented on the lack of capacity to answer her questions within DoH, despite regular meetings with David Geddes, the BDA and herself.
She believes that the cooperation between NHSE, CQC and GDC will help rebalance regulation and reduce red tape. New leadership at CQC and GDC is leading to a more pragmatic approach.

Her aim is to push hard to include oral health within the 5 year forward view for the NHS. Oral health is an integral part of general health, particularly in an aging population, and we must not accept dentistry being seen as a competition for funding when it is a fundamental part of health.

The LDNs are vital with clinical input into local based commissioning and LDCs must be involved with these. Funding for LDNs and MCNs is essential and extremely variable.

The full roll out of contract reform is moving back- 2018 looks unlikely, so does 2019 with an election in 2020.
Again she advocated collection of the PCR in a different way, not at the practice. With a capitation based contract this will be more important.
She agrees the need for some form of MPIG as payments for activity are levelled out.

Activity metrics may not use the UDA.
Discussion over how long contracts will be, unlikely to continue to be for life.
However to enable investment the time frame has to be as long as possible, before roll on or retender.
Should the new contract cover only a core service? This would reduce the budget and cast dentists as wanting to go private.
How is preventive activity commissioned? Look at good pilot projects eg Smile 4 life in Cumbria.
We need improved information management and e referral.
Reps on MCNs and LDNs should record hours worked to show funding requirement- possibly from clawback money.

Matthew Hill,
Director of Strategy, GDC

A fairly new appointee, and a brave man to come from the GDC to speak to conference.
He accepted the behaviour and standards at the GDC had been poor and apologised.
In 2013 complaints had risen 110% since 2010 and the GDC were unprepared and unable to cope. There was a slippage in standards in FtP and delays were unacceptably long. In part this led to the hike in ARF.
Improvement began in 2014 with an overhaul of systems and processes in FtP, the backlogs were eliminated. A new management team have been brought in.
Improvement continues with lessons being learnt from the criticism from the PSA.
Improvement to the work of the Investigating Committee, and an improvement in the whistleblowing processes. The role of case officers is being implemented since legislation change enabled this.
The road map for the future:
Protection of the patient and the public remains at the core.
Regulation however should be about promoting good behaviour not just punishing bad.
Further improvement in FtP performance.
Appointment of case officers should reduce cases going forward and further reduce waiting times- 2 years is too long for a case to come to a hearing.
Improvement in communication- change to tone of letters, online customer feedback for informants, witnesses and registrants.
GDC Standards- further development with the profession
Registrants on the Practice Committees- 1 dentist, 1 DCP, 1 lay.
Antiquated legislation with an emphasis on sanctions rather than learning creates barriers to using feedback
Working towards local resolution wherever possible- in the practice or at NHSE area team level. (PAG/ PLDP)
Consultation in the autumn re model of dental regulation- DoH may want to reduce the number of regulators to 3 within health professions.
In response to questions from the floor, he agreed the advert in the Daily Telegraph 'was crass'
Mediation is essential –look at no fault resolution.
They are looking at how other regulators eg GMC work to improve their practice.
He heard the request to deal with the patient complaint rather than trawl through the records for further possible charges.

During 2 sessions motions 16-27 were debated
16, 17 and 20 were not passed with 87%, 80% and 56.5% votes against.

Birmingham LDC, Vijay Sudra

16. This Conference calls on the relevant commissioners and national governments to target the limited budget available for NHS dentistry to those who receive free care.

Birmingham LDC, Eddie Crouch

17. This Conference calls for the alteration of all contracts within England and Wales to set aside 20% of the revenue and UDAs to pay for a pilot targeting prevention to patients under 5 years of age to reverse the scandal of GA extractions for children.

These were included to stimulate debate rather than the customary nod through. It was generally felt that offering a core service or a service to a core group would further remove dentistry from the NHS health and oral health agenda. Dentists would have reduced NHS funding and would be seen as wanting to privatise the service.

There was some agreement for 17, but it was felt to be unworkable in the format presented.

Birmingham LDC, Steve Clements

20. This Conference calls on those colleagues involved in MCNs and LDNs to withdraw support, until the funds available for functioning and delivery of care proposed by these networks is substantially increased to make their work viable.

Another Birmingham motion to encourage debate, it was felt that withdrawal from MCNs and LDNs would just remove professional input from commissioning and be seen as a failure to engage.

The other motions were all carried.

We had the usual presentations from Dental Guild, Ben fund and Dentists Health support trust.

It was confirmed that legally LDCs can support these from their statutory levies as they are for the support of local dentists, albeit by partner bodies.

Alistair McKendrick will be chair of next year's conference in Birmingham, June 8-9 2017