LDC Officials' Day

December 2nd 2016 @ Cavendish Conference Centre, London

Eddie Crouch, Vice-Chair of PEC, in his welcoming address, said that BDA was keen to hear from members who had had issues with overperformance, rejected claims due to the two month rule and attaching new performers to the list.

There was a strong case to be made against NHSE regarding patient charges, but individuals needed to come forward to be 'test cases'.

Henrik Overgaard-Nielsen, Chair of GDPC, addressed some of the motions passed at this year's LDC Conference.

There were problems with the prototypes in hitting targets for both patient numbers and UDAs. GDPC could not sanction full roll-out if this situation were to continue.

There were also problems with clawback which could be as high as 10%. The Government was saying that the prototypes would not be the final model of a reformed contract.

Time limited contracts were ultimately a waste of taxpayers' money as ATs were logistically unable to administrate the increased numbers of tenders that would ensue.

Breaches should expire after three years as it was unreasonable for them to be kept in place. NHSE had suggested setting up a work group that could come up with a binding policy on this issue.

GDPC was attempting to shame politicians into remedying the situation where patients' charges were exceeding UDA values.

LDCs should be guaranteed places on LDNs.

Jill Matthews from Primary Care Support England gave a presentation which included a grovelling apology for the sheer ineptitude of Capita.

Regarding Performers' lists, PCSE was standardising processes and implementing better training tools and were setting up panels to fast-track applications. The grace period was being extended to the end of January 2017 for the September 2016 intake of FDs.

A better tracking system was now in place for the Customer Support Centre and supplies management had now improved.

Kevin Holton from NHSE gave a presentation on Managing Complaints.

85% of complaints are made directly to the Provider but around 1,000 complaints per year are made to NHSE. Most complaints are about the NHS price list not being displayed, the attitude of Providers or a lack of openness regarding costs.

NHSE is commissioning a toolkit on complaint handling. The CQC inspection checks that there is an accessible complaints system in place.

Matthew Hill from GDC spoke on Rebalancing Regulation.

Most of GDCs funding is spent on fitness to practise and not on ‘prevention’, the current buzzword for which is ‘upstream’ and includes education, registration and standards through CPD.

The balance of regulation needs to be shifted upstream.

GDC should improve, or insist on, ‘first tier’ resolution with expanded access to mediation and re-focus FtP on genuinely serious matters.

In the afternoon session there were presentations from the office of the CDO.

Sara Hurley, CDO, said that a ‘lot had happened over the last year’ and her aim still was to increase access and to improve dental health.

Further points made were, the need for leadership within the profession for reformed contract roll-out and transformation of digital services to include ereferral, eprescribing and NHSnet accounts for all. There needed to be oral integration across the health care system and an improved performance for patients.

Eric Rooney, Deputy CDO, had been working closely on contract reform especially on clinical pathways and on speciality commissioning guides and locally integrated services. LDNs were to deliver evidence based clinically led commissioning.

Janet Clarke, Deputy CDO, spoke of the future of Dental Service Regulation with CQC, NHSE and GDC working together.

A preventive ‘upstream’ approach was necessary to improve quality with an emphasis on self-regulation through peer review and clinical audit.

LDCs should be involved in peer support and formal supervision but limitation of practice should be handed over to the regulators.

Hamid Butt from DoH spoke about contract reform.

The prevention pathways of the pilots had been welcomed by both dentists and patients but had been too radical a shift. Prototype pathways were similar but the DQOF data was not robust enough yet for things to go forward.

It might be possible for a reformed contract to be rolled out in 2018/19 but this was very optimistic. When it comes, roll-out will be phased and gradual.

Of the 82 prototypes, 58 were former pilots, 21 were new sites and the remaining 3 were Community sites.

Paul Worskett, a GDP in Stourbridge, gave a presentation of his experiences of running prototype practice.

There had been a 15% increase in clinical time spent chairside and an increase of 12% in list size under the pilot. Now, his prototype consisted of 88% capitation and the rest was activity based.

His experience was generally positive, but this was not echoed by other prototype dentists in the audience.

David Cooper (LDC Secretary)