HAMPSHIRE AND ISLE OF WIGHT LOCAL DENTAL COMMITTEE

Report to Portsmouth City Council (HOSP): February 2016

The Annual LDC Officials' Day was held on Friday the 4th December in London and Sara Hurley the new Chief Dental Officer for England delivered the Keynote Speech to the 170 nominated LDC representatives. Sara's speech was refreshingly empathetic and reassuring and she demonstrated that she was aware of the current problematic commissioning and contracting issues with NHS England. Sara was very keen to look at new preventative oral health initiatives and she discussed the emerging Vanguard sites with special focus on diet control support. The CDO discussed the option of dental team diversification with the dentist as the leader of the team. The new CDO felt that future revalidation in dentistry should be owned and designed by dentists. Sara mentioned aspirational access targets of 75% for adults and 85% for children, which is quite a hike from the current state of 53% and 69.6% respectively. Sara was concerned that in the future there may be a shortage of dentists as currently only around 23,000 are making claims for treatment within a £900 million budget (88.9 million UDAs) which equates to around £75 per head. The CDO felt that there were enduring but no emerging themes. There were so many questions but not enough time to air some important issues but hopefully these will be addressed as the CDO visits all the regions of NHS England in the coming months.

John Milne the Senior National Dental Advisor CQC gave his update which included reassurances that the new and emerging inspection process will always be relevant and carried out by a Dental Specialist Advisor in attendance with the CQC Inspector. The future development of identifying notable practices showing good compliance with standards was advised. CQC will not rate dental practices for the foreseeable future.

Other Current LDC Activity during November and December saw the final Joint LDC, NHSE, PHE meeting and the first replacement meeting was held on the 22nd January 2016 which was a two part meeting with a new (2nd part) Dental Oral Health Meeting component. The first much shorter part of this meeting will continue to be dedicated to joint performance and contractual concerns and queries raised by the two LDCs in NHSE (Wessex) and the second part will involve a much more diverse, area based stakeholder group that includes local authority and CCG input which will commence consideration of wider agenda items e.g. children's oral health.

A Dental Commissioning Group has also been set up and the second meeting took place on the 28th January. This important group on which the two LDCs sit, feeds directly into the Board of NHSE (Wessex) and it is a recommendation rather than a decision making group. This group not only

looks at commissioning dental services but also at layers of contract performance data to quality assure commissioned services.

The Future for LDCs is a recent paper developed by the Hampshire and Isle of Wight LDC Secretary and is meant to be an aide memoir/reference document for dentists within our constituent area to rationalize LDCs' and this committee's activities but with an eye to future developments within our NHS provider/performer representative remit:

LDCs in England and Wales have been in existence since the birth of the NHS in July1948 and have survived many organizational upheavals but since the National Service Act 2006 the changes have been more significant, culminating in the major changes in 2013 emanating from the Health and Social Care Act 2012 whereupon 152 PCTs were replaced by 211 CCGs.

Many LDCs have struggled to maintain their coterminosity with firstly the 27 Area Teams before 2015 and now with the sub-regional offices of NHS England. This area specific problem and associated representative costs might be solved by association, federation or indeed by merging LDCs to provide an efficient and more dynamic representative input. At the very least LDCs should consider meeting with neighbouring LDCs to share representative common ground.

LDCs are one of four local representative committees that may or may not be recognized or actively consulted by sub-regional offices of NHSE with a number of existing and future roles that potentially benefit NHS England, patients and constituents.

Clearly, LDCs are currently 'at 'risk' of marginalization and therefore it is of paramount importance that we secure our role as an important and valid representative stakeholder within various facets of the organizational NHS/Local Authority 'new world'.

LDCs created in statute are funded through the statutory levy (SL) to perform a plethora of representative duties. The SL funding also covers the expenses incurred by committee members/officers and supports the funding requirements of the associated administrative burden that is a consequence of this significant role. The H&IOW LDC also collects voluntary levy contributions that are aligned with other funding activities such as the British Dental Guild and the BDA Benevolent Fund.

FUTURE and CONSOLIDATED ROLES IN WESSEX

- Core membership of the Local Dental Network (LDN) is essential. This is a chance to influence the commissioning strategy of the LDN which is the commissioning heart of the sub-regional office of NHSE (Wessex) and thereby promote GDP membership of the emanating Task and Finish Groups that will address specific tasks orchestrated by the LDN. LDC members are well aware that education and training support will be necessary for GDP providers and performers as the commissioners

address the emerging problems of commissioning services, for example tier 2 non-specialist providers. LDCs may through the BDA and LDC Conference motions help to influence the tier 2 training/accreditation programmes that are currently under discussion with Eric Rooney and the two faculties (FDS and FGDP). It is important that two Wessex LDCs provide valid and informed commissioning advice that protects providers, services and patients e.g. the future re-commissioning of time limited PDS Agreements in orthodontics.

- Membership of the emerging new (Final draft National Commissioning Guides directed Managed Clinical Networks (MCNs) that are likely to be more formalized with a constitution, terms of reference, financial structure/accountability. These new MCNs will be somewhat different to the older and current versions of these peer review type groups. MCNs and other groups going through gestation are consultant/specialist led but LDC members can bring a sense of realism and non-conflicted advice to the table as champions of primary care providers and for example provide updated 'real world' comparisons between the 2006 contract and the emerging contract reform prototypes. Should we consider that LDCs might be involved in the development of future *Strategic Clinical Networks* that CCGs employ? LDCs should be aware that NHSE works on national policies with some local flexibility.

- Representative funding of GDPs within the new structures is an issue for the two LDCs and no doubt both committees will need to further debate in depth how this use of the statutory levy can be justified. We and other GDPs need to be 'in it to win it' and to exert our directive influence. The restrictions and limitations of the existing contract and contract reform need to be aired and understood by commissioners and non-clinicians.

- Constituent support was a theme expressed by David Geddes at a recent joint NHSE/LRC meeting. What might this support look like? LDCs operate PASS, WISDOM and equivalent pastoral schemes for self-referring dentists in low levels of difficulty and the H&IOW LDC has trained Appraisers, Mentors and Coach/Mentors that in conjunction with Health Education England help more serious cases of dentists in difficulty and up to GDC fitness to practice levels. GDPs have never been at a greater career risk than they are now with not only a draconian and perverse regulator but also from the perils of CQC, NHSE data scrutiny/NHS Protect and the National Performers List regulations. Occupational Health and PCS support is diminishing for dental teams and it is possible that the Disclosure and Barring Service will be taken over by umbrella organisations – should the LDCs 'step up to the plate'?

- Education support – The H&IOW LDC already provides CPD events that are normally non-core and this is an area that could be developed further into a more protective and informative career/business/regulatory awareness training resource for our constituents.

- Performance panels –The two LDCs in Wessex already provide non-voting invited members to sit on NHSE Performance Panels ie Performance Advisory Groups (PAG) and NHSE should be encouraged to provide the same level of training that has been employed for the voting Discipline Specific Practitioners that are funded by NHSE. The H&IOW LDC will continue to develop peer appraisal skills that signpost and support the personal development of our constituents and identify early signs of difficulty.

- Regular Joint LDC/PHE/NHSE liaison Group meetings are a good discussion contact point between the various local NHS stakeholders and especially as NHSE (Wessex) staff no longer attend LDC meetings. As mentioned earlier in this report it is concerning to note that contact between the LDCs and the contracting team of NHSE (Wessex) is under threat. The LDCs sit on the core group of the Local Dental Network (LDN) but this only addresses commissioning decisions.

- Meetings with other LRC groups can be beneficial to share commonality of purpose e.g. Local Pharmaceutical, Local Optometry and Local Medical Committees. The five-year forward view, vanguard sites, multidiscipline provider sites and co-commissioning (CCG) should be of interest to all providers of primary care. The H&IOW LDC regularly meets with both the Hampshire based LOC and the LPC to share local intelligence.

- The two Wessex LDCs have voting members that sit on the local NHSE (Wessex) Contract Recommendation Panels that consider contract performance and the outcomes from the internal contract and BSA monitoring processes.

- Liaison with patient representative groups e.g. local Healthwatch is important to help both groups to understand service provision to patients and the operational difficulties under the 2006 dental contract.

- The LDC websites, newsletters, social media and group email contact are essential means of communication between the LDC and its constituents. Published useful and up to date information is invaluable.

LDCs still have a very important role to play but the LDCs in Wessex must be flexible, entrepreneurial, knowledgeable, reasonable and provide positive support within our representative envelope.

LDCs in Wessex must also bring an informed and extra dimension of engagement with the NHS health care systems that govern the lives of dentists and to the benefit of patients.

The CDO visited Wessex on the 9th,10th and 11th of February to engage with the whole of the area's dental workforce. The LDC Chairman and Secretary were given the opportunity to exchange intelligence and views in a short interview slot on the 10th February. The two LDCs in Wessex organised an evening event in St Mary's Stadium, Southampton on the evening of the 9th

February for 170 delegates. The evening event was opened up to NHS dental teams, NHSE representatives and dentists working in secondary care so that they could hear the new CDO‘s vision for the future and also it was an opportunity for the CDO to assess the morale of the Wessex primary dental care workforce.

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