Reflection from Northern Ireland

A new primary dental care contract in Northern Ireland has been implemented which follows the same direction as proposals outlined in the Steele Review. Simon Reid reports on the latest developments...

There's an old joke often recounted here about a lost traveller stopping to ask for directions from an old farmer somewhere in rural Ireland. The farmer carefully went where the traveller wanted to go, paused to think and then said, "Well, if you're heading there, you wouldn't want to be starting from here!"

Having been heavily involved in the development and negotiation of a new Primary Dental Care Contract (PDCC) in Northern Ireland since late 2006, our work and proposals in the Steele Review are heading in the same direction. Up until the 2006, the new dental contract was introduced in England and Wales, while Northern Ireland and Scotland had taken the existing GDS model and then made regional adjustments to bring it within their legislation. Most of the framework and regulations were carried across and there were obvious resource advantages for Northern Ireland and Scotland in 'piggy-backing' in this way. Other components were added to or modified in the GDS contract to suit both countries' individual needs. Both these parts of the UK have continued to use their regionally adjusted GDS systems.

Need for reform
From Northern Ireland's perspective, the work in England on the modernisation of dentistry with the Options for Change Agenda, led to the realisation that our current GDS system needed reform. The drive for change began with our Oral Health Strategy in 2004 and Primary Dental Care Strategy in 2006, which have led to the development of a bespoke contract to meet our specific public dental health needs. In November 2006, negotiations began between the Department of Health, Social Services & Public Health, Northern Ireland and the Dental Practitioners Association for developing the Original GDS, the PDS model and the draft N. Ireland Dental Care Contract to meet our specific public health needs, but it is also important to have the right approach to GDS. Our aim is to increase practitioner commitment by recognising that a mixed economy exists and by clearly defining the range of clinically and cost-effective treatments, as “Essential Services”. If the contract is not available under the new system. As such, the expectations and responsibilities within the system would be clearly communicated to patient and practitioner alike. We aim to allow access to “Occupational Services” for those requiring urgent care but to encourage long-term patient care and preventative measures by using a Patient Care Pathway and with associated registration.

Registration simplified
We propose an enhanced capital payment for registration via the Patient Care Payment to cover the patient journey through the Patient Care Pathway. As such, it is more representative of patient care needs than the original concept and funding of registration and continuing care payments under GDS arrangements. DHSSPSNI is currently developing a weighted capital payment formula to calculate a patient-specific payment dependent on patient need and truly reflecting expected workload.

We now note that the Steele review recommends registration and payment for the continuing care of patients.

Effective communication
We propose to have clear and open communication between patients, practitioners and commissioners. The aim is to ensure that all understand their own responsibilities while being aware of what to expect from the other parties in this relationship. The aim is to correct past market failures of what Professor Steele calls the ‘imbalance of knowledge’ and what Professor O’Neill describes as, ‘Asymmetric information’.

In our model there will be a key duty for the commissioners to produce a “simple and transparent” system that is, “easily accessible and understandable” for patients. Such a system could be achieved by primarily using web-based information. Equally we must communicate effectively with practitioners and facilitate them to adjust their practice to the new and different ‘philosophy’ of our new contract.

Key items of common ground between the Steele Recommendations and the draft N Ireland PDCC model

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• Staged pathway
• Registration for continuing care
• Urgent care
• Prevention care
• Evidence based guidelines
• Financial registration/quality/activity payments
• Proposed development of quality measures
• Defined data set
• Proposed range of restorative treatments
• Weighted capital formula

Review, while not defining a list of treatments, a stage by stage approach for routine care and “advanced/high skill treatments” through provisions that not all practitioners may provide these.

Improving access
We believe that local commissioning will be the key to improving access, but it is also important to hold data sets and minimum data sets for reporting, to reduce the administrative burden. There has been some criticism of the 2006 contract resulting in reduced data capabilities for the BSA and the Steele Review proposes the development of a common set of indicators. An effective data capability can inform weighted capital systems. We also concur that data reporting should be carried out electronically and we hope to develop an ‘IT-lite’ system for simplified reporting, which could also be linked into existing integrated practice management systems for those practices that are fully computerised.

From a Northern Ireland perspective we are pleased with the independently-led Steele review which appears to support many of our current proposals. We hope that our colleagues in the rest of the UK can now reflect on our work and are reassured by the tremendous similarities with the findings and recommendations of the Steele Review.

Currently we are undergoing great structural changes here following a review of public administration in health and social care, but are continuing to develop our new contract and are actively working towards piloting. Local commissioning groups have been set up and with the establishment of a single health and social care board (regional equivalent of PCT), there is a huge opportunity to develop effective local commissioning arrangements. We await with interest the results of the work that will follow on from the Steele Review and we in turn, will be able to reflect on those findings.

About the author

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