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 observed 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 can now reflect on the findings and recommendations of the Steele Review.

Currently we are undergoing significant 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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Feature

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imimately one third of dentists’ earnings was from non-item of service), but he recommended that we should develop the blend two GDS systems. We were already operating a blended approach.

Extensive work on the format and components of the Patient Care Pathways has led to the following proposed blended system of remuneration.

The system we have developed is not targeted as much as with the UDA system, and has been developed in an attempt to reduce the ‘treadmill effect’ and facilitate regular payments for improved practice cashflow. Importantly, quality of care will also be recognised and rewarded.

A core range of treatments

A key process has been to consider the component ‘essential treat- ments’ and what we call “Essential Services” that should be available under the new contract. These are the treatments that we consider are the most cost effective and are evidence-based using a hierarchy of evidence.

We have defined and listed this range, but also have a process to allow opportunity for equality of access to care in exceptional cases where clinical necessity is proven, the “Exceptional Treatments”. The Steele PDCC model

• Staged pathway
• Registration for continuing care
• Advanced care
• Prevention care
• Evidence-based guidelines
• Slot-based allocation
• Quality/active payments
• Proposed development of quality measures
• Defined data set
• Proposed range of restorative treatment
• Weighted capitation formula

Key terms of common ground between the Steele Review, our recommendations and the draft N Ireland PDCC model

Review, while not defining a list of treatments in stages, is a similar approach for routine care and “advanced/high-skill treatment” proposals that not all practitioners may provide these.

Improving access

We believe that local commissioning is the key to improving access, but it is also important to make the contract attractive to GDPs. Our aim is to increase practitioner commitment by recognising that a mixed economy exists and clearly defining the range of clinically and cost-effective treatments, as “Essential Services” that are available under the new system. As such, the expectations and responsibilities within the system would be clearly communicated to patient and practitioner alike. We would allow access to “Essential 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 capitation 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 banding of capitation and continuing care payments under GDS arrangements. DHSSPSNI is currently developing a weighted capitation 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 fully 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.

Data and administration

Our proposals are to have a simplified system of administration and reporting with practice-