BDA local commissioning research

Case study
Heart of Birmingham TPCT dental practice accreditation scheme (DPAS)

March 2010
Acknowledgements

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Introduction

The following case study draws on interviews with the Dental Practice Accreditation Scheme (DPAS) Project Director, the PCT Commissioning Manager for Dental Services, the Post-graduate Dental Education Tutor, the Consultant in Dental Public Health, a LDC representative, and three practice owners/providers from phase one DPAS pilot practices. The interviews were conducted between June and November 2009.

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Overview

The first pilot of the DPAS scheme in Heart of Birmingham was launched in June 2008 and involved six volunteer practices. The PCT was starting the second round of pilots in early 2010.

Baseline visits from the project team, and self-audits conducted by the practice itself were undertaken in each of the pilot practices. These covered each of the following themes: infection control; child protection; dental radiography; staff, patient, public, and environmental safety; medical emergencies; evidence based practice and research; prevention and public health; clinical records, patient privacy and confidentiality; staff involvement and development (all staff); clinical staff requirements and developments; patient information and involvement; fair and accessible care; clinical audit and peer review.

An action plan was developed for each practice, outlining what it would need to achieve over the next six-to-nine months in order to become accredited. In addition to items highlighted in the baseline visits and the self-audit, practices were expected to take part in a number of other initiatives such as attending a tailored education programme of seminars and events, completing a health promotion project of their choice, and achieving membership of the BDA Good Practice scheme.

The funding for the pilot was made up of two components, one fixed, and the other linked to contract value. The payments were made in monthly chunks during the accreditation process and will continue once the practice is accredited if the practice can demonstrate that it has maintained the required standard. Details about how the practice will be required to prove this maintenance of standards were not finalised at the time of writing. Payments would be suspended or recovered if it became clear that a practice was not going to meet the accreditation standards within a reasonable period of time.

At the time of writing, the PCT and LDC held very different opinions on whether DPAS has been successful.

Development and philosophy

The impetus for developing DPAS came from Ros Hamburger, the Consultant for Dental Public Health at the PCT. Ros and her colleagues had been looking at means of promoting a quality agenda for some time but obstacles such as the introduction of the new contract in 2006 had often got in the way and shifted the priorities within the PCT. Once the transition to the new contract in 2006 had settled, the PCT felt that the time was right to introduce DPAS.

The LDC was potentially supportive of DPAS initially. It saw DPAS as a welcome deviation from Units of Dental Activity (UDAs). It has now, however, formally retracted its support due to concerns it has that the scheme is not fulfilling its intention of rewarding quality. The LDC feel that the scheme should be incorporated into a pilot for the Steele review.

The scheme has a strategy board and a pilot board, both chaired by the project director, Neil Lockwood. The strategy board oversees the project while the pilot board provides an opportunity for the pilot practices to meet with the PCT and discuss any issues or logistics to do with the scheme.
The strategy board membership includes the external project director, consultant in dental public health, dental practice adviser, representatives from the LDC, the post-graduate dental education tutor, dental nurse practice adviser, and PCT representatives from the commissioning, clinical governance, and finance departments. The LDC felt that while it was given opportunities to comment on DPAS at various stages, it very much belonged to the PCT. It has expressed disappointment that its comments were often not taken on board.

*We felt that they were basically looking to make the system work, even if the system is flawed. They weren’t actually prepared to deal with the constructive criticism we were offering.* LDC

The Strategy Board decided on six pilots initially, looking to encompass different sized practices spread throughout the PCT. The PCT was surprised and pleased at the positive response to the pilot as over half of the practices invited to take part expressed an interest in doing so.

*I would say that a majority voted in favour of participation. From a standing start, only a couple of years from the imposition of the new contract, it’s a pretty positive response.* PCT Dental Lead

The Strategy Board was tasked with deciding the funding arrangements for DPAS, which proved to be an area of contention and eventual compromise. The Board decided to award a small fixed value sum to each practice and a larger part-payment linked to the contract value. The flat rate was to acknowledge that all practices shared the same burden at a certain level, and a graduated payment to acknowledge that aspects of the scheme have a greater impact on larger practices.

*How do you value what is being done? Do you give everybody the same block amount or do you respond to some of the larger practices saying ‘we have more staff to put through this, it is going to take us a bit more time to do some of the development work’. In true British fashion there was a compromise and it was part lump sum and part money geared to the size of the contract. This has meant that everyone is reasonably happy but no one is really happy. It was more everyone’s second choice.* PCT Dental Lead

The LDC feels that having the bulk of the payment for DPAS linked to Units of Dental Activity (UDAs) is flawed and would have preferred a funding arrangement that was linked to the actual quality of the outcomes rather than UDAs. It reported that both the smaller and larger practices feel they have been disadvantaged by the current funding arrangement.

The PCT describes DPAS as a formative rather than summative approach which is intended to be a learning and relationship building experience as much as anything else. In this sense, it feels that the new skills and quality focus learned during the accreditation process contribute to more than just achieving accreditation from the PCT. The PCT is quick to protest that this is not simply a box ticking exercise.
This is about the difference between formative and summative. This is all about forming and moulding, and working with. It is not all about ticking boxes and counting up compliance A to Z, one to infinity. It’s not a summing up of all the good things. It’s more systemic and sophisticated...Do you tick all the boxes and know the cost of everything and leave it at that or do you want to understand the value as well as the cost and also work with people not just this year, but over time, have an empathy and a sympathy and a better relationship and understanding? PCT Dental Lead

While the LDC was initially interested in the philosophy behind DPAS, it does feel that it is more of a box ticking exercise than it would have liked.

The LDC thought that perhaps instead of chasing people who actually try to do quality work but don’t hit the number of UDAs eventually facing clawback, this was actually an alternative method of actually analysing what dentists actually did for their patients. It hasn’t turned out like that but that was the reason that we were originally so interested in it at the start because we thought that was what it might do. LDC

The PCT maintains a strict attitude to contract management, which it tries to keep somewhat separate from the DPAS element of the relationship. The PCT feels this segregation of DPAS and contract management is vital to the success of such a scheme.

We have strictly adhered to regulations when it comes to contract management so for greater than four per cent under-performance we have arrangements for that. We don’t pay for unauthorised over-performance and if you under-perform beyond four per cent tolerance you do get it clawed back. We keep it absolutely straightforward in terms of managing activity, whilst at the same time having a very formative and supportive approach when it comes to quality and practice development. PCT Dental Lead

The LDC was quick to point out the apparent contradictions of this rigid approach. One example of such a contradiction was the PCT clawing back money from a practice closed for a short time in order to make renovations to become compliant with HTM 01 05 decontamination guidance and subsequently underperforming slightly on its contract. This practice was not given any flexibility to carry forward these UDAs to the following year and instead the money was clawed back by the PCT. The LDC described this as a Jekyll and Hyde approach to rewarding quality, and a factor in the LDC’s decision to retract its support from DPAS.

The cost involved in DPAS would be sufficient to open another practice in the area. While access is high on the dental agenda, the PCT strongly feels that raising the bar of the existing practices will result in better quality, better relationships with the existing providers, and better value for money in the long term. The LDC however cites reduced access figures for the Heart of Birmingham as proof that DPAS has not been successful.

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1 In response to the LDCs concerns, the PCT has since reviewed and relaxed their policy on under- and over-performance on UDA targets.
We would argue that just opening yet another practice doing just what we have always done before probably wouldn’t add much value. If we could get the funding to work properly by spreading the value of one more additional practice across all our existing contracts, we would hope to get better value for money and also be doing the right thing. PCT Dental Lead

DPAS had not been formally evaluated at the time of writing and this had proved to be another area of contention between the PCT and the LDC. The PCT has interviewed a sample of the pilot practices to look at their experience and is using these to form the basis of an informal evaluation of the first pilot. It intends to commission a full and rigorous external academic evaluation at some stage in the near future and, despite the LDC withdrawing its support of DPAS, the PCT plans to invite the LDC to be involved in the evaluation.

The LDC does not believe that the PCT is open to a full independent review of DPAS and worries that the PCT would hamper an evaluation by being too prescriptive about what aspects of DPAS are evaluated. The LDC feels that an evaluation should have been undertaken before the second round of pilots commenced and is concerned that the PCT is so determined to make DPAS a success it is not willing to take criticism on board.

We were pushing for an independent evaluation to see if it had been a success before they rolled it out to other practices. They were keen to roll it out to other practices even without totally evaluating the first six pilots and we thought that that made no sense. We couldn’t see what they would get out of piloting it on more practices that they hadn’t already got out of the first six. LDC

It was almost as though they wanted the thing to succeed so much that they were quite prepared to ignore some of the things that they found so that they could say the thing had been a complete success. When to some it had been a success but for others it had not been a success… From our point of view as an LDC, if they had been more amenable to a completely independent evaluation of what had happened so far and been open to the criticisms that we have made and slightly reduced the payment mechanism from UDAs to some other method of rewarding quality within the practice the LDC may have been more supportive. LDC

Indicators/requirements

DPAS activities are classified under seven domains: Oral Health promotion, patient engagement, governance, premises, clinical, personal and practice workforce development, and contract compliance.
<table>
<thead>
<tr>
<th>Oral health promotion</th>
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<tr>
<td>o Take part in Health Exchange scheme</td>
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<td>o Complete agreed Health Promotion project</td>
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<td>o Support under-fives call-up</td>
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<tr>
<td>Patient engagement</td>
</tr>
<tr>
<td>o Attend launch lecture from PPI Manager</td>
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<tr>
<td>o Evidence of patient forum meetings/other</td>
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<td>o Employment and comments</td>
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<tr>
<td>Governance</td>
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<tr>
<td>o BDA Good Practice Scheme</td>
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<td>o Practice visit – Friday PM</td>
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<tr>
<td></td>
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<tr>
<td>Premises</td>
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<tr>
<td>o Internal/external appearance acceptable</td>
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<tr>
<td>o DDA compliance/ arrangements</td>
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<tr>
<td>o HTM 01-05 compliance/ ICS audit</td>
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<td></td>
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<tr>
<td>Clinical</td>
</tr>
<tr>
<td>o Practice presentation</td>
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<tr>
<td>o Recall card audit</td>
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<tr>
<td>o Exception report status</td>
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<tr>
<td></td>
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<tr>
<td>Personal and practice workforce development</td>
</tr>
<tr>
<td>o Attendance at HoB Forum (tailored education session)</td>
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<tr>
<td>o Staff supported to train for CPD</td>
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<td>o Staff meeting notes available</td>
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<td></td>
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<tr>
<td>Contract compliance</td>
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<tr>
<td>o Suitable activity delivery (UDA)</td>
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<td>o Suitable activity delivery (other)</td>
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The baseline visits were attended by the postgraduate dental tutor, dental practice adviser nurse, an expert patient, the project director, and an LDC representative. During the baseline visit the dental nurse adviser observed in surgery, undertook a baseline infection control audit, and taught staff about the self-assessment audit. The expert patient took notes about the premises while the others talked to the practice owner. The discussions with the practice owner were semi-structured. The visit was conducted at the same time as the PCT’s existing contract management visits.

The self-audit contained a number of indicators and a description of both basic and accreditation level standards for each of these indicators. The indicators were grouped under the following headings (see Annex 1 for further details).

- infection control
- child protection
- dental radiography
- staff, patient, public, and environmental safety
- medical emergencies
- evidence-based practice and research
- prevention and public health
- clinical records, patient privacy and confidentiality
- staff involvement and development (all staff)
• clinical staff requirements and developments
• patient information and involvement
• fair and accessible care
• clinical audit and peer review

While the scheme is tailored around specific practices and includes projects such as the oral health promotion project chosen by the practice, there was not a huge amount of variation in what was required from one practice to another in the first round of pilots.

Each dentist spoken to liked a different aspect of DPAS. One was particularly keen on the Child Dental Appointment scheme in which the PCT contacted a child’s parents on the child’s fifth birthday to offer them an appointment that one of the participating practices had allocated to the scheme. This dentist felt the scheme was not only good for the five-year-old but also motivated the whole family to attend the dentist. They expressed disappointment that the scheme had not run for longer than it did.

*When that child came, they had brothers and sisters that got excited and they wanted to be seen and it just helped really to get them back in the environment.* Dentist

The health exchange programme was seen as a success by the PCT. The health exchange workers were able to give general and oral health information to patients. This was particularly helpful for some of the migrant patients who were often unsure why they were taking certain medications. The health exchange workers explained these medications to these patients.

Despite being one of the most onerous aspects, applying for the BDA Good Practice scheme was recognised as having a positive impact on the practice and the way in which patients regard the practice.

*I think all of them have been good but I think certainly the Good Practice guide has been very beneficial…to get the Good Practice scheme would be a very, very, positive thing for the practice.* Dentist

The LDC was supportive of the advice that the infection control nurse gave to the practices during the infection control audit. It did, however, feel that DPAS was initially lacking in indicators relating to treatment outcomes and were concerned that pilot practices could potentially tick the DPAS boxes and become accredited while performing below par dentistry. The PCT acknowledged this concern but feel that a quality infrastructure is vital to be able to perform quality dentistry.

*Improving the structure of the practice doesn’t automatically improve clinical care, but if some essential items are missing then it is impossible to provide quality care. I think we can say with some confidence that our DPAS practices have the structure and most of the processes in place to provide good and safe care.* Post-Graduate Dental Education Tutor

The PCT agreed that the scheme could lose credibility if practices achieved accreditation but performed low quality dentistry and were adamant that, despite supporting practices as much as it could, it would not accredit a practice if it didn’t meet the required standard. At the
LDC’s suggestion, the PCT have included information from the Dental Reference Service to monitor the quality of clinical outcomes.

*It would just discredit the whole scheme as far as all the practitioners are concerned. Because people know if it is a quality practice or not. Local colleagues have an idea of what is actually being delivered in practices because they see patients that drift in and out.* LDC

*The other key thing is, we want all practices to have the opportunity if they wish to pass or to graduate. But it is not an automatic done deal; you are not going to just get it by turning up; you do have to do what you say you are going to do. You cannot afford to be non compliant when we look at the exception reporting data that we now have for FP17 discontinued treatment etc. The baseline and follow up practice visit checks key clinical governance issues such as decontamination and patient notes. We also check last DRO visit reports.* PCT Dental Lead

The LDC also feels that some of the evidence required to achieve accreditation could be more robust. Another concern was that infection control audits are only effective if they are actually spot-checked without warning, something the LDC believes did not happen.

*If you know you are going to be inspected, everyone can achieve fantastic quality standards on cross infection procedures and control, on an individual day, and so you can tick all the boxes completely on Monday but what happens Tuesday Wednesday, Thursday and Friday when no one is looking at you?* LDC

**Impacts**

**Patients**

Dentists from the pilot sites felt that the impact on the patient experience would have been minimal in the first year of DPAS as most of the improvements are happening behind the scenes and others will only filter through to patients in the longer term.

*I will be quite frank with you and say I am not aware if they have noticed any change...what has improved may not be apparent for the patients. But I think the benefit will be passed on to the patient in due course because, if we improve our standards and everything else, that will benefit the patients, perhaps indirectly rather than directly.* Dentist

*A lot of it is to do with management of the practice, the actual treatment remains the same. We are still carrying out the best possible treatment for our patients. But it made us focus more on other aspects, practice management, clinical governance, things which we already have in place but we just have to review and improve them.* Dentist

The PCT argue that while many patients may not notice changes, DPAS has improved patient safety with regard to infection control, and in the quality of clinical treatment as it has seen an increase in preventive measures such as smoking cessation advice and cancer screening in the pilot practices. Over time, it expects the available clinical data to show improved clinical outcomes as well.
We have evidence that structure and processes have been improved in practices. We have logged evidence of improvements in the infection control audits. If we start to see changes on the clinical indicators that we have, like exception reports, then we will be able to show an improvement on clinical outcomes as well. The record keeping audit did show improved levels of knowledge and clinical investigation on things like smoking cessation advice and other preventive measures, and soft tissue screening for oral cancer etc. Post-Graduate Dental Education Tutor

Although the practices themselves did not feel that patients would notice a difference at this stage, some did feel that being accredited and having some form of visible recognition would make the patients think more highly of the practice. This was one of the main reasons for at least one of the practices volunteering to take part.

They will just feel a bit more comfortable coming to the practice. They will be a bit more reassured. Dentist

Aspects of DPAS that would have had a more immediate and noticeable impact on patients were the scheme to telephone the parents of five year-olds on their birthday and others such as the oral health promotion project and the health exchange scheme, although the patients would probably not have been aware of the drivers behind these initiatives.

As part of the write-up from the practice visit, the PCT noted all suggestions for how it could better support practices to improve quality. One example of the PCT following through on such a suggestion was in changing its rules around capital grants for decontamination. From practice visits, it found that a lack of instruments was preventing practices from using the newly-purchased decontamination equipment. Allowing for the purchase of new instruments under these grants will ensure that the new equipment is actually used.

Impact on dentists

The dentists spoken to were all keen to be involved in the pilots because it was the first opportunity they had to work alongside the PCT in an initiative focusing on quality rather than basic contract management. They also saw it as a means to improve quality in their practice. Each of the dentists spoken to felt that their involvement had been positive overall.

It is the first time ever the PCT has thought to do something quality focused instead of quantity. There was nothing really like it in our patch. It was just all about improving the quality which was lacking for us in the past. Dentist

I was quite keen because it enabled me and my team to look at our existing practice of dentistry in many forms and see how we can improve the whole thing. Dentist

Overall I think it has been a very positive thing. Dentist

The dentists spoke of the way in which DPAS forced the practice to keep focused on quality. While most felt that their practices were running to a high standard of quality prior to their involvement, they felt that participating in DPAS brought quality to the forefront for everyone working in the practice.
Having DPAS meant that in the back of your mind you knew that you were part of a system, like being part of BDA Good Practice, you need to maintain the high standard. I would say yes, overall it has helped us to become more focused. Dentist

The PCT and the practice owners both felt that one positive impact of DPAS was getting the whole of the team to work together for a common goal. DPAS also encourages practices to use the dental team to their full ability, enabling them to be more efficient and providing them with an opportunity to use skills that may not have been fully utilised in the past.

It is important that the dentist is not frazzled to death with non-clinical work but also we want our newly registered nursing colleagues to be adequately valued. They have an opportunity to shine as well as share the burden with the contract holder. PCT Dental Lead

I think the dental nurses liked it...maybe their skills aren’t always fully used and they can do things to help the practice run smoothly. Using their skills was important to them, and a little bit of a push from outside was sometimes necessary to help them implement it. Project Director

Overall, I would say yes, it has been very beneficial for everybody… I think the staff enjoyed taking part. Dentist

In addition to working towards a common goal, the dentists also hoped that the resulting accreditation would instil in the staff a sense of pride in their achievement and in the practice.

I think on the positive side it was a good thing for the dentists, practice managers, and other dental nurses to be involved. We are working hard for a common goal which is recognised by the PCT. Dentist

Improved communications between dentists and the PCT was one of the peripheral benefits of DPAS that was recognised by both the PCT and the dentists involved in the pilot. DPAS provided an opportunity for the dentists to air any grievances with the PCT, as well as an opportunity for them to show off some of the positive things they are doing in their practice. This was one area of DPAS that was also recognised by the LDC as being a possible success.

I think with some of the practices, there is quite a lot of a pride at stake. They like us to come and see what they are doing, often under quite difficult circumstances. There is a wish to share some of the current issues such as “did-not-attend” rates and reasons for repeat FP17s, discontinued treatments etc. Some say I know what I am supposed to be doing but the associates don’t. We have had some interesting conversations there in terms of supporting contractors to manage their own staff appropriately. PCT Dental Lead

I think that is definitely a lot better because you get more hands-on and more one-to-one. Communication is ongoing. Sometimes you could do with a bit less communication! But it is definitely helpful to build that relationship with the PCT. Dentist
Although it is not mandatory I think it is something very positive. I think the PCT have worked very closely with the dentists – which is good because you are working closely and have a better and different relationship with the PCT. Dentist

Some of the dentists also enjoyed the interaction with their peers from the other pilot practices and found that over the course of DPAS they were sharing information with each other about ways in which they could improve quality. The PCT welcomed this aspect of DPAS.

Because they met regularly as a group they began to feel a bit more like a team and they were sharing things. I couldn’t be sure I am 100% right but my feeling was that that doesn’t normally happen, you don’t normally get people meeting and working together on a quality agenda across practices on a regular basis. Project Director

The LDC is concerned that becoming accredited would give the DPAS practices an advantage over other dentists when it comes to tendering, or otherwise be treated more favourably by the PCT than other practices. The PCT was quick to assure that this was not the case and actually welcomed the scrutiny of the LDC in this regard.

Some of the comments the PCT made at the LDC meetings were that these particular practices would be more likely to become training practices with vocational trainees; they would become perhaps more acceptable to us with things like incorporation. They have actually said that if one of the practices becomes a DPAS practice they may allow that practice to incorporate whereas they are not allowing the other practices in the PCT to incorporate. They may allow additional funding for HTM-01-05 compliance, these practices may be looked on more favourably with tendering for additional or new contracts. LDC

The LDC are concerned that we are creating a two-tier system, or some elements within LDC, are concerned about creating a system that will make DPAS practices automatic candidates for additional UDAs. We don’t wish it to be seen in that way and we are not operating some sort of grace and favour system so that our pals in the best practices are getting accredited and thereby providing the assurance required in bids for additional UDAs. Generally that particular tension that the LDC brings is I think extremely valuable. PCT Dental Lead

Workload

Most dentists thought that the workload was significant, and generally more than they had anticipated. The work was commonly shared across practice owners, practice managers and, to a lesser extent, the dental nurses.

They said it is more than we expected. We could have done with less but on balance it has been worth it because we have got so much out of it. I think it surprised them how much they had got to do. Project Director

It is quite a lot actually. Initially when we got into that we didn’t realise how much paperwork and stuff it involves but I would say if you do your clinical governance that pretty much covers everything but there are a few additional requirements. Dentist
It has been extra work but once we jumped over the hurdle, it has been fine. Dentist

In the LDC’s opinion, single-handed practices would be hit particularly hard by the additional workload because they cannot spread any additional work across multiple staff members.

_Someone from a small practice and someone who has six dentists and a practice manager, within that framework would have huge variance in how they coped with the additional work involved. Because every single practice that was involved was expected to comply with the sort of framework that they had set up for it and they did make it very difficult for single-handed practices. LDC_

In most cases, the dentists felt that the additional workload was justified by the fact that they should have been meeting many of the requirements already, particularly around clinical governance. Many of the dentists also recognised the benefits for the practice that offset the additional workload. The requirement to take part in the BDA Good Practice scheme was the most time-consuming aspect of DPAS for many practices.

_Things like the BDA Good Practice guide and all the other compliance things we have to adhere to have taken their toll. But I could be frank and say we would have had to expect that anyway. There is nothing unusual for us to have to go down the road of making sure the paperwork is all sorted out. Dentist_

_The way I look at it is from a long-term point of view. It is a good thing to be part of and if we can satisfy all of the criteria to be a DPAS practice it will be beneficial for the practice, the patients and the dentist, so it is justified. Dentist_

The dentists felt that DPAS gave them the push they needed to get up to standard on many aspects of running a practice, and to get a head start on other aspects such as decontamination. Most felt that they are now ready for HTM-01-05 decontamination guidance which they may otherwise have left until it became mandatory.

Similarly, most of the dentists felt that the additional workload warranted more of a financial incentive than what they were given. However, when coupled with the other benefits and improvements to their practice they felt that their involvement was worthwhile. On balance, all of the DPAS pilot dentists spoken to agreed that they would recommend DPAS to other dentists.

_I think it will improve the standing of the practice in the community and I think it gives self-satisfaction for the dentists and the staff and a pat on the back from the PCT who say: well you have achieved something positive…If someone else was thinking of doing it I would encourage them to go ahead and do it. Dentist_

**Dentist-suggested improvements**

Although the dentists were generally positive about their involvement with DPAS, there were some elements that they felt could be improved. For one dentist, this would involve reducing the number of practice visits and reducing the time involved for the dentists.

_I think it should be squeezed into a maximum of two visits, not more than that. One to set the roles and goals and what you want to achieve and maybe again to see if you_
have achieved it or not. It needs to be a bit more organised, especially the practice visits, and having less visits than what it has been. Paperwork-wise it has been fine. It is just fine-tuning the time which the dentist is investing and if they have solid goals of what they need to achieve at the end of it that will help. Dentist

One of the dentists found the meetings with the other pilot practices to be particularly useful and would have preferred to have a few more of these in the latter stages.

We haven’t had any pilot meetings for a long time. I think that the PCT, for the next round, should keep these meetings as frequent as possible because then we can have the feedback from the PCT to find out what else we need to do, if we are up to date with everything we are doing. Dentist

The LDC feels that the best way to improve DPAS would be to incorporate it into a Steele pilot. It would also recommend changes to the funding arrangement, specifically to remove the link to UDAs and, if possible, reward practices based on the level of quality achieved. The LDC also believes that DPAS in its current incarnation could never be rolled out to all practices because of the extensive resources required from the PCT. The scheme would need to be altered to make it more efficient in terms of the resource required to administrate it.

Success factors

Despite the criticism from the LDC, the PCT feels the project has been a success overall and that the number of practices volunteering to take part in the second stage is a testament to how highly the scheme is regarded.

The proof of the pudding is that there were many practices, many more than could be accommodated, that put their names forward for phase two. When people vote with their feet, that tells you what the general opinion was. Nobody left and lots of people wanted to join, so that must be working well really. Project Director

The LDC refutes this claim and believes that practices are volunteering to take part out of fear that they will be disadvantaged if they do not take part.

When they actually put it out to express interest in the second wave of pilots, they will say that they have a huge amount of people who were interested in taking part. Now our analysis of that is that these people were only interested in taking part because the PCT virtually had intimated that if you didn’t take part you would be disadvantaged with support from the PCT and so they felt that they would be better off being in than being out. LDC

We have already had quite a lot of phone calls from practices in the area saying thank you for speaking out against DPAS, we didn’t want to get involved in the scheme but felt we had to get involved. LDC

While the PCT would refute this claim, it does acknowledge that the high NHS commitment of the practices in the PCT has helped them to obtain the high level of interest that it has seen.
Our practices and the number of NHS and private patients they have are different from the other PCTs. Their practices might be a bit more able to ignore the PCTs initiatives. In Heart of Birmingham they probably do feel as though they need to work with us, and prefer to see it as an opportunity rather than extra work. PCT Dental Lead

The PCT cites a number of other factors that have contributed to what it sees as a successful first pilot of DPAS. It believes that DPAS has a strong clinical lean and a genuine focus on quality improvement, which has helped to gain the trust and enthusiasm of the dentists involved.

The fact that they have been dedicated to something that has been genuinely pursuing quality improvement and not performance management, has been really well received. Project Director

The PCT feels that the project success is also, at least in part, due to a highly motivated and experienced team at the PCT. The team has a very clinical focus and a high level of expertise. Having the clinical knowledge within the team gives the PCT confidence that what it is asking of practices is feasible in a working practice and not just in theory. The PCT also felt it was important that the whole project team was involved at ground level. Taking part in practice visits gave the whole team a very practical rather than theoretical understanding of how DPAS works in the context of a working dental practice.

The heavy clinical involvement is vitally important. It has got to be clinically rich. The practices have to feel as though the people they are talking to understand them, really understand them and live the sort of lives that they do. Peter Thornley works in his own practice, they know that, they talk to him knowing that. And that’s very important I think, for getting our practices on board and our practices wanting to be on board with this. It also makes it quite tough though for practices because they can’t pull the wool over Peter’s eyes. The same is true in respect of Judy Bevan our Dental Nurse Advisor… It is no good a Practice saying it’s all too difficult because Peter and Judy will say well it is difficult but it is do-able because not only are your peers doing it but I am doing it. PCT Dental Lead

The main commissioning team at the PCT has been stable over a number of years – something that is not always the case in other PCTs. Those involved felt that this stable project team has been a definite strong point as the dentists involved are confident that they are not starting something that the PCT may lose interest in as staff come and go.

In our PCT they are known entities who have been here for a while. In other PCTs the wider commissioning team is either less in number and/or it keeps changing, so why do you want to get yourself involved?…It’s hard enough dealing with something as challenging as this with people you know.

It also comes down to people. Dentists know Ros, Peter, and Judy as well known and respected clinical peers. Dentists know and respect the finance team. Dentists are keen to maintain relationships with the PCT Team, Not only do we want to maintain good relationships, practices do as well. PCT Dental Lead
Having an external project director has also been of benefit to the scheme. The PCT feels that this helps to maintain the required distance between contract monitoring and DPAS (although this was criticised by the LDC). Although the LDC eventually withdrew its support of DPAS, the PCT felt that the earlier involvement of the LDC had been beneficial, particularly in making sure that the DPAS practices are not getting any special treatment and insisting that the scheme is not rolled out to all practices until all of the details have been ironed out.

The LDC wants us to be fair and even-handed with all the practices. The LDC wants us to recognise refurbishments at the practice – time spent on training courses, possession of all the right protocols and procedures. LDC and the good practices often know who the weak practices are, those that don’t invest and keep up to date but who we keep paying...It really upsets them – they want to know what we are going to do about it. PCT Dental Lead

Also considered important in the pilot phase was to maintain a flexible approach and to consider the pilots as a learning experience, although, once again, this is an area of contention as the LDC does not agree that the PCT has been open to criticism of DPAS.

I think the thing that helped on that as well is that Ros has always been clear to everybody that this is a learning project. It is not something that everybody thinks well that is exactly the right way to do it and therefore we have got to just implement it. Ros has always taken the view that we are learning as we go along. So in that sense the project itself changes shape as we learn more from each pilot phase. PCT Dental Lead

That is our criticism, the fact that they were only prepared to see the positives about it and none of the negatives. Unless you look at the whole picture, what is the point of running a scheme to other people that in our opinion isn’t working as well as it should? We’d like it to work, they’d like it to work, but there is no point putting a set of blinkers on and saying it is all working absolutely fine when quite clearly it isn’t. But it doesn’t surprise me that they have said it has all been a fantastic success. And it wouldn’t surprise me if the participating dentists are frightened to say that it hasn’t been a fantastic success because as I say they won’t want to be as outspoken as the LDC on it because they are still in it. LDC

Advice to other PCTs

Those involved were careful to stress that a scheme like DPAS is not something that can be ‘cut and pasted’ to another PCT, but they did have advice for another PCT considering implementing a similar scheme.

I guess at the end of the day it may gain acceptance as an approach that has worked for us. It may have some lessons for elsewhere. However each practice is different, each group of practices can be different, each PCT can be different. You have to be very careful that you don’t have a one-size-fits-all type arrangement. PCT Dental Lead
This is the major theme really of how do you transfer good practice in the NHS? You can’t do it just as a set of policies and procedures and an approach, you’ve actually got to really want to do it and own it. So there is always that danger that people might think you can just take it off the shelf. I don’t think you can, you have got to take ownership of it. Project Director

The main advice that they would give to another PCT revolved around maintaining focus on quality and not to get the scheme mixed up with other business as usual. Although as mentioned previously, this was one of the major criticisms from the LDC.

My main advice would be to commit to focusing on that you are there to help them to improve and don’t move away from that, even if times get tough. It is a commitment to a joint working on improving quality and don’t get that mixed up with your performance management agenda. Project Director

The second strand of advice was for the PCT to be aware of the financial and other costs involved in such a scheme, including opportunity costs. They felt that PCTs should be aware that a scheme like this does not happen in isolation and that they need to be prepared to be flexible to accommodate changes to the political context they are working in.

I’d say do it, but be aware of the costs, the real financial cost and also the opportunity cost – if you are doing DPAS, you probably can’t do something else. PCT Dental Lead

Future

At the time of writing, the PCT had not finalised the details or practical arrangements for monitoring practices post-accreditation to ensure they continued to meet DPAS standards and justify the continued payments that come with accreditation. It had however, broadly agreed to implement formal monitoring based on the seven domains of DPAS and exception reports. The lack of clarity around this monitoring was a concern for the practices involved, and the LDC. One specific concern for the LDC was that practices could potentially have to meet escalating requirements in order to receive the same level of funding. It was also concerned that, once all practices had reached accreditation level, the payments would be withdrawn as accreditation standard would become the norm.

That was our worry, that perhaps it was almost a raising of the bar on each subsequent year, so you would get the same amount of money but are expected to year on year to keep on raising the quality within the quality. There was also a fear in other members of the LDC committee that if all the practices within the PCT would become accredited then they would just regard that as the norm and disregard any form of quality payments completely. LDC

Another grey area at the time of writing was how DPAS would work on a larger scale once the pilots had finished. The LDC strongly urged the PCT to carry out another round of pilots as it did not feel that DPAS was ready to be rolled out to all practices. It suggested that the second pilot should focus more on smaller practices in order to fully understand the mechanics of how DPAS would impact on these practices, and how the practices could be encouraged to work together in order to remain viable in the current commissioning
environment. Acting on this advice, the PCT is running phase two of the pilot with two groups of four small practices working in collaboration.

During phase two of the pilot, the PCT will have an opportunity to look at how to sustain DPAS in the long term without having to commit the current high level of PCT involvement indefinitely. Both the PCT and the LDC believe the additional workload placed on the PCT by DPAS in its current form would be unsustainable if DPAS was to be rolled-out to all practices. The current thinking on this issue is to initiate some form of self-monitoring system where the practices themselves are taking some of the burden from the PCT by monitoring each other.

What DPAS does do is place a big burden on the PCT staff to do extra work on top of the normal checking that they would do. Part of phase two will be about, can we build in as we go along, some way of ensuring that peer groups will be formed?…When we reviewed the first phase that was one of the lessons that struck us an important one. As I say it is as much about sustainability and hitting the right balance of input from the PCT. Project Director

The whole scheme is that it has turned out to be very very intensive on man hours and visits and people coming to the practice and the participation in the practice and although they have managed to run it in six practices with quite a bit of effort, to actually roll that out to all of the other practices within the PCT would have been impossible with the manpower that they have at the PCT. LDC

The LDC feels that evolving the scheme into a Steele pilot is the best way forward. It would strongly welcome the independent evaluation that would come from being a Steele pilot. Discussions about the possibility of Heart of Birmingham PCT merging with South Birmingham and Birmingham East and North PCTs will also have some impact on the future of DPAS.

The PCT feel that having been involved in DPAS will put them in good stead for implementing any changes that come about as a result of the Steele Review of NHS dentistry.

I think we’ll use this as experience as we implement the Steele Review. We’ll see whether our seven domains can become the key performance indicator areas that we can put some money against for the new Jimmy Steele type contract. PCT Dental Lead

Since the time of writing, DPAS has been accepted onto the Steele Implementation Programme. DPAS practices will be affiliate pilots in Wave 1 of the programme. The PCT hopes that this involvement should address the concerns held by the LDC about escalating requirements and independent evaluation.