The 59th Annual Conference of Local Dental Committees

Harrogate International Centre

18 June 2010

LDC Conference Chair, Richard Emms, addresses LDC Representatives and dinner guests in the Royal Hall, Harrogate.

Letter from the Chair of Conference, Richard Emms

The Victorians travelled to Harrogate to take the waters to seek a cure for all their ills. The members of LDC Conference ventured into the 'wilds of Yorkshire' not expecting a find a cure for their particular professional ills but left, I hope, having had a cathartic experience at what I felt was a very uplifting, forward thinking and influential conference.

The sight and sound of dinner guests in the beautiful surroundings of the Royal Hall chanting "we're as mad as hell and we're not going to take it anymore" led by guest speaker Dr Phil Hammond, will stay with me for a long time.

It followed on from my conference speech in which I sought to explain the frustrations many of us feel in the target driven, bureaucratic NHS in which we find ourselves. I challenged conference to take a look at our professional lives and to have the confidence to retake a hold on it and to put forward our ideas for change in our rapidly evolving practising environment.

It gave me a slight cause for concern when the deputy chief dental officer, Sue Gregory, said that she had enjoyed what I had said, as it hadn't been my intention to deliver a speech that was (sound of) music to her ears! However she did qualify her comment by saying that she had found it 'agreeably challenging' so hopefully Sue and the department will reflect on some of the comments I made.

Dr Phil Hammond, almost seamlessly, took up the refrain and gave a great after dinner speech mixing humour with important political points to remind us of our professional responsibilities and encouraging an integrated partnership of professionals, because after all, as clinicians, we are the ones that understand health care.

All in all a great evening and, as usual, an opportunity to network, meet old friends and make new ones.

It is an honour to chair conference and it was a privilege for me, during my opening address to conference, to be able to pay tribute to two former chairmen, Trevor Payne and Trevor Mann, who both died recently. Conference stood for an immaculately observed minute's silence as a mark of respect for both of these stalwarts of conference. That short time of reflection was the only quiet part of the day as conference made its voice heard during debate and question and answer sessions.

I was pleased that following on from the previous evening, the need for the further bureaucracy of the CQC was challenged, most emphatically, via an emergency motion questioning its necessity. The results of further motions and straw polls during the question and answer sessions suggested a united profession and one keen to take up the fight.

Jimmy Steele spoke to us again and I never fail to be impressed with his common sense approach and pragmatic view on dentistry, though only time will tell whether all or even some of his recommendations will come to fruition.

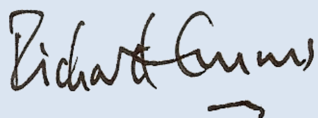
You will be able to read about the presentations and the motions voted on later in this report and I was glad that we were able to pack what seemed like a quart of activity into a pint pot of time. This takes a great deal of preparation and I would like to thank your Agenda Committee for their hard work and wise counsel during both the preparation for conference and the day itself.

And so the ‘bun-fight’ rolls on to 2011 with Mick Armstrong at the helm. Apolline, in the June issue of Dentist, opined that conference was anachronistic, not good value and was ‘opting out of the mainstream of political activity’ by venturing north and having a ‘doctor/journalist’ as guest speaker. I think those that did make the journey would disagree with that and would feel that the £5 per year conference levy that has to be ‘coughed up by poor old GDPs’ proved value for money.

I hope that they would be able to join me in my opinion that to gather together nationally is still worthwhile, as conference is still the heartbeat of the profession, revitalising and energising LDCs to encourage and enable them to function at a local level.

Long may it continue.

With very best wishes,



Richard Emms

LDC Conference Chair 2010

Chair's opening address to Conference

The Chair welcomed delegates to the Conference in Harrogate and called for a one minute silence to remember both Trevor Payne and Trevor Mann and their involvement in previous LDC Conferences. The Chair took a vote on an amendment to the Standing Orders of LDC Conference, allowing for the use of electronic voting at future conferences, which was unanimously passed by the Conference.

The day at a glance

09.30	Chair's opening address
09:45	Update from GDPC, John Milne, Chair
10.00	Conference Motions
11.00	**Coffee break and exhibition**
11.30	An update on the Care Quality Commission, Alex Baylis, CQC Provider Registration Questions from the floor
12.00	Implementing the Steele Review, Professor Jimmy Steele Questions from the floor
12.45	Report of the Honorary Treasurer to the Conference and Accounts for the year to 31 October 2009 Elections
13.00	**Lunch**
14.00	Report of the British Dental Guild by the Chair, Howard Jones Presentation by the Dentists' Health Support Trust, Brian Westbury Presentation by the BDA Benevolent Fund, Bill Nicholls
14.20	PDS Plus: Implementation and the future, Dr Mike Warburton, Department of Health Questions from the floor
15.00	**Coffee break and exhibition**
15.30	Debate about LDC representation and issues raised by the regional groups
16.00	Conference motions
16.25	Induction of new Chair 2010/2011 and address to Conference
16.30	**Closing remarks from Chair of Conference.**

Delegates listen to the Chair's opening address at Harrogate International Centre, 18 June 2010

John Milne, General Dental Practice Committee

John Milne is Chair of the GDPC and sits on the Steele Implementation Programme Board.

John Milne, Update from GDPC

This time last year we were eagerly awaiting the Steele Review and wondering whether it would make any difference or merely follow previous reviews onto the shelf or deeply into the long grass. But to the surprise of many the review was accepted by the secretary of state Andy Burnham and work began to plan how the review would be implemented.

GDPC were cautiously enthusiastic and the big principles of a risk-based oral health assessment, care pathways designed appropriately for patients' risks of disease, with limits such that advanced care should only be provided in a stable oral environment were accepted. Our approach of "engagement with extreme vigilance" reflected the anxieties and lack of trust that have blighted our relationship with government and the DH for too long. Last year I said that our stance would be one of constructive engagement, and that is exactly what we have been doing. The working environment with DH has improved, but we remain vigilant and we have not forgotten that our role is to seek the best terms and conditions for dentists, and we will continue to hold the interests of GDPs at the forefront of our actions. We have been engaged with many working groups on Steele, and I must pay tribute to the energy of my GDPC colleagues who have given of their time and commitment to this work. This work comes at a cost, and I would like to thank the British Dental Guild, which has funded sessional work, and I would ask you again to support them generously, because I am sure there is still much to do.

We thought all was going to go well with the Steele process until the PDS+ contracts landed on our lap in July. The principle of increasing access was absolutely fine, and additional money into dentistry is always welcome. But the contracting mechanism was, in our view, damaging to practitioners and we advised dentists to take care. We were so concerned that this contract might supplant all the work on Steele that we asked for, and were given a meeting with Andy Burnham where we laid out our anxieties. We were told that the access programme was limited with the objective of achieving its targets by March 2011 and that work with Steele would remain the key plank of NHS dentistry reform. After that meeting, work really began in earnest on the Steele programme.

We look forward to hearing from Mike Warburton today how the access programme has been working and whether further changes to the contracting mechanism have taken place.

So, these were the objectives that we agreed with GDPC and the members working on the Steele groups.

Key objectives........ours!

- Develop a preventive based service that improves oral health, enables quality care to be provided and remunerates dentists adequately and fairly.
- Retain independent contractor status and preserve the ability to mix NHS and private practice.
- No detriment to practitioners participating in pilots.
- To preserve (or reinstate) goodwill for practices.
- To ensure that the relationships between providers and performers are not adversely affected

BDA

Slide 4

The first objective has been widely accepted and a lot of work has taken place designing the oral health assessment and care pathways.

We firmly believe it is important that dentists should be able to offer patients choice, and the ability to mix NHS and private care can work to the benefit of patients.

We understand that the effect of different drivers brings risks, but it cannot be right that a practice can be harmed by participating in pilots that are testing ways of improving NHS dentistry.

The NHS dental service is built on investments made by dentists in their own practices, it is right that dentists should see a return on that investment by being able to transfer contracts on the sale of practices. We will continue to press for this to be acknowledged, and will make the point that it dentists take all the risks in providing NHS services.

Associates play a huge part in delivering NHS services; they too deserve a practicing environment that enables them to develop their careers.

These objectives remain firm and should, I believe form the basis of the negotiations of a new dental contract. A lot of work has gone into developing contract options to pilot and these all include a blend in differing proportions of capitation, quality and activity.

Each of these is capable of producing perverse incentives and working against either the interests of patients or of dentists, but I do not subscribe to the view that our profession is untrustworthy. I know that the vast majority of our profession are honourable and put the interests of their patients first. Any new system must respect that integrity and not penalise the majority of the profession because of the occasional aberrant behaviour of a few.

In the working groups, a high proportion of capitation seems to be the emerging favourite.

We must not be afraid to bring our objectives to the table; after all, we understand how dentistry works. It is important that an adequate number of pilots takes place, and that quality indicators reflect clinical quality rather than just the ability to tick boxes. The oral health assessment will be more time consuming, and it is important to reflect that in the expectations of access and activity. Care pathways must not undermine our ability to make professional judgements; this is what we have been trained to do, and where we have experience.

It is important that the breadth of care that GDPs are able to provide is not diminished, and we retain our full range of skills.

The final result must be better.....not worse.

The news headlines about dentists and the Steele review tell a story, and I for one was not happy with the idea that the Steele pilots should be stopped as I felt they offered a chance of real progress in testing changes to avoid a repeat of past errors when change was simply imposed on the profession in 2006.

I think we may have to acknowledge that the poor design of the previous system will have contributed to an environment of fear, where dentists are so afraid of clawback it would hardly be surprising if patients with unknown needs were less welcome than our regulars. But I cannot condone unprofessional behaviour and I hope that as we move forwards that dentists will not be penalised by the system for doing the right thing, which is what sadly so often happens at present. UDA targets are difficult to reach when patients have high needs, and any new system needs to work without UDAs and UDA targets.

Effectively, it seems that the politicians are seeing the present as a time to take stock, reflect, and to understand with the benefit of facts and information just what has been happening with dentistry and what the Steele work has delivered so far to support the development of a new contract.

The new Minister has committed to continuing the reform of NHS dentistry in England. He has pledged to review the progress so far and then take reform forward. Importantly, he has also committed the new

Government to discussing change with the profession and to the piloting of long-term change. This was the result of our meeting last week; a commitment to reform pilots and to working with the profession.

The Minister has already said much the same as we have heard before: “We will introduce a new dentistry contract that will focus on achieving good dental health and increasing access to NHS dentistry, with an additional focus on the oral health of schoolchildren.”

The Minister has also asked officials to look whether some interim measures with the current contract might improve things, and amongst those measures might be additional UDA bands.

We said that we will be happy to discuss such changes, but do not want such “tinkering” to stand in the way of long term reform.

We can’t avoid the overall context which is one where the new Secretary of State is stamping his authority on healthcare and already has quite fixed ideas. Budget cuts or freezes are new, but some are a return to earlier thinking such as GPs holding budgets, the so-called ‘GP fundholding’.

LDC LMC GP consortium contacts are vital to make and nurture as the whole landscape of NHS provision may be set to change, with GPs in control of the vast majority of commissioning. GPs do not have the skills to commission dentistry.

The big challenge...

How can a system improve oral health, deliver prevention, continuing care and advanced treatment whilst paying dentists adequately and fairly, and provide an environment where all this can be achieved with minimal perverse incentives from any direction to enable the patient, the government and the profession to have confidence for the future?

We’re working on it, and need your help and support.

The challenge remains huge, but we have to continue to engage, discuss, argue, persuade and encourage. I know that you are all here from LDCs and that you will play your part.

So will we, and so will I.

Thank you.

Conference motions and debates

Anthony Lipschitz (Bedfordshire LDC)
led the debate about standardising UDA values

Conference delegates began the day with an interesting debate around UDA values and whether they could be standardised or harmonised either across the country, or on a regional basis. Delegates heard convincing arguments from both sides, but eventually voted the motions down.

There was also a debate about LDC representatives leaving the Conference early and effective LDC representation at Conference. Delegates discussed the possibility of the Agenda Committee using their discretion to withhold travel and subsistence expenses from those LDC representatives that leave the Conference before it closes without good reason. Although the vote was very close, this suggestion was narrowly defeated.

A full list of those motions that were passed at LDC Conference is provided below.

Delegates were able to vote on motions electronically, providing a quick and easy to see result to the votes taken on the day.

Motions passed at LDC Conference 2010

Dorset LDC

Jonathan Mynors-Wallis (Dorset LDC) proposed the motion in the debate

This Conference deplores the increased risk of contractual breaches under the new contracting arrangements and believes as a result that it is in the interest of all parties for the local dispute resolution process to be as fair and efficient as possible to reduce the risk of complex proceedings.

This Conference notes, however, the inherent bias toward PCT officials within Contract Dispute Resolution Committees.

This Conference proposes, therefore, that local PCT Contract Dispute Resolution Committees must:

- be independently chaired
- be balanced evenly between PCT officials and practitioners

Leicestershire LDC

This conference regrets that ring fencing for dental funding will cease in April 2011. Without protection for dental funding conference believes it is possible that PCTs will reduce their spending on NHS dental services. This conferences demands that ring fencing for dental budgets be continued past 2011.

Norfolk LDC

Jason Stokes (Norfolk LDC) proposed the motion in the debate

This Conference is deeply concerned that many PCTs are failing to spend their full allocation of NHS dental funds. The funding of NHS dentistry was ring-fenced by the Department of Health specifically because of the importance of protecting NHS dental services for patients.

To ensure the continuation of these important services, this Conference calls for PCTs to provide accurate information to LDCs to support them in safeguarding NHS dentistry at a local level.

Somerset LDC

This Conference regrets the imposition of HTM 01-05 in its present form. We believe many of the elements of the document have no evidence base and we urge the department of health to reconsider its decision to impose the document in its entirety without referral for NICE scrutiny.

This Conference, therefore, calls for submission of HTM01-05 to NICE for a review of the evidence base.

Gary Irvine (Somerset LDC) proposed the motion in the debate

Avon LDC

This Conference deplores the imposition of HTM 01-05 guidance document, as the evidence base has yet to be established.

This Conference demands that the Department of Health withdraws the document, halting the implementation of essential compliance pending the outcome of a review of the evidence base.

Birmingham LDC

This Conference calls on GDPC to negotiate with the Department of Health a single inspection of practices for compliance with Care Quality Commission, PCT clinical governance and cross-infection surveys to limit disruption to practices.

Norfolk LDC

Nick Stolls (Norfolk LDC) proposed the motion in the debate.

The British Dental Guild and Dentists' Health Support Programme provide differing but vital support for the profession. As LDCs see a marked drop in the voluntary levies, their ability to support these bodies dwindles.

This Conference calls for the GDPC to produce clear guidance on the regulations, in relations to LDC levy, and how levy money can be used to support the work of these essential organisations.

Northamptonshire LDC

This Conference notes that practitioners invest a great deal of money and time in their practice, in order to be able to provide NHS services.

This Conference, therefore, calls on the Department of Health to ensure that adequate compensation for practitioners is provided where the transfer of contracts has been prohibited by PCTs.

Birmingham LDC

This Conference demands that the GDPC negotiate with the Department of Health the removal of Clause 12 from contracts, allowing contract transfers to be re-established and to allow future investments into dental practices as viable businesses.

Northamptonshire LDC

This Conference believes that all Key Performance Indicators are designed to lead to an improvement in health outcomes.

This Conference, therefore, demands that the funds associated with these measures must be provided in addition to the contract value.

Birmingham LDC

This Conference notes that:

- dental practices are currently regulated by seventeen separate bodies;
- the amount of time practitioners devote to regulatory red tape and paperwork is already excessive and rising every year.

This Conference believes that unnecessary bureaucracy undermines patient care by diverting dentists' time and scarce NHS resources away from the frontline.

This Conference, therefore, calls for the new Government to save money and support patient care by withdrawing the requirements for dental practices to register with the Care Quality Commission before the beginning of the registration process in October.

Peter Hodgkinson, Dental Adviser to the CQC, spoke for the motion in the debate

Birmingham LDC

This Conference demands that the GDPC act on illegal contracting by PCTs, including demanding the BDA to pursue legal challenges, if necessary.

Birmingham LDC

This Conference requests GDPC engage the GDC to change removal from the register for late payment of registration fees, for cases with mitigation.

Croydon LDC

Dentistry is no longer a self regulating profession because the GDC is no longer elected.

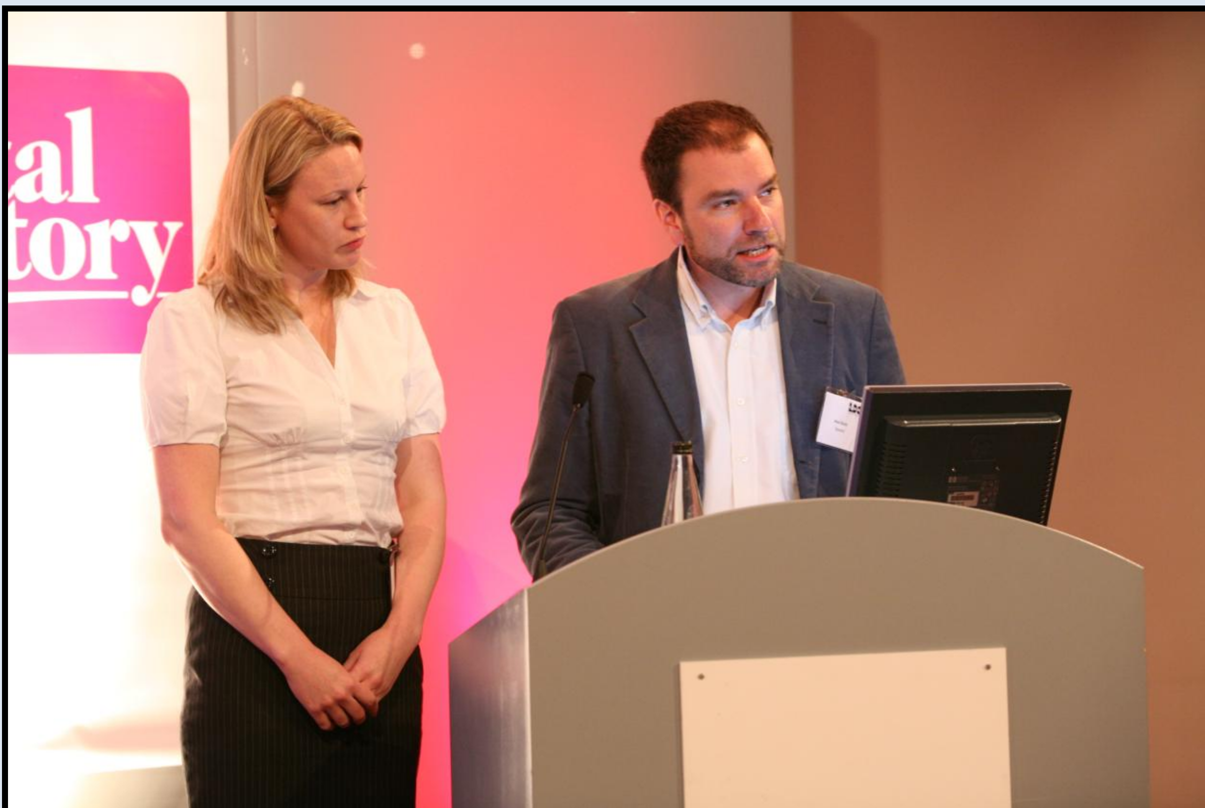
This Conference demands that the profession either regains the power to elect the GDC or let the Department of Health pay for the GDC.

LDC Conference Agenda Committee

This motion was proposed by the LDC Agenda Committee and was led by the Chair, Richard Emms.

This Conference believes that LDC Conference should fund loss of earnings expenses for the LDC Conference representatives to the GDPC.

Registration with the Care Quality Commission



Alex Baylis and Emma Steele from the Care Quality Commission spoke at the Conference and took questions from delegates.

Alex Baylis and Emma Steele, Update on the CQC registration process

Thank you for the opportunity to provide an update on the preparations which are in track for registration of dental providers. This is really just to let you know where we've got to since we were last at your conference, and we'll keep it pretty short to save time for questions.

Just as a reminder; registration is about the essential standards that providers must not fall below. It's not about best practice standards, but it is a safety net to make sure that where there are concerns they get addressed with statutory force behind them. It's very much about outcomes for people and works backwards from outcomes for people. Our methodology is not about having prescriptive checklists of inputs; it's about working backwards, and as such will not be getting into areas that conflict with the GDC. It's a separate, complimentary system, and very importantly it's a single framework which covers all of dental care so it gives the same level of assurance across NHS, mixed and private practice. That's reasonably unique because particularly wholly private practice doesn't have that system of assurance at the moment.

Our timeline is for dentistry to come in in April 2011 as part of a phased expansion of the registration system. The dates are set in regulations so for them to be changed requires Parliament to do that, and the coalition government when in opposition; both parties supported the creation of CQC, the development of registration and its extension to dentistry and primary medical care, and that remains the case. There's been no change in policy on that at least as far as we or the Department of Health are aware. So our assumption is this is still on track and still going forwards.

Registration will apply to providers and registered managers and it's mandatory, so without registration it won't be lawful to trade after the 1st April. And the provider; we're aware that dentistry is fairly uniquely complicated in terms of working out the difference between individual providers, partnerships, informal expense sharing arrangements, partnerships at will, that sort of thing, and we're working through this in a pilot we've got at the moment. We'll be publishing further guidance on it but we're reasonably confident that actually the way the provider system works will be consistent with the GDS regs, and people who are designated as providers under the GDS regs will be registered as providers with us. Registered managers will be required, where it's not an individual who is registered as a provider where it's an organisation, but we do have some ways of making sure that's a fairly straight forward system particularly in partnerships; one of the partners can be the registered manager in a small organisation where the owner of the company for example wants to register. But a manager is registered in their own right, so if they change job they can take the registration with them so there is a separate process to enable that.

How we're developing this? We've developed our model which we published through a booklet that was launched at the BDA conference in Liverpool, and is on our website, and at the moment we're piloting this. So we're in Phase 2 and we're piloting at the moment in West Berkshire, Kensington and Chelsea, and Northamptonshire, and the PCTs in that area have worked with us to identify practices in their areas who are going through a process of filling in the draft application form. They will then have some mock inspections and we will have an evaluation event which will lead to a report that we'll publish about how easy they found it, what worked for them, to be able to demonstrate compliance with our requirements and what didn't. We'll be publishing that in the summer. And we're still on track to have all the information that a provider should need for registration published in August ready for them to be able to apply from October which is when the window will open for registration applications. And we'll be doing a second pilot in the autumn towards the end of the year to look at how we have our methods for ongoing monitoring after people have got their registration.

The system's built on a set of regulations and standards. The regulations are set by the Department of Health; they are the bits that are enforceable. So if there's ever any enforcement action it's the regulations that get taken into account not the standards. The standards are published by us, and the standards are written as prompts, and they are ways that providers should think about complying with

regulations but they're not prescriptive. We allow for providers to say what is appropriate to their circumstances. And they're generic so we are looking at how intelligible they are for dentists, how easy to understand and accessible they are. And we're working with organisations to look at providing tailored guidance specifically for the dental sector, so for example the BDA is one of the involved bodies that we're looking at working with to support them in producing guidance for their members.

The standards that we've written are very much outcomes-based and quite high level and it will be useful to have additional guidance. It's quite important as a way of understanding our methodology what this leads into if you have an inspection from one of our inspectors; it will be very much about open questions of how you know that if there is some sign of abuse detected by one of the dentists in your practice, how do you know that would get acted upon? It won't be starting from "here is a checklist of the things you have to have in place". It will be starting from "give us your assurance and work back from that", with a whole process of negotiation to accept that different things are appropriate in different circumstances. And that will work with whatever national guidance is already out there, rather than creating a duplicating or competing set of detailed requirements.

The other thing that the system's particularly built on is this idea of a quality and risk profile. The approach that I've just described to inspection will go a long way to testing whether providers can demonstrate that their systems are in place. But you also need data too, for example if there were a Doctor Shipman in dentistry you would have to have data as well to detect that. And so this is why we're putting together what we call a quality and risk profile which hoovers up all information about providers and includes analytical software so that we can look for unexpected patterns or outliers. Then our inspectors work with the providers to test whether those are real concerns or whether there are good explanations for them. And this is something that will grow over time, particularly in relation to private practice; there is very little data for it and we're well aware of that. But our trajectory is to build up the information base as well so we're not just using inspection, and our system as a whole is very much about being responsive to things as they happen.

We're very aware of the situation in dentistry where quite small businesses can have quite a large number of inspectorates coming to ask them about very similar issues in slightly different ways. We will not be producing checklists. But we do see it as part of our role to facilitate discussion about how we can get more harmonisation around what we're all looking at in order to get assurances because all the different inspectorates and regulators ultimately have the same aim of looking at quality and safety. And we'll also be looking at information sharing so that if one inspectorate collects information once we'll look at if that information can that be reused rather than duplicated. This is a discussion that we've started taking forward; we had a national workshop last week which has given us very strong backing, particularly from providers and their representative organisations to take forward that agenda in discussion with people like PCTs, NHs dental services, Denplan and other dental plans and so on. So we are taking that forward and we've heard the strong views that have been expressed to encourage us to do that. We're also taking forward some discussion to make sure there is absolute transparency and clarity about how our statutory enforcement powers fit with those that PCTs and the GDC have, and NCAS as well goes into that bracket. We've again consulted through a national workshop and got very strong support for the idea that we should be facilitating that discussion to get absolute clarity based on a principle of not escalating things up to national regulators if they can be resolved locally. So we're taking that forward; that takes a little bit longer probably because there's a process of negotiation with all the PCTs involved but we are seeing that as part of our role in order to progress with registration.

I really just wanted to reinforce that in the registration system there are two elements. So the first one is just getting into registration, which will happen over the six months from October to March for people who are already up and running as providers. We will be looking to make that as simple a process as we can, taking into account all the checks that are already in the system, particularly for NHS dentistry, and we will have some special arrangements for people who are already providing, say for example there would be no fees. But there will be a learning curve for everyone in that it's a new system and so we're particularly looking to go out through PCTs in late summer and autumn when everything's published to

support that. Once you're in the system there will be an ongoing system of checks to make sure that you don't slip below that line of acceptable standards. These checks will involve everyone having some kind of contact with us every two years but increasingly as the quality and risk profiles build up and as our knowledge of the sector builds up, we'll be moving to a much more responsive system where our activity and our resources will be skewed only to the cases where we have concerns. In cases where we don't have concerns we will be happy to say we have looked and we're content for these providers to carry on without us inspecting them. So it's almost a form of validation if you like.

I need to say something about fees as well. There will be regulatory fees. We have not decided how much they will be. Any figures that you hear are just rumours without any evidence behind them at this stage. But we will be consulting at the very beginning of October, and there will be a three month public consultation, with us actively going out to engage people in it. Secondly, we have a statutory duty to take account of what comes back in the consultation so it is worth feeding into it. Then the third stage is to seek the Secretary of State's approval for it all. So with those three processes to go through the fees should be published in about February 2011 but with our initial consultation at the beginning of October we'll be publishing the figures that we think it's appropriate for you to have as planning assumptions, though the final amounts obviously depend on consultation.

This is really just to remind you that the key point of registration is about essential standards not best practice, the line you must not fall below. It's across all services, whether they're NHS or public and it's very much about working back from peoples' experiences rather than the inputs. So we'll now take questions.

Question and Answer Session

Nicky Davey, Hertfordshire LDC: Why should we have to pay a fee for registering with something we've not even asked to be registered with?

Emma Steele: We're required in the legislation to cover the expenses that we incur for registration, and no more than that. So we are consulting on that basis and there is some work being undertaken at the moment by consultants to try and establish the costs of registration, processing applications and ongoing monitoring so that we can then transfer that over. So it's an obligation that we have through the statue that was provided to us from government.

Alex Baylis: All the more reason to take part in the consultation. We have to propose fees.

Chair: You're talking about a phased process of registration for October; can you tell us how that's going to work for applications?

Emma Steele: Yes, we haven't quite determined the number of batches and therefore what number of providers will go in each batch. But we're working under the assumption that from the 1st October there will be a number of batches through to possibly the end of December or January. So for those providers that we have names and addresses for, we will write out giving a minimum of 28 days notice which we're obliged to by law. We will then allocate a particular window within which the provider must apply. If the provider applies within that window it protects them from prosecution should their application not be processed by the 1st April. If a provider applies outside of that window and their application isn't processed by the 1st April then they may be subject to prosecution and be unable to trade after that period. So given the sheer volume of providers in the sector that we need to get through before publishing the register on the 1st April we're approaching it in that staged process. But as Alex mentioned

earlier we're currently planning on publishing all this information in a lot more detail in the first week of August.

Jonathan Mynors-Wallis, Dorset LDC: To be a provider you need an enhanced criminal check. Now, a lot of practice owners haven't got this because as the person at the top of their organisation they can't do a criminal check on themselves. PCTs aren't getting their act together; you need to push for that.

There are 22,000 dentists, the PCTs have had amazing difficulty getting the CQC through the hospitals, isn't the system just going to crash as soon as you start doing it? Have you got the people to actually put it in place properly?

Alex Baylis: In relation to CRBs; yes we recognise that and we're still working out the detail of it, but our principle is that we're not going to create unnecessary checks where there are safeguards in place through CRB, and there's also the vetting and barring scheme to bear in mind with that as well. So we're looking at how to make sure that there is assurance there without creating a burdensome process.

In relation to the volume; you're quite right, it is huge but it's actually not as big as the adult social care providers that we're registering at the moment. We're registering 25,000 of those at the moment, and our systems are standing up to that. So we don't underestimate it but we know we have at least the capacity to do it so we're hopeful that we will be able to do it.

Jane Ainsworth: Looking ahead to when you've actually done all the inspections, could you say something about who that information will be made available to? Will it just be to the practices? Or will the Primary Care Trusts have information? Or will it be published on a website for the general public to avail themselves of all this information?

Emma Steele: There are different layers of information with different detail. So we will retain all of the detailed information that we get through the application process, through inspections. And through the harmonisation work that Alex was talking about we may enter into data sharing agreements with other regulatory bodies like the GDC where we exchange information as we get it. In terms of the PCT, again, it's in the legislation that when we make decisions on a provider's registration we let the PCT, the commissioner, know. So when a notice of decision is issued to a provider on the status of their registration we'll copy in the PCT at that stage.

Jane Ainsworth: What about the public?

Emma Steele: On our website, on the 1st April next year, we will publish the register of dentists. That will look very similar to what we published this year for the NHS, and will do on the 1st October for adult social care and healthcare. So that's a list of providers - it will be their name and address – and any compliance concerns that we may have which will be fairly high level. As we go through into monitoring of compliance, where there is a report that one of our assessors completes after doing a review of compliance; that will be published on our website. That hasn't yet been piloted. We're doing an ongoing monitoring of compliance pilots in the autumn of this year and from that we'll get a better idea of what level of detail will be in those reports and what they may look like.

Shaun Howe, Nottinghamshire LDC: Some time ago I trained as a dental practice appraiser with the Faculty of Dental Practice. Despite having this training I don't feel I have the skills to go into a dental practice and tell a dentist that he or she can no longer see patients. Can the CQC reassure this conference that its inspectors will have the appropriate skills and training to do so?

Alex Baylis: We recognise the issues, and just to put it in context, because I know people do think that a regulator is going to come round closing down practices left right and centre; that is not our experience of what we do in the sectors that we regulate, particularly in the ones like dentistry that have a highly professionalised workforce and are already subject to a lot of regulation already. When we have concerns there will be a process of dialogue - unless it's something really urgent - to get the provider to sort them

themselves out, rather than us taking unilateral action. Our inspectors are not going to be looking at an individual dentist's fitness to practice or competence to undertake specific procedures. They will be coming to you with open questions about "how do you know as a provider that what's going on in your practice is safe and effective?" Then they will work back from that, drawing in expert advice from the resources that we have and the links we have with other organisations to support that as they need it. What will be coming back is very much a system that challenges the provider to demonstrate that they are providing a safe service. It's not that we are going to say we know better than you what is appropriate for your circumstances, but where there are significant risks we can and will take that action if it's necessary to protect the public. It's not about going after the dentists; it's about protecting the public, and that's where the bottom line is.

Esmail Harunani, Lambert, Southwark and Lewisham LDC: We have all got performers working for us, and they are self-employed in their own-rights. Can you tell us if they have to register independently or are we responsible for them? Because they are, theoretically, self-employed.

Alex Baylis: We're working through the detail of this, because dentistry is different to some other sectors in terms of how providers are organised with partnerships at will and associates and leasing arrangements that aren't necessarily legal partnerships because people are as you say are technically self-employed. We're working through the detail of that and we're testing it in our pilots, but our assumption is that it will be whoever is named as the provider under the GDS contract. So in some cases that will be people working really quite independently of each other, where they may each be a provider in their own right, even though they're in the same building. In other cases it will be a partnership; whether it's been called that in legal documents or not, it's actually as good as a partnership. And in other cases it will be an individual who is registered, for example the practice owner who then has arrangements with other people who are effectively working for him as a provider, although not employed. So looking at the options we do realise that this is one of the areas where we're going to need quite a lot of clear guidance because there are a lot of things that are unique to dentistry.

Ian Gordon: Following on from that point, I find it incredible that at this stage you still don't know who's going to be registered. I mean if you can't even get round who's going to be registered it's a bit worrying about everything else. So on that point, if a provider has multiple practices, will they register multiple times or will they register once and that will cover the practices that they have?

Alex Baylis: It's not that we don't know who has to register; we're very clear who has to register. What is important is for us to give clear guidance about how the different lines of accountability fit together so that everyone is quite clear what we will be holding them to account for and how that fits with the other accountabilities they have for example in their contracts. In relation to locations; no you won't have to do separate registrations for each location. If you're one provider working from three practices you'll register as the provider, and then attached to your application you'll say "these are the locations from which I'm providing services".

Stephen Shimberg, GDPC: You say your reason for existence is to protect the public; why should I pay my GDC fees?

Emma Steele: We're looking at the provider level whereas the GDC are looking at the individual performer. That is our remit. We've had a number of meetings now with the GDC, and we are very clear on the differences that we have and we will publish our memorandum of understanding that we're drafting with them at the moment. Hopefully, that will give you more reassurance.

Stephen Shimberg: I'm afraid to say that this conference doesn't really understand the difference between what you do and what the GDC does.

Emma Steele: Our ultimate aim, as with all the regulatory bodies involved in dentistry is about quality and safety but we are looking at a much broader set of standards. We are looking at premises within which a provider provides care to the patient from a patient outcome perspective. It is a very clear and

defined responsibility that I don't think is exactly the same as the GDC. We recognise that there are some sections which will be of interest to both bodies; that's why a memorandum of understanding and a data-sharing agreement is of vital importance, so we don't introduce duplication and unnecessary double jeopardy into this system; that's not our intention. It's to add value to the bits that are very different and to look at provider level performance. It will not be about individual performers.

Howard Jones, GDPC: Maintaining standards and protecting patients are the two benchmarks of the GDC. You have merely reinvented the wheel and are going to charge us to do so. I cannot see the benefit of this.

Emma Steele: The Care Quality Commission didn't create the regulations. The Health and Social Care Act was introduced by Parliament, and it is our responsibility to interpret the law and to apply it fairly and without unnecessary bureaucracy and that's what we're trying to do.

Roger Levy, Enfield and Haringey LDC: What mechanism do you have in place with your pilots to assess the financial and administrative consequences of compliance achievement? And on your consultations how are you intending to advise the PCTs of the consequences of all this on our clinical time and the effect on our UDA targets?

Alex Baylis: We fully recognise that most of dentistry is small businesses, and we don't want a sledge hammer to crack a nut. We are looking at things like how long does it take to make sure you've got the evidence to demonstrate compliance if we ask you. But our whole approach is not about having prescriptive checklists of extra things that you should be doing. We're starting from the position of saying dentistry is already a regulated profession. What we're doing is saying our safety net comes into effect when people fall below the line. So where there are providers who are providing an acceptable service already, our expectation is that we will not be expecting them to do extra work or to collect extra information beyond what we're doing. Our pilot will be checking that but our assumption is that this will not be huge amounts of extra work for providers.

Roy McBurnie, LDC Agenda Committee: In these days of financial restraints how can you quantify the health gain to patients by having these extra inspections? I would also further point out to you that you said we won't be able to trade until we are registered. I wasn't aware I was trading at the moment, and my colleagues here don't trade either. We're members of a profession with all that that entails. A profession means maximum trust and minimum administration. It seems to me that all we're getting now is maximum administration and minimum trust, and that's no way to carry forward a profession which has existed for centuries. It's in the Health and Social Care Act well fair enough, but don't you think in these days of financial restraints and financial strictures, that this unnecessary expense should be postponed until the country is in a better financial state?

Alex Baylis: For the providers who are providing an acceptable level of service, we're not expecting to do lots of extra inspections. We are expecting to validate that these providers have had an independent scrutiny and are okay to carry on. Where there are providers such as wholly private providers, where there is no public assurance at the moment, then we think there is a role for someone to come in and say that there is a system of checks in place. Now whether that translates into health gain, we will need to track that over time. It's not going to happen over-night, obviously. And in terms of cost/benefits that is something that again needs to be tracked over time. I'm just trying to make clear to you that that is where we're coming from; to minimise the bureaucracy and provide validation for services that are acceptable, but where there is no assurance or where there are concerns to add that extra safety net.

Question: The Care Quality Commission structure is based on the structure in America of the Office of Safety and Health Administration. Many people in this room are familiar with the case of Bergalis and Acer; a healthcare worker who intentionally infected his patients with HIV. OSHA failed fundamentally the duty of care to the patients; what assurance can you give us that the CQC will not forsake and let down your duty of care not only to ourselves as professionals but to our patients, and to whom are you responsible, and to whom are you registerable, and to whom are you accountable?

Emma Steele: I think the answer to the first part of your question is a combination of how we're going to use the quality and risk profile, and how capable our inspectorate workforce are. Those are skills that are being acquired at the moment and will continue to develop as we go through monitoring of compliance. The second part of your question; we're accountable to government and we're accountable to the public. We have to do a state of care report to Parliament on an annual basis where we detail what we've done and what impact we've had on healthcare so as we extend our remit beyond health and social care as in previous legislative arrangements under the Health and Social Care Act, we now have dentistry and will be including that. We also now have regular meetings with various public bodies where we are held to account publicly for what we do.

Robert Seath, East Sussex LDC: You have said that the government has created the need for this; that they feel that this regulation is necessary. You've already touched several times on the fact that you accept we're a very highly regulated profession. If the government feel that the regulatory checks so far are not fit for purpose should the CQC not be replacing rather than adding to all of these regulatory checks?

Alex Baylis: I couldn't possibly comment on that, but there is an issue in dentistry where there are anecdotal concerns that there are known cases around the country of people who are felt not to be up to standard and that the systems are not effective in dealing with them. The thing then is to make sure that what we're doing is not on top of or different to the overall systems so it has to fit with PCTs, has to fit with the GDC to make sure there are swift ways of getting concerns dealt with, and that's what we bring.

Robert Seath: If those systems that are present aren't picking up on these things, then surely that's ineffective and they should be eliminated?

Alex Baylis: Well that's not for us. We have our remit and we're looking to coordinate it to bring the systems together and fill gaps. If there's change to the system then it's for government rather than us.

Straw-polling

- Are delegates confident that non dentists will be able to judge the quality of care provided in dental practices?

Yes	5
No	139
Undecided	5

- Are delegates now confident that the process of registering all dentists will be completed by April 2011?

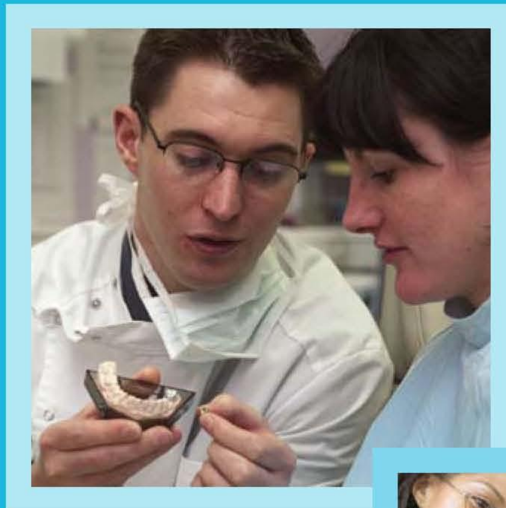
Yes	14
No	126
Undecided	13

Implementing the Steele Review

NHS dental services in England

An independent review led by Professor Jimmy Steele

June 2009



Professor Jimmy Steele, Newcastle University

Professor Jimmy Steele: Last year you very kindly invited me to speak to conference and as you know it was a difficult point in time. A lot has happened in the last year and I want to go over a little bit of what's happened, a little bit of what might yet happen, and look towards one or two points for the future.

Professor Jimmy Steele described how he saw the Steele Review process developing and what his hopes were.

When I was here last year the review had not yet been published. I spoke on the Friday and it was published on the Monday. I had just seen the Secretary of State on the Thursday afternoon before I spoke on the Friday morning. I'll be honest; at that stage I had no idea how the review that I had undertaken would play. There were a number of reasons why I had no clear idea of that and the main one is that it was an independent process which meant that it happened away from the dental team at the Department of Health. It happened with no ministerial or Secretary of State interference; which is quite a fortunate place to be. However, it's also quite a risky place to be because I didn't know what would happen next, and I had to take some decisions about how to present the material and the recommendations. One of the decisions I made was to keep it essentially non-ideological, because ideology, I think, can often get in the way of common sense and good healthcare, and that was the tack that I took with it. I was also aware that we live in a democracy, there was an election coming up, and that making strong recommendations one way or another in certain areas might be very difficult and potentially derail what was an important process.

So I had no idea how it would play. Andy Burnham came out in support of the recommendations, which was good. If you just consider for a moment what might have happened if he hadn't have done that. I think if that'd happened there would have been a couple of consequences. The first thing is that a number of people sitting to my right would have probably had a much quieter year. But I think also there would have been quite a risk of something just being imposed from above, and that's happened before in dentistry, and I'm glad to say that that hasn't happened. Whatever happens next; that hasn't happened in the last year. That political support for an independent process was probably quite important.

It might be worth just spending a moment or two thinking about back in mid 2009 what wasn't in there. The most obvious one is patient charges. We did discuss patient charges but we didn't make firm recommendations, which was deliberate. There were three reasons for this. The first is that if you start to alter charges, it has unknown effects on demand. If you start altering dentists' contracts, it has unknown effects on supply. Trying to alter both supply and demand at the same time was probably not going to be very sensible, and the priority we felt was to try and get the contracting arrangements right for dental practice, and then charges would need to be dealt with. I believe that patient charges do still need to be dealt with. The second is that changing charges requires primary legislation, and it's a difficult thing to do. The third thing is that for the government in power at that point, coming from the party that started the NHS, changing or raising patient charges was a very politically charged process.

The other thing we didn't talk about were lab fees which of course are aligned to patient charges, but we did throw some options in for that. I think there were two or three different options for work that requires laboratory input. There was and remains a strong case for a disassociation of the lab fee from the dentist's fee for the work that's done; I think that would be quite helpful.

We also didn't talk about a five year tie-in which as you know is part of government policy now. A five year tie-in is when you qualify, you're tied into the NHS for five years. We thought about this very carefully; it is quite a politically powerful and would have been a politically popular statement, but I think there are real risks in the practicality of a five year tie-in. Whilst I appreciate the principles and attraction of it, implementing it would be incredibly difficult and actually I don't think it's a particularly good thing for the NHS. I think there's a risk that you end up with quite a resentful younger practicing population.

We also didn't say much about UDAs because if we're talking about a contractual system which is largely based on capitation and quality perhaps with some element of activity payment, the importance of the UDAs is substantially reduced.

We did make one or two recommendations about banding, but that's why there was not a lot in there about that because we just saw it as irrelevant and probably better gone.

Let me just talk for a second about patient charges because I think this is a really important issue and its one that I think we need to think about quite carefully. I think the importance of thinking about charges in the context of the priorities for public investment is quite valid. On the left hand arrow it says "reducing priority for public investment". In other words, when you go up the triangle there's less priority for tax payers' money going into the system to pay for it, and the advanced and complex care's at the top. But also on the right hand side going up the arrow there's an "increasing personal preference and cost" so in other words as you go up through these things, there's probably increasing diversity in whether people want some of them or not. Where there's that element of variation in demand from the population I think it's reasonable to start thinking about differential charges as you go up that column. That would have some advantages. It would allow NHS dentistry to keep reasonably comprehensive. It would raise some revenues which would be important, and it would control demand. I think for the citizen that would be quite a good thing, and I think probably for the dentists it would be quite a good thing as well. We'll see what happens with patient charges over the next few years. It's obviously quite a long game this one, but I think something will have to happen.

When I then handed that report across there was something that I wasn't quite ready for; I handed it across and they said "yes, we'll support it and thank you and leave it with us". I did the press conference and got on the train and wondered "what happens next?" What happened next was actually absolutely

nothing for about three or four months. I now understand what that was about; it was about fighting for some money within the Department to set up the project management. However, it was pretty disconcerting at the time and what it led to me to realise was that it wasn't mine any more. I no longer controlled it; I just made some recommendations. I'm no longer in control of the process, because it had been an independent role and when I delivered that report my role was effectively finished.

Then things moved forward and things started to change in about November. I was given an option about whether I have any role or not in moving forwards. There were two choices. The first option is to say goodbye and when it all goes wrong I can cheer from the sidelines and go "well you never really understood it". I could have done that, and that would have been quite an easy option. The other option was to try to contribute and I was invited to be on the project board which meets once a month basically as a method of reporting, to try to make sure they didn't veer off course, and I've done that. But the work, the real work and the real decisions have been taken elsewhere and they've been taken in fact or been contributed to and taken by a lot of people who are in this room, who have worked incredibly hard to try and engage in the process and try and make sure that principles are adhered to, that dentists get a reasonable deal out of the process, as well as making sure that the basic themes are carried forward.

The Steel Implementation Programme was devised but I'm not in any control over it. Part of the Steele Implementation Programme was the employment of a project management team who have taken every recommendation to pieces and worked out every step that needs to be undertaken. It really is a complex process and I think that probably it was the right thing to do to get professional project management in. However, it does carry with it risks: there's a great risk of getting lost in translation which slows the process and I know it's a huge frustration for those who are involved but I think it's probably inevitable.

So where had the process got to? I have to say it's not been an easy thing; it's been particularly tough for those who've been deep in the discussions. The first thing that's happened that's been tangible is that a first wave pilots have been introduced. This was largely political expedience, and let's be completely honest about this: it was about getting something done early before the election. Having said that what it basically did is capture some things that were going on anyway and if we're being really honest, that good, innovative stuff that was happening at PCT levels should have already been collected and the Department should have known about it. This was just a mechanism for pulling it together.

An oral health assessment has been scoped and planned out. A set of outcomes or quality measures have been generated, and are still under discussion but there's something to work with now. PCTs and practices who are interested in being involved in second wave pilots have been identified, and the contract options have been narrowed down. So a lot of the detail has now been put in place. There's a lot more detail to go, but that's what's happened essentially so far.

After the election there has been a period of uncertainty, because new people come into post and decisions have to made and direction has to be taken. If you look at manifesto promises, they're just incredibly broad. So they then have to be interpreted at a local level to see what's going to happen. I think that the coalition government will want to make its mark. They want to make their mark on dentistry as with everything else. I know John and Susie and some of the dental team at the Department of Health have met with the minister; I've not. Although as I understand it that is planned.

What I'm about to talk about now is what I think is in, and what I think is not. Prevention is in. That's very popular. I am growing to dislike the term 'prevention', because I think it can be very misleading. In my mind a lot of what this is about, is clinicians using their own wit, intelligence and experience to get the message across, as opposed to necessarily any particular procedure or material. I think that's a really complex message which is quite difficult for politicians and commissioners to understand, and I think that it's the job of all of us to try and reflect on what that involves and what we need to achieve that.

Blended contracts are in, and as you know that was one of the main recommendations of the review. Around capitation registration and quality and whether or not there may be an activity element is still up for some discussion; I think there are some options there to be quite imaginative about that.

It looks like pilots are probably in; that's a very informal statement but I think that's probably the direction of travel. And let's face it; if there's going to be contractual change, and they do seem to be committed to contractual change, then pilots would be pretty sensible.

One of the big questions that came up last night is who will commission services? That is critical. Just today, Andrew Lansley has made some comments about a fundamental rethink of the organisation of the NHS, but I think that one of the things that will change is how dental services are commissioned. There's talk of going to GP commissioning – I think it would be absolutely ludicrous for GPs to commission dental services I have to say – absolute madness. However, there are options here. Not for GPs to commission, but if we're moving away from PCTs I think there might be great sense in having larger commissioning units, because at least you might be able to put together a team of some expertise, rather than what we have which is expertise dissolved across 152 PCTs at the moment, with no particular expertise in dentistry in many places. So I think there might be an opportunity there that we could work with.

We need to await the next stage and just to remind you that the Minister actually doesn't know very much. You can't expect a Minister to know very much. They have no background in dentistry so they wait and they listen to the messages that come in. So the messages that come in – and we've all got a role in this – have to be appropriate.

There are a few concerns over the last few months as things have progressed that have come up. Quality measures, the oral health assessment, dentistry by numbers, advanced care, and the concept of micro-management. I'll just take each of these briefly.

The first thing about quality measures is that I think they are inevitable. There is a risk that quality measures become completely meaningless and I think everybody here has a role in trying to make sure that that doesn't happen. At the same time I think we also have to accept that quality measures probably have to be just a little bit challenging. If quality measures are all about things that are easy then they'd become meaningless quite quickly. I think they will also be standardised. Some may be attached to payment. Some may be for monitoring. Some may be for self-monitoring. I think there's still discussion to be had about how that will work in some detail. Suffice it to say that I think any quality component of the contract won't be very large anyway. But they can be used in all three ways, and that level of detail and monitoring is, I think, inevitable. The other thing that's really important is that they should be evolutionary. So the first ones that appear may not be right, or they may be exhausted fairly quickly, so this will be an ongoing process and I think it's important to understand that and that's why there's pilots there. Ultimately I think they should be outcome based. In other words they should be based on the success of the care that's provided. That's very difficult in the early stages because there's no baseline, but over five or ten years we should be getting to that point. The other point to remember is that they're probably most suitable for relatively local comparison. In other words it may be unfair to compare Sunderland with Surbiton, but it's reasonable to compare Sunderland with Sunderland and Surbiton with Surbiton. So, how they're used is important and again that's a message and something for discussion perhaps at more local level.

The oral health assessment is the other thing that's been quite vexing and quite challenging. The concept of having an assessment that is formalised for patients is a challenge, and we've made some progress on this, or at least the group that's been working on it has made some progress. I think there's a real question of for whom and when this should be done; I think there's a real risk of trying to do oral health assessments in everybody from day one. So there's discussion about how this should be introduced. However, I think the concept of an oral health assessment, a formalised way of making sure that the process is undertaken, is probably right.

The second thing is what IT is required and one of the more positive things that's happened recently is that one of the commissioning groups of PCTs in the North East, in Teeside, have been working with Kodak R4 on their system to try and programme it in, and it's all pretty possible. All the material's there, it just has to be reordered. There are a few bits that need to be ironed out, but that looks as if it's going to be

reasonably feasible. I think the other point is that if you're going to have an IT-based thing with computed elements, these have to be advisory. We've all had at least five years training and a lot of time beyond that; you can make decisions, and you can override that. There's no problem. I think if you start to override it every time either the system's wrong in which case that needs to be changed, and it will be a common problem, or you're making decisions which seem to be at odds with evidence. I think that's why it needs to be piloted; to get these glitches out.

One of the other things that's been really difficult has been advanced care, and it's been very difficult for a number of reasons and I just want to split it down into three elements. The first is the clinical eligibility of the patient. That's the bit about progressing through the pathway and not undertaking advanced care where it is inappropriate because of the oral health risks that are present. That's something which I think could be introduced in the pilots and could be run through rather easily. There are challenges there; I've been trying to operate this with my own patients and there are people who you feel need to progress through it and things can be far from perfect; accept that and that can be built in. There's also clinical guidelines within advanced care in terms of what the NHS will support; that's one area of clarity that I think we really need. And again, I think a start can be made on that. The point of this is, and the reason that clinical guidelines are required, is to allow the clinician to say "no I'm not going to do that" because if we can't actually rule certain things out we're not going to be able to rule in the other things that we might want to do. I would like it to be possible for edentulous patients who are in need of two implants and over denture to have two implants and over denture but it probably means there's other things that we don't do. The start of that process is being clear about when we can say "no this is silly we're not going to take them on". I hope that that will be in the pilots and it's certainly being discussed.

The third part is about skill mixed commissioning in contracts, and that is much harder because it's a much longer term gain. One of the recommendations we made was that there should be separate contracts in the way that there are for orthodontics or surgeons for certain parts of particularly complex care. In order to do that you've got to have the skill mix, you've got to have the commissioning strength and the commissioning intelligence to be able to do that, and I don't think we're there yet. However, I do think that that should remain a long term ambition; it's about getting people to do what they're best at and what they most want to do. We'll take that out of the equation for the moment because I think that's going to be difficult within the pilots, but the other two things I think are viable.

In terms of micromanagement, I'm not sure who's going to do the micromanagement because there's going to be some fairly massive cuts in health service administration. I think what people want is genuinely informed contract management, and there's no easy solution to that, but I do think that bigger commissioning groups does make a lot of sense. Whatever happens, it shouldn't be GPs. I think it would also be wrong to do it centrally; that would be my view. But larger commissioning groups at 20 PCT level would make a bit more sense and be a bit more light touch.

Remember that the Minister doesn't know very much and it's our job to get the language right and engage. The fact that that has happened so far is very positive. We face a choice because something will happen, and it will either be with the profession - and over the past year there might have been frustrations but it has been with the profession - and if it's not with the profession it will be to the profession. Therefore, thinking about our messaging and the language that we use and how we present dentistry at that level, at PCT or SHA level, or to patient level, is terribly important.

In terms of our NHS we've got quite a lot to be proud of, including a lot of what happens in NHS dentistry. And I think everybody in this room is an NHS dentist. 60 years of NHS dentistry has served us okay but it is time I think to move on, the world has changed and something is going to happen and I would urge you to be positive and take part in that process. Thank you very much.

Question and Answer Session

Jim Lafferty, Sheffield LDC: Jimmy your programme's predicated on IT... The government has promised to axe NHS IT programmes; the last two meetings of the IT committee in the implementation programme have been cancelled; any thoughts? Are you worried?

Jimmy Steele: I am worried about the IT. However, there are different levels of IT here. There's IT that works in the practice; Software of Excellence and Kodak R4, and the first and most important level, is to get that system aligned with what we might want to do. That system is for a wider global market and it's very much orientated towards fee for service and payment for item. I was astonished when I went to look at R4, and I said "I want to record the plaque level or some level of indication of the level of risk in this mouth", and I had to go through about 12 different menus to get to it; it's just wrongly set up. So there are things that could be done there quite easily, and they're working on that, which is supportive, because if you can't get that right then you can't get the rest of the process right. But it is pretty simple stuff. So I think that can be lined up and it's up to the companies to do that and I think it's probably worth their while to do it.

What is much more of a problem is linking the IT to collecting data at above the practice level – at PCT or national level, and being able to transfer the data from one to the other. I'm really keen that that is addressed, but I'm not sure that that is a priority for the meantime. Priority for the short term is to get the commercial IT systems aligned with things like the pathway and I think that can be done reasonably easily. There's a bit of a question then about who pays for the IT systems, but the PCTs should have an interest in that to be honest.

Phil Davenport, GDPC

Phil Davenport, GDPC: Can I return to advanced care? You talked about developing clinical guidelines and about what the NHS will support. Do you mean support financially? Do you mean support in terms of health improvement? And do you agree that that's the one aspect that could be very heavily influenced by political interference?

Jimmy Steele: Yes it could be but I think ultimately if it's too political and top down some erroneous decisions have been made. One of my favourite things is endodontic re-treatments which is something that I don't think the NHS should necessarily support, except perhaps in very specific circumstances, and that can be covered and there can be exceptions. We might also start arguing about whether we are going to be prepared to do endodontics on molar teeth or not. It's a difficult one but we can be having these discussions. That also feeds into the stuff about the patient's own risks and at what point you say "no" and at what point you say "yes", and I think it's partly about managing demand. That's empowering dentists to be able to say "no". Whatever is introduced to begin with will be flawed because you can't have evidence based guidelines in the way that the third molar guidelines work for example because there just isn't the evidence base, but there is a lot of good practice and common sense out there.

Philip: Isn't there a risk with the advanced care guidelines that we could move more towards a core service, with practitioners saying to patients; "ok I can actually do your multiple crowns, I can do them on the NHS. I can refer you to a specialist; you'll have to wait six, eighteen months whatever. But if you want to pay me privately I'll do them for you now"?

Jimmy Steele: That's already happening. That's not a new phenomenon. Yes of course there's that risk but that risk is apparent and already in operation. I don't like the term 'core service' because it can mean a number of different things. It can either mean restricting those who get care or it can mean restricting the care that everybody gets, and it's not clear. I understand what you're saying and if I'm saying that certain things should be missed out you might count that as core service, but right now we already have a core service.

Anwer Dhanji, Ealing, Hammersmith and Hounslow LDC: The Cochrane Collaboration suggests that less than five % of trials from the medical profession are actually the gold standard randomised controlled trials, and in dentistry it is even less than that. So who is actually going to set these care pathways? Who are these people who will come up with a care pathway that we as clinicians cannot individually find for all patients?

Jimmy Steele: What you're saying about Cochrane Collaborations and trials are quite right; you're never going to have a trial on a care pathway. It's almost impossible to do. The care pathway that we set out was very basic, and it was subject to wide consultation, including with the profession. When we put that up, most people were saying "well that's what we do anyway". There was a process of consultation, which to a certain extent is still going on. I don't think there's anything complicated about it; the difficult thing is 'advanced care'. That presents you with a difficult argument. There might be times when you have to say "I've taken all that into account and I'm going to have to progress, even though things aren't ideal". I think that's probably acceptable. But the principle of evaluating and monitoring, limiting and restricting risks before moving ahead, is a sensible one.

Straw-polling

- How confident are delegates that Professor Steele's recommendations will be implemented, now that we have a new Government?

Confident	15
Unsure	105
Not confident	49

PDS Plus and the future

Dr Mike Warburton, Department of Health

What struck me when I listened to Richard and Phil Hammonds' speeches was that actually, and you may not see it like this, but it's a time of tremendous opportunity. The new coalition government have said that they want to abolish all of those targets; they want to focus on health outcomes. They want to focus on professional autonomy. So, providers doing what they think is best for the patient and not micromanaging them. Giving them a broad health outcome and rewarding them for doing so. And below those headlines I know they aren't clear on the detail yet. I know Jimmy will have told you about the work programme that he's been leading or working with. There is a huge opportunity to shape the future at the moment and shape it in a way that the profession would like. So it could be a very positive time.

Mike Warburton from the Department of Health, described his work developing PDS Pus and what future he saw for the project.

Just by way of introduction; my background is as a GP. I worked as a GP for 15 years in a small practice in a semi-rural setting. Whilst it's very different from dentistry; it is a small business. We had all the pressures of managing a team, a budget, of dealing with the PCT, of reduced income and increasing expenses. So whilst it is different from dentistry I think I can empathise with some of the challenges that you face. I then worked in a PCT where I worked as a director of commissioning for five years. That was a fantastic opportunity, and I was responsible for commissioning all services; hospital services, mental health services, and dental services. There were a number of things which I learnt during that time. One of the things was the way we communicate between managers and professionals, and how often we get it wrong. As a professional - a doctor working in a management environment - I found out how difficult it was. So the reason I wanted to come today was to try and talk through what issues we are trying to address and what issues PCTs are trying to address, direct to you, because somewhere in that communication, lots of things get misunderstood and misrepresented.

Just a final bit about me; I joined the Department of Health about three years ago to lead the GP access programme, and that was a commissioning role and a GP role. It was perceived to go well; we put a lot of new services on the ground, and then they asked me to lead the dental access programme. The role of the programme is to support the NHS to deliver improved access. It's not to tell you how to do it, it's not to performance manage you. It's to help the PCTs and help providers to deliver access, whatever that means. I do a lot of listening to PCTs and over the last year I've done a lot of listening to dentists. So if there's more that we can do for dentists I'm really keen to hear from any of you about what you think we should be doing.

As you know, the health service has gone through huge change, and a period of huge investment that built capacity. This reduced waiting to 18 weeks, provided capacity in A&E departments, provided GP access, and over the last two years; additional money, ring-fenced allocation to dentistry to improve dental access. Then Darzi came along and focused much more on quality issues, patient experience, and safety. Now the new government; Earl Howe has already said that he's going to focus on access and on contractual reform. I'll show you what Andrew Lansley's priorities have been. You'll see the words "patient experience" and "patient involvement" there a lot. So first of all; a patient-led NHS, and a focus on health outcomes, rather than on process and targets. They've definitely heard why chasing a UDA target isn't a great idea for health outcomes, and so the question is "what are those health outcome measures for dentistry?" We've got some proxies for that, but we're certainly not there yet. So what are those PROMS, those patient related outcome measures?

A more autonomous and accountable system; the idea is that you do have autonomous providers - GPs, dentists, hospitals, community trusts, doing what they do for patients and have some regulation there. But not micromanagement. That's the theory. How it plays out in practice we will see. This is what the coalition have said they want. This is probably the only thing we've got in writing; "a new dentistry contract, a focus on achieving good dental health, and increasing access to dentistry and a focus on oral health of school children".

The access programme has four main strands. The top three are all support strands. So, support to a PCT's procurement procedures, support to PCT's contract management, and better communications to the patients. Because there's a real issue; in some areas we've got really good access, but the perception is that you can't get a dentist in there. So we've done some work around supporting PCTs to do that better. The only thing I'll say on our new measure is that from next April, PCTs won't be measured on their 24 month access figure - that historic supply measure. They'll be measured on a patient experience measure; "have you tried to access NHS dentistry and were you successful?" It really is quite a patient focused outcome measure. The PCTs will have their results from the first survey – a thousand people in each PCT – which is statistically significant at PCT level, to say what their figure is now. They'll have their figures either today or Monday, and they'll be able to reassess what their access goal is for their particular population. We know that with PCTs and their demand estimates - how much access you need - some of them over overestimated, and probably some of them underestimated, so this is another piece of information that will help them get that right.

On procurement: the reason why the PDS+ template agreement was developed was that in 2007/8 there was an 11% increase in the ring-fenced allocation for dentistry. And what we saw at the end of that year was a fall in access. So PCTs had been given a lot more money but there was less access after it. Some of it was probably just a lag, some of those investments would take time to come on stream. But some of it; that investment hadn't delivered access. So the Director General at the time said that if more money was to be given, it should be ensured that it would deliver access. The PDS template agreement was designed to deliver that access. It was just at the time of Jimmy Steele's review, and coming out of that work was

a need to focus on quality as well as access and UDAs, so we built that into the contract. It wasn't the prime purpose, but it was a good opportunity to build in some quality markers. It was never intended to be the forerunner of any national contracts. It was only intended for a relatively small number of procurements, and my job in that was to ensure that the template agreement was attractive enough to bidders, and that it delivered what PCTs were saying they needed. PCTs needed a contractual framework that delivered access, and if it wasn't being delivered, some levers to issue a breach notice and end that contract that was not delivering.

The contract has been successful in as much as there's been lots of bidders for every scheme. Under the GP programme that we led, we had out of three hundred procurements about ten or fifteen that had to go round the loop again; they all got there in the end. So far we haven't had any in dentistry that I'm aware of and so far we haven't had any fail through lack of interest. It's just starting; we don't know what it'll show. We will be monitoring it, and we really want to hear the feedback. We've got an event at the end of June for people who have won contracts to give us feedback on how it's working on the ground. One of the issues is that we develop guidance for PCTs, and PCs sometimes follow that guidance and sometimes don't and that isn't helpful, because we're saying it should work like this but they're doing something different. We want to hear that from providers; is something funny going on? Can we do anything about it? And our role is to support PCTs, but we can't tell them what to do.

We know that over the last year we've had a 1.4million increase in access and we know that we've got around three hundred procurements on the books that have either happened or will happen within the year. So there has been a real step change in capacity, and most of that money and most of those procurements are in the southern half of the country because that's where the access gap was bigger. In the north east they got relatively little additional money because their access was already good. I'm not sure that's fair but that's how the money was allocated.

Contract management is also going to be very important this year. Getting efficiencies from all health contracts whether that's acute contracts, GP contracts or dental contracts is going to be a theme going forward in this financial climate. Therefore the contract management handbook was something that PCTs was needed. The capacity and capability of PCTs and commissioners is variable. It's just as with any other professional group; the quality is variable. So the handbook and workshops around the country, one in every region to support to PCTs do better contract management was the starting point. What PCTs said to us is "we need to have a discussion with LDCs about the framework for working. What are the rules of the game? Let's agree them together and let's stick to those". So that's what that performance management toolkit is. It's a template agreement for the PCTs to take to their LDCs and say "this is what we think should happen in these circumstances, do you agree?" We'll pass all of these through the BDA first of all, and so they'll go to PCTs, but they can still change them, they can still not use them, they still have their own versions, and it's just as a guide. If everybody's trying to develop one, we're trying to do that first, and we'll consult with everybody in doing so. As part of that, there's a compact. I think it was developed in the north west between dentists and PCTs, saying "we expect this from our providers, and the providers say we expect this from our commissioners". So it's an explicit understanding of the way they're going to work together.

I've explained where the new PDS+ contract came from. I know we didn't please everybody and that's why it's on the agenda, but we did really try and listen to dentists. We spent a long time, and the BDA spent a long time in trying to get it right from their perspective. We did look at quarterly payments and quarterly reconciliation. However, dentists said for cash flow that they wanted even monthly payments with annual reconciliation, and a year's grace for the key performance indicators. The contractor flexibility is really important, as well as putting in a continuation clause. The contract length is five seven or ten years but as long as you've got a continuation clause in it, the PCT doesn't need to go through procurement to repeat that every five seven or ten years, so they can continue it without procurement. This is important for dentists but also in the big price for these contracts.

‘Diminished reliance on UDAs’ is something that everybody said we should be bringing in. That’s what we tried to have in the template agreement. However, it was only ever planned for around 150 procurements. Of the three hundred procurements we think around 150 would be PDS+. Some happened before the PDS+ contract was available and some people haven’t used it. PCTs make their own judgement and it is there if they want to use it; it’s not imposed in any way. So we expect around 150, which is nothing compared to the existing national contract, but it’s not a model for that.

I’m going to go on to re-attendance because it’s an important issue. Every patient who comes back is as a result of a clinical examination and discussion with the patient, and that should give them their recall interval. To say what’s wrong or right at a very high level is very difficult. Therefore I think it’s a legitimate area to look at. I remember when I was the Director of Commissioning I worked with all commissions in reducing follow-ups in hospital, and it was really difficult. There are social and clinical reasons for re-attendance that are absolutely understandable. And there’s patient demand; everyone of my age knows you go to the dentist every six months. So there are huge drivers that are driving re-attendance, but we need to get below those and start to understand it more effectively if we’re going to make the best use of our capacity.

With regards to marketing; we carried out four campaigns in four PCTs to see what was the most effective. The headline view on that was that campaigns made only a little difference to public perception. These were radio ads. They did drive people to help-lines very effectively. In Brighton I think there was a 150% increase in calls to the help-line after the campaign, so it drives people. But they are people looking for a dentist. However, they’re a tiny percent of the people that need to change that perception. Therefore we need to think about what we can do in this tight financial climate to make patients aware of services, and one of the best examples is just good signage in dental surgeries; big banners saying ‘NHS dentistry here’, just something that makes the patients aware that NHS dentistry is available. I think there’s a place for campaigns but I’m not sure we’re going to afford many of them looking forward.

The patients did value leaflets with dentist names on them, with names and addresses. One of the key sources of information for patients, NHS Choices, has 9million hits a month. You can go on NHS Choices, you can click on ‘Find a dentist’ and you get inaccurate information. You need to work with PCTs to make sure that information is up to date; patients try and they give up. So we’ve got to improve that information on NHS Choices. There are the questions in the GP patient survey: ‘When did you last try to get an NHS dental appointment?’, and ‘Were you successful?’, and there’s some sub-questions as well.

One of the things that’s quite interesting is some PCTs are using existing contract flexibilities to reduce the reliance on UDAs. So with an annual contract variation, where either a proportion of the contract is given as a lump sum -Manchester is a £10,000 lump sum given to improve access - look at clinical governance and quality issues. In other areas they’ve done sessional payments and that allows you to not chase the UDA targets in the same way if

there are enough of those sessional payments, and I think there's some value in that, if we have to make changes in the short term before any contract reform. It's a PCT by PCT process, which means there'll be all sorts of variation. It takes quite a mature experienced commissioner to be able to make that sort of thing work but I think where they can there's huge potential in the short term.

'Clinical engagement'; it's so important that clinicians and managers work together on this. On the role of the LDC; it's absolutely key, and that's why I'm delighted to be here, to try and get across what PCTs are trying to achieve. If you think what PCTs are going through; you've got your lone dental commissioner with fifty contracts, who's a relatively junior manager, not huge support from within the organisation because they're focused on the acute trust, and just at this time they're thinking about 30% of their workforce are going to be made redundant, and above them the whole structure of the NHS will change and they're going to be devolving their responsibility to GP commissioners. So it's a hugely difficult time for your PCTs and your PCT commissioners, and in that scenario, if your LDC is working with you and coming up with some of the solutions, they'll welcome you with open arms. I think it's a real opportunity for LDCs to take that role. It happens in some ways, and Professor Drinkwater's report for the BDA showed that there are some really good relationships out there. Without that, PCTs are going to be struggling over the next 18 months. It's going to be a tough time, especially when we think about contract reform coming up and a whole range of other challenges for the PCT. So it's a real opportunity for LDCs to help their PCTs find the answer. Then you can be in control.

Question and answer session

Question: You said that you were looking at 150 procurements. Could you tell me why you wouldn't invest that money into existing practices to improve access, rather than setting up new procurements?

Mike Warburton: Yes. It was really that what had happened in the previous year is that money had gone to existing providers, and we hadn't seen an improvement in access. I don't think that means you can never get better access through the existing providers, and in fact I know you can. But the dictat and the approach from the Department of Health is that any new big investment should go through an open and transparent process. It doesn't matter if it's a hospital service, a community service, they're the rules. So PCTs, to stick to those rules, had to go through a procurement. It didn't mean existing providers couldn't bid of course. But it did mean you couldn't just give that provider an extra ten grand and that provider an extra hundred grand; you couldn't do that in the rules.

Stuart Eaborn, North Tyne LDC: Could you tell me why you've developed a system which virtually excludes young practitioners from getting set up in their own practices?

Mike Warburton: I think what you mean is that the procurement process doesn't allow young practitioners to win those bids, and I have to say that that's not the case at all, and one of the first contracts was won by associates. We've seen that these contracts have gone to all sorts of bidders; some corporate, but not that many. We've had associates come to us to say "we have had an opportunity, thank you". We could probably have done more, and I appreciate it's not perfect, but it has helped some associates get their own practice.

Tony Clough, LDC Rep: I've got two questions. The first one is that we've seen that you've got 353 tendering processes that you've gone through. We know from dealing with our members that the average UDA value for these is coming at about £20, which is quite low. One of the things you've mentioned is that you're looking for access but you're also looking for quality, and really I'm just wondering how you equate a UDA value of £20 with quality.

The second question is you mention that access is worked out on numbers of new patients. The NHS has a rather interesting way of calculating new patients, because you have a rolling 24 month period, and as you take on new patients they fall off the other end. So although you may say "my practice saw a thousand new patients last year" in fact your figures will only show about 80 or 90. Could you also comment on that as well?

Mike Warburton: With the first question, I don't know if that £20 is right or wrong. We don't have that information. But the process asks bidders to demonstrate how they're going to show quality. It asks them for their processes and reassurance about how they're going to deliver a quality service, and then they put in a bid. They're judged on getting past the line on quality issues, then they say what the bid price is. They're saying "I can deliver this service for £x", and it's not generated by anybody else. So it's whatever the market says the price is, rather than the government or a PCT.

The second question – the measure is not a particularly helpful measure. PCTs are measured on it as well, and that's why we're moving to a patient experience measure for the future. So PCTs are not measured on that historic supply measure. They had no control over that, two years ago. We'll still keep that management information so we know what's happening but I think the sooner we get away from that the better really.

Eddie Crouch, Birmingham LDC: Could you tell us how much your project has cost, and do you think it's a good use of taxpayers' money?

Mike Warburton: Of course won't give you a figure for that. But what I will tell you is what the size of the support is, and tell you why I think it's excellent value for money. First of all, my team is now, and from the summer; myself, a project manager and a secretary. Up until now I have also had the commercial team's support and they finish in the summer. There were four people working on the procurements, and they supported PCTs. And what we do is basically we do once what every PCT has to do. So we develop resources and tools that otherwise everybody else would have to do themselves. So the template agreement, the IT, the scoring, the evaluation, is done for PCTs, so it saves the PCT doing all that. The procurement process is time-consuming and costly in person hours, and I think the new government have a decision to make on that one. However, that's the European rules that we have to follow for any significant investment; you have to go through an open and transparent process. So given that PCTs have to do it, why don't we do some of those things once? The workshops again were hugely well attended and hugely well evaluated by PCTs. So I genuinely haven't got the cost off the top of my head but I do think it is good value for money.

Jerry Asquith, LDC Rep: The word on the street is that you and Barry Cockcroft don't get on very well, and under the last Secretary of State you obviously won the battle. Have you had meetings with Earl Howe yet as to who's going to be implementing dental changes in the next few years?

Mike Warburton: I get on fantastically with Barry Cockcroft and genuinely I promise you I've never had a cross word with Barry and I think we see eye to eye on everything we've discussed. We don't discuss a huge amount together. My role is very much NHS focused. So I'm out a lot. I spend probably just two days a week in the office, one day a week with the dental policy team. And my influence in the dental policy team and the ministers is very minimal. My role is to take whatever the NHS is being given as a target and help them implement it. Through things like the PDS+ contract and all the conversations I have got some feedback to feed into the policy team, and I do that. However, I'm not one of the policy team and they can happily disregard that.

Ian Gordon, Tees LDC: I had better declare interest to Conference; I am a provider in a PDS+ contract. As Mike will know, it wasn't signed without a fight from me as a provider, and the contract as it was presented to us was completely unsignable in terms of things like the indemnity clauses, and we did have to get that changed. However, I think it was one of the first PDS+ contracts in the country, and there were quite a lot of amendments made at that time. My question is really on the point of good will and on the point of trust. Why do you think the contract was oriented to the protection of PCTs in very much a win/lose way, where it was very much to protect the PCT and not those of us who invest in practices. Why wasn't it used as a pilot, so that the information we got could roll into any other reviews? If it does roll into a review do you think the PDS+ will become part of the mainstream, new GDS that this next administration comes out with?

Mike Warburton: Dealing with the last question first, I don't think this new PDS is going to roll into a new contract. I do think that we'll learn, and we capture all that data so that therefore we can use it.

I understand completely with the win/lose PCT thing - that's how you perceive it and I understand why. However, PCTs had a very clear ask of us; that we have a contract that specifies access and quality markers and has levers and sanctions if they are not met. That's what they asked for and that's what they got. We had to make sure it was attractive enough to get enough bidders to apply, and I think we did do that. I think it's not as attractive as you'd like it, and therefore almost certainly it couldn't be a national contract because we would need the vast majority of you to like whatever's going to come out. I know that and I feed that back. In discussions I've had since it came out, I've learnt a huge amount, and looking forward to a new contract I think there are huge amounts we could do to make it more balanced.

Straw-polling

- How have PDS Plus contracts been received in your area?

Enthusiastically	3
Unenthusiastically	101
Uncertain	48

- Given the impending cuts to the healthcare budget, do delegates feel that PCT commissioners will have the capacity necessary to carry out the micro-management of contracts, required under PDS Plus?

Yes	5
No	131
Undecided	8

LDC Conference Elections

The results of the elections held at LDC Conference 2010 are as follows:

Chair Elect for Conference 2011:
Jim Lafferty

Honorary Treasurer of Conference:
Tim Harker

Two Honorary Auditors to the Conference:
Brett Sinson
Jonathan Randall

Conference Representative to the Agenda Committee
Jane Ainsworth

Two Representatives to the GDPC:
Jonathan Randall [3 years]
Jerry Asquith [1 year]

Representative to the Board of Managers of the British Dental Guild
Clive Harris

Jim Lafferty was elected Chair Elect from LDC Conference. He will Chair the Conference in 2012

New Chair, Mick Armstrong, takes office

Richard Emms presents the new Chair of Conference, Mick Armstrong, with the Chain of Office