LDC Conference Report 2009

Letter from the Conference Chair, Jerry Asquith

Thank you all for the great honour of electing me to chair the 58th Annual Conference of Local Dental Committees.

Arranging for Professor Jimmy Steele to speak proved a tricky task as the publication date of the Review was not finalised until near the Conference. As a result, what Professor Steele would be able to say at the Conference was unclear until the final few days of planning. With the help and support of my Conference Committee, we were able to plan for both eventualities and Professor Steele provided us with an entertaining and thought provoking presentation, illuminating many of the issues covered by the work of his Review. Above all, Professor Steele emphasised the importance of good communication and engaging with both the profession and the public.

I wish to extend my thanks to all the members of the Panel for sharing their insights and thoughts with the Conference. We had a most stimulating conversation around a variety of topics related to 'professionalism', discussing the regulation of dentistry, training, incentives, the professionalism of PCTs and the professional responsibilities of clinicians.

Thank you to delegates for submitting a number of motions on topics of mutual interest. Whilst a few motions encouraged some good debate, the majority were carried on issues that we have all felt strongly about for some time. I hope that delegates will continue submitting motions that provide us with the opportunity to thoroughly debate the central issues of the day.

I have truly enjoyed my involvement with the Conference over the last twelve months and I hope to be able to participate in and support future LDC conferences. Celebrating my half-century birthday at LDC Conference and inviting family and friends to the dinner, is perhaps asking for trouble. I had a lovely evening and very much enjoyed spending the

night eating and drinking with friends and colleagues at such a lovely venue, right on the river Thames.

I am particularly looking forward to next year's Conference, as we will be beginning to see the policy outcomes of the Review of NHS Dentistry from Professor Steele. This Conference will provide an invaluable platform for the profession to react to the ongoing work, as a result of Professor Steele's recommendations to the Secretary of State.

Finally, I wanted to thank again the members of the Conference Committee who have provided invaluable advice and support throughout my tenure as Conference Chair. I also wanted to extend my thanks to the delegates of LDC Conference, who continue to represent the profession at what is an important event for a profession about which, we all care deeply. I am hopeful that future conferences will concentrate on getting our 'messaging' right, so that dentistry maintains its position as an esteemed profession.

Jerry Asquith

Chair 2009

The Chair with his guests at the LDC Conference dinner 2009

Update from the Chair of the General Dental Practice Committee, John Milne

John Milne introduced himself and the recent work of the GDPC, telling colleagues that he was acutely aware that the economic downturn brought with it particular challenges for those within the private sector, in addition to the increasing weight of regulation and inspection.

However, as the key responsibility of LDCs, John concentrated on the NHS. He recognised the importance of LDCs in improving the working lives of colleagues practising in the NHS, stating that a discontented frustrated workforce is both bad for the NHS and bad for patients. He highlighted the importance of GDPC, the BDA and LDCs working together, in the face of the fast-moving reforms.

John also talked about ongoing problems associated with the inflexible way that many PCTs interpret the contract; the way that the UDA is often treated as the only thing that matters; and the priority of driving up the quantity of treatments and increasing access meaning that some PCTs think that the only thing that matters is driving the cost down, without understanding the consequences. He noted that a quality NHS service could not be provided on a minimal budget, and that PCTs needed to invest in sustainable services and health promotion, which has been recognised within World Class Commissioning.

John talked about working towards regular constructive engagement with the Department of Health and the CDO Barry Cockcroft, and that he was keen to meet with the Department every two months. He also mentioned the recent opportunities he had to meet with parliamentarians, noting that working with the Conservatives with a view to the approaching general election, was an important part of his work.

John noted his discussions with Anne Keen about the loss of goodwill in the sale of practices. He also mentioned the discussions he had had about HTM 01-05, recognising the fears of the profession and the difficulties with all practices moving to 'best practice'. John noted that the meeting with the minister was positive and that he would be meeting with the Health Secretary, after the publication of the Professor Steele's Review. John also thanked Professor Steele for the opportunities that he and his Executive officers had been given to engage with the work of the Review.

John Milne reinforced his belief in the importance of LDCs in this climate of local commissioning. He stressed that engagement between the PCTs and the profession was of paramount importance. He also mentioned the forthcoming publication from the BDA on getting the local commissioning of dental services right.

John urged PCTs to engage the profession when planning, designing, and commissioning local services as local practitioners have skills and expertise often untapped by PCTs.

He also spent time talking about the rights of Performers in the NHS, noting their right to a pension, delivered through the correct contributions, their right to sick pay and their right to maternity and paternity pay. John also highlighted the relationships between dentists as a crucial part of being professional. Not exploiting colleagues, particularly when those from other countries may not know what their entitlements are, must play a part in being professional.

Finally, John noted the opportunities that a period of policy change offers the dental profession, stressing that it was for the LDCs to seize that opportunity in order to demand a better future for the dentists they represent.

The Steele Review, Professor Jimmy Steele

Professor Steele, leading the Independent Review of NHS Dentistry, spoke about his work.

Professor Steele articulated how pleased he had been to have been asked to be to take on the work not least because of his concern about what was happening in the profession. He outlined the process the review team had undertaken and highlighted some of their key findings, whilst considering where both the profession and LDCs sit within all the Review.

He began by talking about the origins of dentistry and oral health, emphasising the impact of changing demographics and, therefore, the relatively new importance of 'teeth for life' and this concept in NHS dentistry.

Professor Steele noted that over the six month period of his research, he has had to deal with some very strong and contrasting opinions. In particular, whilst the profession has been hostile to the 2006 reforms to NHS dentistry, conversely the Department of Health has been asking why, when more money has gone into the system, they are not achieving the access they set out to achieve.

Professor Steele highlighted a particular concern which had emerged as part t of his work; that there is significant confusion amongst patients about both what the NHS offers, and what dentists can do for them. Patients are suspicious about why decisions are made in the way they are and this has resulted in a loss of trust of NHS dentists and NHS dentistry. He recognised that this was an unhelpful situation for patients and the profession and was something that all practitioners had a responsibility to think about and play their part in addressing.

Professor Steele emphasised that the Secretary of State has real power to affect change and whilst they *listen* to the profession, what they *hear* is the public. For this reason, Professor Steele urged delegates to be particularly mindful of the messages sent from the profession to the public. The three key stakeholders – dentists, patients and the NHS – all have a valid, if differing, grievance, which good communication on all sides could go some way towards resolving.

He also recognised that there is a great deal of extremely good world class dentistry happening, worthy of the NHS brand. Professor Steele stressed that, as a patient, he would rather be treated under the NHS system than under many of the systems in other developed countries.

Despite this, he acknowledged the negative findings in his work. While access has been high on the lists of patient concerns, and this what politicians have heard, this has been less relevant to individual dentists. Instead, they have spoken about highly variable and sometimes inappropriate services. He noted his concern that some of the best dentists can be almost prevented from providing the treatment they wish to provide. At the worst end, NHS dentistry has sometimes tarnished an otherwise strong NHS brand. Professor Steele then went on to consider where the problems lie.

The first issue highlighted by Professor Steele was the very considerable variation in the quality of commissioning. He noted the existence of some extremely good commissioning practice where PCTs were working closely with practitioners, and he recognised the important role for LDCs to play in this process. However, Professor Steele also stressed that there was also a great deal of poor quality commissioning taking place. This was normally the result of commissioners not spending enough time talking to and meeting with practitioners. This often resulted in practitioners feeling frustrated and exposed to risk, something which he noted many commissioners did recognise. This has been compounded by the lack of data collection since the introduction of the new dental contract in 2006, leading to insufficient data to commission and monitor services effectively.

Professor Steele also spoke about the highly variable delivery of services. He talked about this being partly the result of the whole system still being focused on quantity rather than quality. Since *quality* has never been used to drive NHS dentistry, we are currently struggling to reform the system. At present, there is an unrealistic remuneration system for certain a treatment which is compounded by the variability in the UDA rate. Professor Steele noted that the variability in UDA values has been one of the most concerning parts of his work for the Review. He noted that the incentives sometimes appear to be perverse and it is often not clear what the system is trying to achieve. There are also questions about clinical practice.

Professor Steele spent some time outlining the recommendations that his report would make. He talked about the variability in commissioning, noting that there needs to be much more robust performance management of PCTs and much better use of appropriate advice, however stressing that this could only happen with the backing of the Secretary of State and the Department of Health. Professor Steele also emphasised that better coordination of information should provide patients with an easily accessible resource to help them find a dentist, as part of the access problem was down to patients not knowing where they could look.

Data and IT systems were also highlighted as a priority. He recommended that there be better data collection and better use of that data. Professor Steele noted that the lack of investment in dental IT systems has been shameful and requires dramatic improvements.

Finally, he addressed perverse incentives within the current system, noting that the incentives within the contract needed to be aligned with the needs of the population. At present, they operate on a different track and are consequently heading in a different direction.

The Review team had also spent considerable time considering whether a fundamental change to the system was needed, concluding that it was. Professor Steele noted that it was important to remember that dentistry is a market and therefore subject to market-failure, which the NHS seeks to manage; however within that environment, we must be mindful that it is not an industrialised process but an individualised healthcare profession.

Professor Steele reiterated the importance of remembering what NHS dentistry is there for. He noted that it there *for* patients and *for* taxpayers. Unfortunately, it is not there *for* dentists. However, he said it was true that you could not have a high quality NHS dental service, without a contented profession. NHS dentistry is about securing health and not just more dentistry. He noted that ultimately, there is a fixed pot of money with which to do so. Therefore, there are priorities and inevitably there are some tough decisions to be made. Those decisions, said Professor Steele, should not be based on numbers of fillings but on ‘value for money’.

He discussed a second challenge to the profession; around quality. Professor Steele recognised that this would require us all to submit to both measurement and feedback about our own performance.

He noted the importance of dentists being visible in taking responsibility for their own treatments, as well as being financially responsible for their failings. This means that if a practitioner was unable to meet certain quality measurements, they would be penalised financially.

Finally, Professor Steele stated that the profession should think carefully about managing its own image. This needs to be done by recapturing the language of health through leadership, and this presents a job for us all. With this in mind, he said that it was important for the profession to both appear and be, cooperative. For when the public is on your side, much of what the profession has been wishing for should follow.

Professor Steele set out the principles within the Review:

- Committed high level support for NHS dentistry from all parties
- Ensuring oral health is the outcome, rather than just 'more dentistry'. This means aligning the contract to oral health and ensuring that prevention is well understood and is well-funded.
- Alignment of incentives within the contract by looking at what is rewarded and where the incentives are. This would mean being rewarded in a 'blended' way, not just for activity, but also for quality and number of patients on your list.
- Specific recommendations about quality and how nationally agreed measures for quality are needed, which are comparable across all PCTs. Responsibility for that quality has to come from the provider.
- Piloting has to happen. The challenge for the pilots is to ensure that a robust, tested system is in place but that there are pressures to sort out the system; therefore there is a real risk of not running a pilot for long enough. We must be careful not to jump in too early. Therefore, we need a degree of patience with these pilots. Professor Steele also mentioned patient charges and how they need to be carefully considered and piloted.

Professor Steele noted that, if the report was generally seen by the profession to be fair and reasonable, the hardest part was its implementation.

Questions to Professor Steele, from the floor

Paul Kelly, Dorset

It seems as though there has not yet been a paradigm shift in the Department of Health, from treatment to prevention. Do you agree?

Professor Steele stated that he did agree, although he noted that it was actually quite a difficult concept. He recognised that clinicians were intrinsically tuned in to quality, whilst civil servants – many of whom are actually economists – find this more difficult. It is quite difficult for people to make such a paradigm shift and it is a difficult message to get across. He stressed that this was actually about good messaging more than anything else.

Eddie Crouch, Birmingham

How much interest have the Conservatives shown in your work and how much have they been listening to what you have been saying?

Professor Steele noted that he had been keen from the start, for his report to be entirely independent of any political influence. He gave credit to the Secretary of State and the Department of Health for allowing him the freedom to get on with his work on the Review. He said that he spoke to the All Party Parliamentary Group (APPG) on dentistry back in February and that was the only interaction with politicians. Professor Steele emphasised the apolitical nature of his work, stating that it was not about politics but about good healthcare.

Mick Armstrong, Wakefield

Does the Department of Health acknowledge the significant increase in burden placed upon practitioners by the new standards in cross-infection control?

Professor Steele responded that he had not asked the Department about cross-infection control specifically, although some of the bureaucracy around regulation was certainly a concern for him. He also mentioned that there was a need to align regulation so that there might be, for example, a single inspection process.

V. T. Rhaasa, Croydon

In the past, piloting has been used as a 'white-wash' exercise by the Department of Health, where new systems have been implemented, even before the piloting has finished. Could you give us any reassurance about your proposed pilots?

Professor Steele noted that this was quite right and the history of piloting was not good. He noted that this had been the reason he had been explicit in his Review, about the need for properly run pilots, reasoning that in dentistry particularly, it often takes some time for outcomes to become clear. He stressed that the next stage would be implementation and that bodies such as LDC Conference must ensure that the communications from the profession is clear and that pilots must run for long enough to be of use.

Jane Ainsworth, North Tyne

When I came to one of your road-show events, the diagram you presented about the prioritisation of spending had private dentistry at the top. Private dentistry now seems to have disappeared. To give you a local example, in North Tyneside five years ago, there were twenty-seven NHS dentists providing comprehensive NHS dental care. Now, eight of those practices are no longer treating adults on the NHS. What private practices are doing is not, glamorous makeovers etc. but good preventative dentistry. Could you say something about how you see the two systems working together more closely, rather than as seems to be the case at the moment, being diametrically opposed to one another?

Professor Steele recognised that the pyramid diagram needed to have private practice running up the side, as it covers all aspects of dentistry above public health. If patients wish to choose private treatment there should be no barrier to them doing so. He stated that the private sector did actually supported the NHS, through reducing the numbers of patients requiring NHS treatment.

However, he said that it was important to think very carefully about what NHS dentistry is, noting that there was a fundamental question over NHS dentistry being 'universal' and 'comprehensive', as the two terms were very different things. He reasoned that in looking at the NHS constitution, there was actually more emphasis on the universality of treatment than on the comprehensiveness of treatment. He

stated that he thought that universality was a very good thing and that the point of the pyramid diagram was to show where the priorities for funding should be and how funding could be cut, if it needed to be. Professor Steele considered to what extent NHS dentistry could provide a 'comprehensive' service, saying that he thought that we did not yet know how far the resources in the service could go because the service was not yet aligned to health prevention.

Vijay Sudra, Birmingham

Do you think dentists can serve patients and the taxpayer better if we were freed from the shackles of PCT interference?

Professor Steele noted that one of the core reforms in 2006 was the introduction of local commissioning, stating that there were good 'public reasons' for the commissioning of services locally. He suggested that the real issue with this was not the principle, which seeks to see services delivered locally, but it was the competence of the PCTs themselves to commission well and really engage with the process.

Tony Jacobs, Bury and Rochdale

How do you feel the profession should address the reduction in funding within the NHS overall in the near future? What can we do now to be ready for this reduction?

Professor Steele noted that the first way to prepare was by getting the messages from the profession across to PCTs clearly. He said that it was also important to demonstrate that the resources currently going into dentistry were being used appropriately by the profession. He also noted that an awful lot of money has gone into the NHS over the last ten years, whilst the proportion of funding spent on dentistry has not kept pace with the other areas of spending. He reasoned that this was quite a powerful argument against cutting funding for dentistry.

Tony Clough, Essex

We keep hearing a lot about quality. It is easy to produce quality work when you are earning thirty pounds for a UDA, it is not so easy when you are earning sixteen pounds for a UDA. It is no coincidence that some of the problems with poorly performing dentists and dentists not making their contract values are happening at the lower end. I would like to know whether some of your proposals will address the enormous variability in UDA value and make it a little more acceptable.

Professor Steele stated that keeping the UDA as the sole measure of payment was wrong and that to adapt how it was used would be important to the improvements that would be made to the contract. Ultimately, he said that it was about rewarding activity differently and that the profession should break away from concerns focussed on the UDA specifically.

Panel discussion on ‘professionalism’

The Panel took questions from the floor about ‘Professionalism’ within dentistry in the UK. From left to right: Martin Mayhew, Ian Gordon, Jerry Asquith (Chair), Rupert Hoppenbrouwers and Barry Cockcroft.

Martin Mayhew

Martin qualified from Liverpool in 1979 and spent twenty-two years in the RAF. He has an MSc in dental public health from the Eastman and, since 2000 he has been clinical director of ORA dental group, which has subsequently merged with Oasis. He is now clinical director of Associated Dental Practices, which has approximately 1.5 million patients from Devon to Durham.

Ian Gordon

Ian qualified as a dentist in 1984 and set up a group of five predominantly NHS practices in Teesside, which he later sold to IDH. He worked for IDH for six months as a clinical assistant, before leaving to open a private practice and later founding the Alpha Dental Group in North Yorkshire. This group now has five mainly NHS practices. Until recently, he chaired Tees LDC and is a founding member of Challenge, together with John Renshaw and Eddie Crouch, has consistently called for dentists not to be regarded simply as ‘UDA generators’.

Rupert Hoppenbrouwers

Rupert is head of the Dental Defence Union and was previously a GDP. He is a former director of the School of Dental Hygiene, at University College London and has lectured and written widely on risk management and dento-legal matters. He has a particular interest in litigation and is the former Chair of the UK Dental Law and Ethics Forum.

Barry Cockcroft

Barry qualified from Birmingham Dental School in 1973 and worked in general practice for twenty-seven years. Prior to being CDO, he was Deputy CDO, Chair of Warwickshire LDC and served on a number of committees of the BDA, as Vice-chair of the General Dental Service Committee in 2000. From 1997 he was involved in a Personal Dental Services pilot in Rugby and is currently the CDO for England.

Questions to the Panel

Clive Harris, Birmingham

The subject of the discussion today is Professionalism. I know of several dental surgeons who have contracts in excess of half a million pounds and are single-handed practices, have in excess of 20,000 UDAs to perform. I know of the potential scams under the new contract such as ionomers in little pinholes in Es and Ds, one-tooth dentures for single tooth molars over two appointments, extractions rather than root canal fillings, etc. Where is the professionalism in that? It is just a money-making exercise and a waste of taxpayers' money. It is the honest, ethical dentists who have to pay for this. It is these dentists that are so often having money clawed back by their PCTs. Could you give me your views on this please?

Barry Cockcroft – There has never been a system designed in the world that prevents people from 'gaming'. Item of service could be 'gamed', private capitation systems with no monitoring can be 'gamed'; all we can do is rely on the professionalism of people not to do that. I find it sad that a question like that one from Clive, actually damages the whole profession, when it comes through the media. The issue here is 'are there drivers?' Not every nurse is a Beverly Allet, not every doctor is a Harold Shipman. I firmly believe that professionalism means doing the right thing on behalf of your patient. If a treatment is clinically appropriate for your patient, the practitioner has a professional responsibility to carry out that treatment. If you start to look at every little treatment, then it gets very difficult. Clive talked about the rise in extractions. In actual fact, there has been no such rise in extractions. We cannot identify this trend.

Ian Gordon – I think it is good that Barry is so supportive of the profession and has confidence that the profession is generally behaving responsibly and providing appropriate clinical treatments. There is no doubt however, that where the remuneration system you work under has such a direct effect on your treatment planning that associates will take this into consideration when providing treatment. It would be interesting to know how many practice owners pay their associates purely through UDAs or through a different system. The type of behaviour that Clive alluded to earlier really undermines the professionalism of the profession and we need to do some soul-searching and not just pretend that it is not happening. It is a question about how the drivers may lead to unprofessional behaviour.

Martin Mayhew – In any system the method of payment will direct the delivery of healthcare underneath it. The model must have some responsibility. However, we are a profession and we must also take responsibility. As professionals, we do have to take responsibility for our behaviour and we can choose whether we operate within that system or not.

Rupert Hoppenbrouwers – One nice definition of a professional is 'doing the right thing when no one is looking'. We have not

seen a huge number of contract-related cases. This suggests to me that the profession is largely honest.

***Barry Cockcroft* –** The issue of associates' pay is one that we are aware of. We have been developing a basket of indicators for about three years. Quantity measures are very easy, quality indicators are less easy to devise and highly complex. We are already working on that. There are often more difficulties with the contract between the performers and providers. I have raised this issue with the BDA, as they provide a performer-provider agreement. This is purely based on UDAs and I am hugely concerned about this. So, not only does the contract between the PCT and the provider need to reflect quality better, but so does the contract between the provider and the performer. It is easy to say this but more difficult to implement it. My job is to implement this and it is a difficult one.

Mick Armstrong, Wakefield

Given the recent retirement of Chris Audrey, can Barry now assure us that the regulations will not be written treating us all as fraudsters, but will be written in the interests of patients? In addition, where there is evidence of gaming, why are the PCTs so unwilling to take action?

***Barry Cockcroft* –** I do not believe that the regulations are all written as though everyone is a fraudster. The regulations as they stand now, allow the basket of indicators discussed earlier by Professor Steele to be used without any need to adapt the regulations. One of the difficult things for PCTs is that they came to this without much commissioning experience in 2006 when they were going through a lot of change. In some areas, commissioning is now excellent, although in some areas it is not. I know that there are a number of people in this room that are working very constructively with their PCTs. Developing the commissioning capacity of PCTs is incredibly important but clinical engagement is two-sided and requires joint-working between professionals and the PCTs.

Dave Cottam, Birmingham

Complaints about associates now fall to the provider to be dealt with. I feel that as professionals, we should always be made responsible for our own clinical work and would like the panel's opinion.

***Rupert Hoppenbrouwers* –** The prime responsibility for a complaint still rests with the clinician who provided the treatment and they should generally respond to complaints. Contractual obligations at PCT level are only part of the equation; the other part is GDC guidance and litigation. Therefore it is only a contractual component between PCT and provider that requires you to ensure there is a response. In general, we would advise that the practitioner that provided the treatment should normally be the one to respond.

***Martin Mayhew* –** It is interesting. It tends to bounce between the indemnity society, the provider and the individual practitioner who provided the treatment. There is a flaw in this system and what we are failing to do here is to put the patient first.

***Ian Gordon* –** I would agree with everything that has been said. I would add that perhaps this responsibility on the provider should help to focus their minds on the type of people that they are employing to work in their practices.

***Barry Cockcroft* –** I just wanted to agree with Rupert, that the provider holds the contract and is legally responsible for delivering on the contract. The clinicians, who carry out clinical work, are responsible to the GDC for their clinical work. The only point to mention is that if you are a provider, providing services, the GDC do ask that you ensure that any of your associates have the correct indemnity cover and other documentation.

Phil Gowers, Hampshire and Isle of Wight

Like OFCOM in the communications industry and OFGAS in the gas industry, do you feel that an 'OFDENT' would increase the trust of the public?

***Ian Gordon* –** My own view is that we have far too many quangos in this country already. We should be able to regulate ourselves as a profession and I feel that yet another regulating body would not be something that I would want to support.

***Barry Cockcroft* –** We effectively have OFDENT in the form of the Care Quality Commission, which has a legal responsibility to regulate healthcare provision and will come on stream for dentistry on 1 April 2011. I agree with the comment that what this must not be is an additional layer of bureaucracy, but is must fit in to the current system. What you are asking for is already there.

***Martin Mayhew* –** Let us hope that the CQC has some dental representation on it from dental professionals who understand the

business and will be able to participate in the regulation of the profession.

Rupert Hoppenbrouwers – The dentist – patient relationship is a fairly unique relationship and it is generally dentists themselves that are best at sorting out problems between professionals and patients.

Paul Kelly, Dorset

The 2006 contract has failed. The BDA tells us that, LDCs tell us that and the Health Select Committee tell us that. The only body that does not tell us that is the Department of Health. We do not believe that the contract is working. We need to move away from a position where a measure (the UDA) is not a measure; access is not access – access to what? And, prevention is not prevention. Does the panel disagree with anything I have mentioned there?

Martin Mayhew – Obviously it depends on your definition of failure. If your aim is to control dentists and limit spending, then is has been a success. From the point of view of patients and the profession, I would have to agree that it has been less than a positive move.

Rupert Hoppenbrouwers – It is our perception from out members that there is a feeling that this 'big brother' style of control gives them precious little room and time to get on with real dentistry and treating patients. They spend a great deal of time 'ticking boxes' and I think we all need to take stock of that.

Barry Cockcroft – Access fell by 1.2 million following the introduction of the new contract. This was not the result of the new contract but was to do with rejected contracts feeding through. Any of you who have seen the latest data on access will see that access is clearly going up. For me, access is not the issue, it is about access to a quality service. We found out two significant things from PDS piloting; these were that you do need activity monitoring and that people did not know what evidence based prevention was and that was why we published the evidence based prevention toolkit in 2005. Access will get sorted, but changing the focus to a quality preventative system is what we are focusing on. The new system allows the Department to allocate money to PCTs, rather than relying on dentists to invest in their service.

Ian Gordon – My view is that the contract has not failed. I do believe that the problems are entirely caused at the PCT and commissioning level. One of the major problems with the new contract was that it relied on PCTs, many of which were in an embryonic state and did not know about dentistry. I hear more and more stories about dentists building a relationship with contacts within a PCT, only for that contact to move from the PCT and the dentists then having to begin building that relationship with someone else. If we talk about professionalism, I would put the problems with the new contract, firmly at the door of the PCTs. I think Barry will agree in some ways, but that the Department is relatively powerless to make the PCT behave in a certain way. To my mind, the biggest failure of this contract is the failure of local commissioning.

Vocational training allows the mentoring of professional values. As a vocational trainer I prioritise trustworthiness as the main value when training newly qualified dentists. I realise that the panel have different roles and would be interested in which value they would prioritise and whether they have any advice for mentoring newly qualified dentists.

Rupert Hoppenbrouwers – I think trust is fundamental to the dentist – patient relationship. This is a two way street and patients have to respect the professional as well. In general, just being a role model is the best way to achieve this. I think it is very difficult to 'teach' professional values.

Barry Cockcroft – It is not just an issue for VT but for undergraduate training as well. It is all very well teaching them how to cut a perfect cavity, but they must understand why they are doing it. The trust that the patient is putting in you is important. I think that it is important to look at what potential individuals have to develop as a caring healthcare professional at entry to graduate schools. I think it starts when you select people to go into dental schools.

Martin Mayhew – It should be in undergraduate training and not in VT.

Ian Gordon – I think that the VT process has been one of the greatest privileges of my career to work in. I think the system is a credit to the dental profession. There are some new assessments from COPDEND which are coming out to let the trainers know more about the often very high standard of candidates coming out of university.

Eddie Crouch, Birmingham

One of the things we have found most frustrating in the last three years is that the Department have refused to accept very valid criticism from the profession. Even this morning, there has been a denial that the number of extractions has gone up. The Health Select Committee found that they had. This question is about professionalism within PCTs. How can we make the PCTs more professional?

Barry Cockcroft – I think it is less about professionalism within the PCTs and more about capacity. In terms of extractions, if I am shown any statistical evidence demonstrating that extractions have gone up, I would agree. The statistics simply do not support the assertion that the number of extractions had gone up.

Rupert Hoppenbrouwers – There is a huge variation in PCTs from our perspective. Some PCTs are excellent and will work with practitioners who are having performance issues to help them get back on the straight and narrow. There are others that simply want that practitioner off their patch. I do not know what the strengths of the good PCTs are, but it strikes me that the failings of the bad ones are simply that they do not understand dentistry.

Martin Mayhew – I have to agree that the variation in the quality of PCTs is considerable. We had to do a great deal of work with our dentists when the new contract came out, to let them know what the idea behind it was and how it should be delivered. In a similar way, more work needs to be done with PCTs. They should have little check-lists that tell the PCT how they must engage with professionals.

Ian Gordon – My feeling is that if you have a bad PCT, it is incredibly difficult. Unless you want to move areas, you are stuck with them. The Department must be frustrated but might also hide behind PCTs being free to make decisions at a local level. One of my fears about the Steele Review is that if someone in a PCT says that the new guidance interferes with their risk strategy, the PCT will not be willing to implement it. It seems to me that if the PCT do not want to answer your question, they just ignore it. That, to my mind, is wholly unprofessional on their part.

Complying with HTM 01-05

Lesley Derry, Head of Education and Standards at the BDA, spoke about the decontamination guidance for primary care dentistry, HTM 01-05.

The Conference heard that there was an expectation from the Department of Health that by the end of the first year of the implementation of this guidance, all primary care dental practices will be working at or above the essential quality requirements.

This twelve month period would begin once a hard copy of HTM 01-05 and DH/IPS audit tool had been received by the individual practice. Lesley also informed Conference that practices would need to ensure that they had an over-arching infection control policy in place.

Having published the guidance, the Conference heard that the Department of Health intends to carry out a national survey to look at the process of decontamination of surgical instruments. She told Conference that the first meeting of the Dental National Decontamination Survey Consultation Group would be held on 14 July and attended by the BDA. This national survey will establish baseline data for the current quality of existing decontamination measures: compliance with *HTM 01-05*, the types of premises used in dentistry (including the ability to support decontamination activities), the current decontamination equipment used, and the nature and extent of training received by the dental team. Lesley informed Conference that a pilot survey would be undertaken in August with practices from ten volunteer primary care trusts.

The Conference heard that the Department would be publishing HTM 01-05 in hard copy and sending this to all NHS practices, along with an Infection Control Audit Toolkit produced with the Infection Prevention Society. The Audit toolkit will be CD Rom based and hyperlinked to the HTM 01-05 so that it will highlight, for each question, specific paragraphs in the guidance. The toolkit will also have analytic capabilities that will not only allow practices to ensure they are compliant with 'essential requirements' or their level of compliance with best practice but will also generate action plans for further improvements. The BDA has met with the Department and the Infection Prevention Society to discuss the contents of this toolkit.

Further information is available on the BDA website: www.bda.org/infectioncontrol

Motions carried by LDC Conference 2009

Tackling PCT poor performance

Gwent: This Conference demands that the Department of Health implement a rigorous structure of accountability to police the action of individual LHBs and PCTs.

Sandwell: This Conference believes that PCTs should not be discriminatory in providing additional resources for some of their areas in detriment to others.

Sandwell: This Conference believes that all PCTs within a Strategic Health Authority region should be consistent in their policies towards UDA achievement.

Birmingham: This Conference urges GDPC to negotiate with the Department of Health, similar arrangements for the over-production of UDAs as to the under-production of UDAs. All PCTs should recognise up to 4% overproduction in either additional funding or a reduction in future year activity.

Failure of the GDS contract

Northamptonshire: The Northamptonshire LDC moves that the new dental contract has failed and the profession must tell the country before it is too late.

Avon: This Conference believes that the current contract should be replaced.

Sheffield: This Conference believes that UDAs are utterly useless as measures of output, quality or access.

Deskilling of the Profession

Surrey: This Conference believes the drive for simple courses of treatment under the current contract is leading to the de-skilling of established GDPs and preventing younger dentists from acquiring the expertise and experience necessary to plan and perform complex treatments.

Funding of the General Dental Council

Northamptonshire: The Northamptonshire LDC moves that since the profession is no longer self-regulatory the government should fund the GDC.

Seniority Pay

Ealing: This Conference calls upon the Department of Health to maintain Seniority Payments for all eligible practitioners and to ensure that they are informed of the correct procedure for claiming by the due date.

Impact of the Recession

Norfolk: This Conference believes that the current financial crisis shows the vulnerability of many UK small businesses. This motion asks that PCTs are required to provide long-term stability, assist with capital funding and give leeway to underperforming practices during these stark economic times.

BDA support for legal action

Avon: This Conference demands that the BDA financially support a member with legal costs where the outcome of an action against a Primary Care Trust, Strategic Health Authority or Department of Health is likely to be of benefit to significant number of the profession.

Associates' pay and conditions

Birmingham: This Conference believes that as a profession, we should recognise the Doctors and Dentists Review Body award for all dental performers so ensure pay rises for all dentists within the NHS.

Provision for additional UDAs in band 2

Bexley and Greenwich: This Conference demands that extra UDAs must be allocated for all new patients in Band 2, where treatment exceeds agreed criteria of treatment level.

Legal challenge over patient charges

Birmingham: This Conference insists the BDA legally challenge the Department of Health over taking patients charges and not accrediting activity financially to Dentists that overproduce UDAs.

Decontamination

Norfolk: This Conference believes that the publication of HTM-01-05 will put an intolerable financial burden on practices. These changes need to be fully and effectively funded now and in the long-term, by the Department of Health.

Trafford: This Conference calls for Central Funding to be made available to all NHS practitioners to meet both the capital costs and ongoing maintenance costs of implementing HTM-01-05 guidance – Decontamination in Primary Care Dental Practices.

Birmingham: This Conference urges the GDPC to challenge unproven recommendations of the HTM document and dispute measures that are not evidenced based with regards to additional expenditure and added running costs for general dental practices.

LDC Conference Agenda Committee meetings with the Chief Dental Officer

LDC Conference Agenda Committee: This Conference believes that LDC Conference Representatives should not continue to meet with ministers and the Chief Dental Officer.

Richard Emms (right) receives the formal handover from Jerry Asquith (left) as Chair of LDC Conference for 2009/10

Election of Officers and Representatives

Chair Elect 2010/11

Mick Armstrong

Honorary Treasurer of Conference

Tim Harker

Two honorary auditors to the Conference

1. Esmail Harunani
2. Brett Sinson

One representative to the Conference Agenda Committee

1. Tony Jacobs

One representative to the Board of Managers of the British Dental Guild

1. Julie Williams

Two representatives to the GDPC

The previous representative to GDPC was directly elected to the GDPC during his term of office. There were therefore two vacancies for representatives to the GDPC at this year's Conference, one full-term representative and one to fill the mid-term vacancy.

1. Dave Cottam (3 years)
2. Jerry Asquith (1 year)

Many thanks to Howard Koch, for providing the photography at LDC Conference 2009