LDC Conference 2013

LDC Conference at the Hilton London Metropole
Chaired by Dr Richard Elvin

7 June 2013

From left to right: John Milne, GDPC Chair, Richard Elvin, LDC Conference Chair 2013, Tony Jacobs, LDC Conference Chair Elect and Tim Harker, LDC Conference Treasurer.

Conference 2013 at a glance:

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An update from the General Dental Practice Committee (GDPC) of the BDA, John Milne, GDPC Chair

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Conference Speech, Chair of Conference, Dr Richard Elvin

Ladies, gentlemen and honoured guests, welcome to London and to the Metropole hotel.

A particular welcome to our guest speaker this evening: John Motson. I shall be brief so that we can hear from John sooner, rather than later.

It is an honour to be standing here before you all this evening. I asked some of the previous holders of this high office what I might say for the few minutes that I have available to speak to you. Most of the advice was simply that I should say as little as possible, but there was also a murmur that this should be my chance to speak out about things that irritate me about our working lives. So I gave some thought to what the really major things were, which have irritated me over the last 32 years of practising dentistry. It probably only comes down to two or three things, and I certainly won't be covering all of them, but I will address a couple of points that I have found particularly annoying.

I think the worst irritant for me over the last 32 years has been the constant change. I'm not talking about the new dental contracts, although there have been enough of them. I'm talking about the change in the management structure of primary care. The apparent desire of every new government, whatever their colour, to come in and completely dismantle the existing primary care management systems and start all over again. I can't work it out – to me its madness! It achieves nothing. As an example, take my own area of Hertfordshire. In 1996 we had one primary care management structure for the whole of Hertfordshire. I think it was an FHSA then. Along comes a change of government and let's all start again. So from one FHSA we go to 12 PCGs; remember those – primary care groups? They then morphed into 8 PCTs and, to cut a long story short, some 15 years later, we were back to one PCT for the whole of Hertfordshire; back to one primary care management structure.

So we had come full circle. What did it achieve? What was the point of it all? And of course this didn't just happen in Hertfordshire but was mirrored all over the country. There were buildings where the leases had still to be paid, yet no one was working in them. Little things like the headed notepaper had to be junked and reproduced. There were many local schemes in planning or operation that now had to be discarded, or that there was suddenly no money available to fund. And for what benefit? Who does constant change benefit? Certainly not patients. Constant instability benefits no one.

With John Motson here I could use a football analogy. Clubs that continually change their managers rarely have any kind of long-term success. And this is true within the primary care health service structure. How many meetings, how much hot air, has been generated not talking about patient care, but talking about new structures, new management systems, new committees and new groups? How many trees have been chopped down to make paper for all the reports that have come out about new ways of working? It doesn't benefit anybody. By all means tinker with systems; tweak

systems; rearrange parts of systems. But to completely dismantle, to take apart piece by piece and then to rebuild the thing from scratch every few years doesn't do anybody any good. Least of all patients.

Now, we are doing it all over again and this time it seems even worse. The best description that can be given to what is happening out there at the moment, as far as dentistry goes, is “chaos”. Would anybody here like to bet that within a couple years, these area teams, these massive area teams, have been split up into smaller, more manageable groups? So why does it keep happening? Seemingly because every government wants to make its mark. But you know governments come and go. Health ministers come and go. The only people who spend 30 or more years working with patients and trying to improve the health of their patients are the dentists, the doctors, the nurses and all the other health professionals. A Minister for Health is maybe in the job for two or three years, and then they're on their way to mess up somewhere else. It's complete and utter madness. Who draws up these marvellous plans? Who are these faceless people sitting in windowless offices inventing all this? And why do they think that they know any better than you or me? You only have to look at the mess that rail franchising is in to realise that the people working within government might not be the best in the business.

So what can be done? Personally I think the health service somehow needs to be taken out of politics. It needs to be independent and away from politicians. It should not be the political football which it has become.

Moving on: I'm not going to say too much about the 2006 contract because I think it is now commonly accepted it has been completely discredited. What does concern me though is that although this contract has been discredited and we keep hearing talk of new contracts in the offing, we still have to work under the old contract with all its errors and problems. I think more should be done in the interim to try and deal with some of the worst excesses of this 2006 contract, because continuing to work under it in its present form is not helpful to patients to dentists or to the practice of good dentistry. I would hope that there is continual and constant pressure to try and address some of the worst anomalies of the current contract before we get to the promised land of yet another new contract.

So, a very brief word about these new ways of working which are currently being piloted: I hope, perhaps naively, that the pilots are allowed to run their full course and are properly and independently evaluated, using all the data available, before a new contract is launched upon us. Haste did nothing for patients and dentists alike in 2006; let’s not make that mistake again. And a note of caution: as we listen to those that tell us that dentists really like working in this new way, we must remember that dentists really liked working in the PDS pilots, prior to 2006; but it wasn’t quite what we ended up with.

I shall try to move on to something else, to help lower my blood pressure. Another thing which I find intensely irritating, is people living in Croydon. For the uninitiated, Croydon is either South London or North Surrey (depending on your point of view), so what on earth are people who live in Croydon doing supporting Manchester United? I mean, what is that all about? Mums, dads, take your offspring to see your local team; whether it’s Barnet, Crewe Alexandra, Bolton Wanderers, Dagenham and Redbridge or even the thinking man's football team, Queens Park Rangers. As much as anything else, the M1 northbound from London is just so congested when Manchester United are playing at home!

Now on a more serious note, we learned of the tragic suicide of a dental colleague in the last couple of weeks. It is not for me to make accusations or to point fingers here, but what I would like to do is to fully endorse and echo the BDA's call for an independent investigation of the circumstances that led to this tragic act. I will say no more about that incident now. I would like to highlight, however, that the pressure placed on dental practitioners by PCTs over the last couple of years – often encouraged and egged on by law firms trying to claw back money under dubious pretences – has been immense.

The methods and approaches of some of the PCTs defy logic. Imagine if you were stopped for speeding on your way to work. The police officer asks you how often you drive down this road. You reply that you drive down this road everyday on your way to work and have done so for the last twenty years. Imagine now, that the police officer says "Ok then, I am going to assume that every time you drove down this road you sped, and as a result I am going to give you 27482 points on your licence". It does sound ludicrous when put like that, yet that's exactly the system that PCTs thought was fair. That practice has now stopped and PCTs have gone. We wait to see how the new centrally directed area teams are going to behave.

Without wishing to sound like the Oscars I would like to say thanks to a few people. To my colleagues on the Conference Agenda Committee – Past Chairman, Jim Lafferty, Chair Elect, Tony Jacobs, Treasurer, Tim Harker, elected members, Mick Armstrong, Roy McBurnie and Jane Ainsworth, and to John Milne from GDPC. Thank you for your wisdom, advice and support, and for your humour that you have brought to our meetings. My thanks too, to Will Newport, Secretary to the Conference Committee, and, in his absence, to Nicky Strutt and Rachel Noble. Behind the scenes Andrew Bowers, Denise Kenny and Steve Van Russell have once again done a great job. I would particularly like to thank Katherine Fort whose help, support and organisational ability has once again come to the fore.

Many of you may know that I was a member of the Executive of the BDA Benevolent Fund for fifteen years and so I am delighted that this year, for the first time, we are having an auction from which all proceeds will be split equally between the Benevolent Fund and the Dental Health Support Trust. We have heard of some of the extra pressures on dentists these days and sadly, some of our colleagues do turn to alcohol as their crutch. The Dental Health Support Trust does a fantastic job in helping those with this addiction. We have also seen how tragedy can strike. Unexpected events can and do happen, and the Benevolent fund can be a great source of help to those who find themselves in financial need. So please dig deep for these two great causes.

John Motson has kindly agreed to run the auction for us and has also donated some prizes and I am grateful to John for this. I would also like to thank John for suggesting having an auction in the first place. To Peter Hodgkinson and Henrik Overgaard-Nielsen, my sincerest thanks for donating your prizes, which I am sure everyone will agree are amazing. I would also like to thank my good friend Jerry Asquith for arranging the trip around parliament. Jerry was able to do this because 'he knows people'.

Unfortunately we have had to withdraw one of the auction prizes; we were hoping to auction a foundation training place but sadly, we couldn't get hold of one…apparently we are not the only ones.

Thank you for listening, enjoy the rest of the evening and have a good conference tomorrow.

Chair of Conference, Dr Richard Elvin

The Chair of Conference, Richard Elvin, welcomed representatives to the Conference in London. He thanked all those who attended the Conference dinner for joining in and making the evening a real success. He expressed his gratitude to all those who had been involved with the auction, noting that the total amount that had been raised for the dental charities was almost £5000. He also took time to thank the Conference sponsors, in particular Denplan, the platinum sponsor.

From left to right: Conference Chair, Richard Elvin, Conference Chair Elect, Tony Jacobs and Conference Treasurer, Tim Harker.

An update on the work of the General Dental Practice Committee (GDPC), John Milne, GDPC Chair

John Milne Mr Chairman, Chairman-elect, ladies and gentlemen, good morning and thank you for inviting me to address you once again. Thank you too for your hospitality yesterday evening.

LDC Conference is an extremely important event for GDPC as it gives us chance to join with you in discussions and debate, to enjoy networking with you and share in a few beers, but above all, it enables us to hear your views and to reflect on the motions that you pass here.

GDPC does consider them carefully, and I know that you have in your papers our responses to the motions that were passed last year. I think what is particularly helpful is that your opinions usually confirm the direction GDPC is taking, usually reflecting the views expressed both by GDPC and it's Executive. In those papers you will see that we have tried to demonstrate the continuing work around the issues raised at Conference.

GDPC comprises dentists who are committed to working on behalf of their colleagues, who have a desire to improve the working lives and working conditions of all dentists, and to engage with government on behalf of the profession. We are committed to work on your behalf and I want to acknowledge publicly today the hard work of all GDPC members, and particularly the work of the Vice Chairs, Henrik and Peter, and all the Executive team. We are given fantastic support by the BDA staff; they do a huge amount of work behind the scenes. Their knowledge, wisdom and commitment are beyond compare. And on this occasion, it is important that I give a special mention to one member of the BDA staff, Linda Wallace. Linda is soon to retire from the fray after many years service to the profession. In my short time as Chair, she has been a tremendous source of support, inspiration and wisdom. She has put up with my failings with good humour and always finds the right words in tricky situations. These few words cannot do justice to the way she has enabled the BDA to represent dentists and dentistry through the years.

There have been many references already to football; I thoroughly enjoyed meeting and listening to John Motson. I am more a rugby man and, particularly, a rugby league man. There is the odd similarity between rugby league and football and it is the tradition of singing the hymn 'Abide With Me', before the cup finals. In those Wembley finals this particular verse of the hymn is usually omitted. The words are as follows: *Change and decay in all around I see, O thou who changest not, Abide with me.*

It pretty well sums up the life of a GDP at present, doesn't it? We've been hit with a Tsunami of change in recent years. We don't need reminding of the change of contract that brought us the UDA ("the dreaded UDA", as the Minister called it). We don't need reminding of the changes in our decontamination processes that were visited on us after such close consideration of the evidence behind some of the tasks we were made to adopt. It is amazing how instrument pouches used to grow a huge number of deathly microbes in just 21 days, but now, well you could eat your dinner from the inside of those bags for a whole year...amazing. And the change from the visit from the PCT Dental Practice Advisor, often a fellow GDP and usually respected as a person engaged with us in the day job, to the CQC inspector who drops in at a moment's notice for 5 or 6 hours to make sure all is well. On a more positive note, CQC now use some dentists in this process and the Chair of PEC (Martin Fallowfield) and myself have met with the CQC Chief Executive and there are clear signs that they are likely to be less generic and more targeted in their approach.

Let us not forget the changes to the whole structure of the NHS that happened only in April. Gone are the PCTs who suddenly seem to have improved a little in the memory now. Welcome to the new world of area teams; leaner and fitter. In fact, so lean that many of us do not know who is responsible for the management of our contract. But never mind, these area teams are setting about building Local Professional Networks, and last year we had the rose tinted spectacles on as we heard how these networks would enable the profession to actively engage in planning services for each area, assessing the effectiveness of secondary care and the salaried services, possibly shifting some care from secondary care to dental practices to save the NHS money and enable some expansion of practices. I was fully supportive of the concept of LPNs and I still am, but in the harsh reality of the new world the resources for the networks are woefully small. In West Yorkshire, the number of Dental Advisors has been slashed to six sessions across a population base of nearly 3 million. The LPN itself is poorly resourced. Despite all the planning, the lack of resources will limit how effective the LPN can be. I see in the motions today that my own experience merely mirrors that of many of you, and I hope you will take the opportunity of thoughtfully questioning David Geddes this afternoon. It's important to let him know that we, as responsible professionals do care about the

development of services and are willing to engage with the area teams, but that engagement must be resourced, and be more than a talking shop if real beneficial change is to be achieved.

So much for change, let us turn our thoughts to decay. There is a strong whiff of decay around the 2006 contract. Very few now would suggest it has been a rip roaring success. We have all seen the effects of attempts to claw back funding; we have all seen the effects of ham fisted commissioning and attempts to reduce UDA values whenever possible. You cannot change a light bulb without it being an integral part of the contract and thank you. The whole thing needs to go out to tender, or maybe not if you will accept a reduction in UDA value!

I'm no longer a dental advisor, but one of the things that made me very uneasy was when some practitioners had completely unreasonable UDA targets, more than 11,000 for one dentist. Low UDA values and high UDA targets add up to intolerable stress. Such stress challenges even the ethics of a saint. Last year I invited you to tell us at the BDA if your colleagues were subject to oppressive and bullying treatment from PCTs, and if it happens with the new area teams we need to know about it. I know of three colleagues who have sadly taken their own lives in recent months, and you may have seen the BDA press release about a case very close to me in Leeds with the inquest a couple of weeks ago. We all know that dentistry at a clinical level is stressful enough, but the NHS and our regulators the GDC and the CQC must recognise that colleagues who are subject to investigation, however proper that might be, need to be helped to find support and advice. I hope the Minister will respond to this issue this morning when he speaks to us. There should be no place for bullying and aggressive behaviour within the NHS.

As many of you know, I practise in Featherstone and decay is far from defeated there despite my best efforts over many years. As the pilots progress, I am keen to see a contract framework develop that recognises the challenges of disease that many of us still face, whilst encouraging and resourcing a preventive ethos that will pay dividends in the future. The pilots have had many practical difficulties in operating the oral health assessments and the pathway approach, but so far, pretty well all those involved endorse the approach. The Department of Health have proved willing to be responsive by changing the pilot process to reflect the difficulties people have experienced and we look forward to evaluating the pilots throughout this next year.

However, I believe now that we need to put some flesh on the bones of a new contract. Work is beginning to try and design a framework for a contract based on capitation, registration and outcomes that will actually work in the 8000+ practices in England. GDPC will continue to engage with that process, and we will keep you informed as this work continues. There are many challenges in this process, not least the legacy of unequal funding and workload that the 2006 contract has left us with. It is increasingly obvious that the dental budget will not expand significantly, and I hope you are all suitably grateful for the 1.5% uplift that our hard work was able to achieve this year. Don't spend it all at once. But without additional funding to address the inequalities that exist we are faced with the prospect of a degree of redistribution. GDPC will seek to avoid practices being destabilised and our current thoughts are around a transitional income guarantee, similar to that the GPs were given in the past. It is important too, that the NHS is honest about just what level of care is available. Patients must not be misled, but neither should we. The pilots provide care that relates to how well disease is controlled and how well the risks are recognised. It will be interesting to see how that process works, as it seems to be fair and reasonable so far.

I am optimistic that a new contract can be achieved. It is one bit of change that I strive and look forward to. GDPC are working hard on behalf of all of us. Thank you for inviting us to share your Conference today, I'm looking forward to the debates.

Ministerial address to LDC Conference, Earl Howe, Parliamentary Under-Secretary of State for Health

Conference Chair, Richard Elvin:
As Chair of LDC Conference, I am pleased to be able to welcome Earl Howe to Conference today. As Parliamentary Under-Secretary of State in the Department of Health, Earl Howe has responsibility for dentistry. He has been interested and politically involved in health and social care provision for a long time, serving as shadow spokesperson in the Conservative opposition from 1997 to 2010.

As Minister with the portfolio for oral healthcare, he will have been involved in making the decisions about which elements of a potential new contract should be piloted. He will also, of course, be a key player in making a decision about when and how any changes to the contract should be introduced.

Minister, welcome to our Conference and we look forward to hearing your address.

Earl Howe:
Good morning Conference, and thank you first of all for the invitation to speak and thank you for putting up with a less than adequate voice from me. I hope that you will be able to hear me never the less. I hope you all enjoyed your dinner last night. I gather that John Motson was the rather lively guest speaker, I hope that none of you inadvertently came away with a sheepskin coat and that you're all feeling reasonably fresh this morning. It occurs to me that this is a good moment for me to be addressing the Conference of Local Dental Committees.

We are now more than two months into the introduction of the new commissioning arrangements across the NHS. The transfer of contracts and payments appears to have gone smoothly, but there of course remains much to be accomplished. The first year of these arrangements is necessarily one which will make the most significant demands on both clinicians and managers in terms of understanding how the new commissioning structures will work for dentistry.

Now, the reforms to the architecture of the NHS are not of course an end in themselves. But they do present significant opportunities to allow us to continue to enhance the service which NHS dentists provide to patients. The move away from the old system, where about 150 PCTs contracted with dentists to a single contract holder, in the shape of NHS England, but with local contact managed by the local area teams is a really big change for all of us. There are bound to be teething problems for a little while and I think the thing I would urge is patience and co-operation on both sides, which I know is being exhibited. Now, as many of you will be aware considerable work was done in the run up to the launch of the new health and care system, I've already mentioned the transfer of contracts but a great deal of effort also went into drawing up standard operating practices across all areas of contracting for dentistry. Now that these are in place they should serve to ensure a much more

consistent approach to dental commissioning right across the country. That has to be welcome. I know it's something that clinicians have been asking for, for as long as I've been Minister with responsibility for dentistry, and no doubt for a long time before that.

Before I go any further, I think I have to mention the very sad case of the dentist in Leeds who committed suicide and about whom the BDA recently wrote to me, and I have actually replied to the BDA this week. Now, clearly this is an extremely tragic case and I think it is absolutely appropriate for me to extend my deepest personal sympathies to Dr Kamath's widow and to his family. Part of the narrative here, I understand, is around bullying. And I need to make absolutely clear that Ministers believe that there is case whatsoever for bullying in any situation in the NHS. From conversations with leaders in NHS England and with those involved in the commissioning of dental services I know that they agree with that. When concerns are raised about any area of clinical practice in the NHS they must clearly be investigated and this is no exception and I don't think anyone in the room would disagree with that. However, I do also think that it's important that in a situation like this there is support available both within the NHS and from organisations like local dental committees and the British Dental Association. Indeed the emphasis that I want to see in the new system is for dentists to feel supported, not lest by the local area teams. And dentists should feel able to seek that support whenever they need it.

Now, as you all know, all dental care, primary and secondary is now directly commissioned by NHS England. CCGs have no role in the commissioning of dentistry and of course almost all dentistry takes place in primary care settings. But giving the area teams the capacity to commission secondary services should, I think, make for a rational and seamless approach to giving patients the care they need. I think dentistry is perhaps unique in being a speciality that has direct commissioning throughout. Within NHS England they are establishing a system of task groups focussing on specific issues. I announced at the BDA Conference that NHS England, working with Public Health England and Clinicians, would be establishing a task group looking at how we can improve services for vulnerable and hard to reach groups. That group held its first meeting this week. And, of course, quality is at the centre of our purpose in reforming the healthcare system. And by quality we mean ensuring that all patients get the right care at the right time and that the team providing the care is appropriate.

The importance of clinical leadership in the NHS is central to the way that we see the NHS operating. There are many ways in which clinical leadership can manifest itself and obviously first and foremost this is something that dentists exercise in their day to day practice, leading their teams in the surgery.

But I very much hope that in the nexus of LPNs in dentistry that we're setting up to support area team activity in NHS England will offer a developing platform for dental clinical leadership and will serve to intensify that focus on quality which is so important to the profession.

Another important aspect of ensuring quality and consistency of care is the use of the pathway approach and I'm going to be saying a bit more about that in relation to the new contract in a moment. Overall these changes to dentistry which were set out in NHS England's document Securing Excellence in commissioning dentistry which was published in February have I think received a warm welcome. We know that the new arrangements that we've seen since April involve a significant culture change and we also know that these changes can only be successful if the practitioners they affect are fully engage with the process. One result of the move towards the new contract will be that the link between area teams, with their LPNs, and LDCs will be increasingly important. I had in mind, and I'm very glad to see that NHS England formally recognised LDCs in March of this year. Now, I've spoken about the current picture, but alongside all the changes to the current NHS, set up of the work to deliver a new contract has of course continued. It seems like quite a long time since we made clear our ambitions for NHS dentistry in terms of a new contract based on quality with a capitation system of remuneration and of course we signalled our broader changes to the NHS very early on as well. And as a result I can understand the impatience that you probably feel about the pace of reform, but the lessons of the past are that we need to get this right to allow for the development of a robust, sustainable commissioning system which delivers better outcomes for everyone.

Now, with regard to the progress of the pilot programme we are very pleased with the feedback we've received. And that feedback contains the recurrent them that the basic philosophy is absolutely right. Clinicians have welcomed the focus on outcomes based on prevention with need assessed consistently through an oral health assessment and the delivery of care best suited to the individual. Now, this is of course an on-going process. Today we are confirming the names of the second wave of pilots who joined the programme in April having been selected from a shortlist in January. And this will take the number of pilots in the second wave to 90 and we're very grateful for the on-going enthusiasm we've had for the process from the dental profession. We continue to collect really useful evidence from the pilots and this will be of vital importance for the development of the new contract. The new approach to patient care is at the heart of this so it's appropriate that there has been a significant degree of focus on the IT which supports the pilots. We've listened to the feedback that we receive about the IT systems, some of which I heard at this conference last year. And we've reviewed the clinical pathway and this helped improve the process and I would just like to take this opportunity to acknowledge the tremendous help and knowledge and input and commitment that we've seen from the IT companies so far. But as I said last year, I cannot emphasis enough that a pathway approach doesn't mean that your clinical decisions will be driven by computer. The IT that we're developing is intended to support clinicians in making the right decisions in the best interests of their patients. Now, I'm aware that there was an initial reluctance to override some of the prompts that

are built into the system, but I gather that is now changing and rightly so. As I said, we're determined that the process provides us with the lessons that we need to allow us to develop a better dental contract.

During the first year of the pilots, one of the issues that caused significant concern was the blocking of appointment books resulting from over sensitivity in the management of ICMs. There are lessons here for the implementation of any new system to try to avoid this blocking of appointment books on implementation and there are also some fundamental lessons for transition. We know that there will be other difficult issues to deal with. Variability of UDA rates which were based on previous patterns of treatment and earnings has got to be sorted out. And this will inevitably involve, I believe, some frank exchanges of views and probably some disagreement with your representatives.

The Government is fortunate in our relationship with the present leaders of the profession. That relationship is robust and we don't always agree, but it is one where both sides share a focus on the interests of patients, the workforce and the NHS. In the last 20-30 years we've seen major improvements in oral health and patients generally are coming to pace more value on good oral health. We know though that there is no room for complacency whatsoever, we want to continue the progress that we've made, tackle some of the remaining inequalities. We know that this is what you as clinicians also want to do and we recognise that it's right that you want to be fairly rewarded for it. And that this includes recognition of the investment which practice owners make. At the same time, we as a government are committed to helping the NHS to continue to develop a better service which does deliver value for money in a challenging economic climate but also improves outcomes for patients. As we move into a new era for the NHS and for NHS dentistry we look forward to working with the profession to achieve this.

Thank you very much and I'm more than happy to take a few questions.

Chair:
Thank you Minister. The Minister has kindly offered to take some questions while his voice holds up. Could I please make a plea, introduce yourself to the Minister and keep your question as short as possible, so that we can get as many as possible in. We want a question, not a lecture.

Nick Patsias, Bromley LDC:
Thank you very much for coming here and listening to our concerns. At the LDC Conference you were very pleased that we had all performed our access targets but this year I think this isn't going to happen. Why, in my own area our funding has been taken away. In my case a six figure sum in the form of non-recurring UDAs. We were told that non-recurring UDAs was something from on high but our next door borough was given recurring UDAs as a norm. Could you give us a bit of advice as to what we should tell our patients? Should we say they now have to go private? Should they actually go to Bob the Butcher down the road? Or should I revert back to a child and exempt contract? We're in a very difficult situation and it's impossible to see where to go.

Earl Howe:
I'm very concerned to hear that. As a general point of principle, we expect UDA and contract values to be set at levels which allow contractors to deliver a high quality service or good quality service and for the NHS to obtain good value for money and that's the balance that needs to be struck. So in letting bidding for new activity I would expect commissioners and would be providers to be mindful of whether the UDA level offered is financially viable. Now, if as you say in your case you don't regard it as financially viable and you have concerns about existing UDA levels then the right course is to raise this as vociferously as you think appropriate with your local area team. It doesn't sound to me

though as though the process has been thoroughly done in this case. And I seriously would advocate a seriously frank conversation with the local area team if you haven't already had it.

Nick Patsias Bromley LDC:
I have already had it and word is from on high... (interrupted by Chair)

Earl Howe:
I would say that existing contract values can only be changed by agreement between commissioner and provider. So I hope agreement can be reached. I am concerned to hear that.

Alan Ross, Barnet LDC:
I note that you mentioned very briefly in your talk LPNs. There's already been some debate and motions regarding LPN funding this morning. I was at a meeting just this week with the dental lead for London and she was extremely downbeat about the progress that LPNs are making and wasn't at all sure that there would be an LPN in London and that it was due to lack of resource.

Earl Howe:
Well that's very concerning; because my understanding from officials has been that the funding of LPNs can be done through the administrative envelope. I see Barry is nodding in the front row. This may not be generally known, but this is a concern that has been raised with me before. I'm sure that I'm correct in saying this, that there is a funding route for LPNs. We very much want LPNs to be a force for good in binding the system together and generally raising the bar on quality so it is very important that they get established. I think that the thing to do is to pursue that point again with the local area team.

Mark Woodger, Mid Mersey LDC:
I'm sure I speak for everyone when I say that I'm very grateful that there is no place for bullying in the NHS and that support is key when colleagues are going through, quite rightly so sometimes, performance review procedures etc. As employers we follow a very strict code of practice and we ensure adequate timing, adequate information and of course the right to support and representation forms a fundamental part of any invitation to any meeting discussion. We're also held very much to account for the way in which we deal with our employees. Will the Minister commit to holding to account area teams for the way in which they deal with performance reviews and also in ensuring that colleagues are aware, explicitly aware, of the support available to them. Because at a time of stress and panic you don't always think to pick up the phone to your local dental committee or to your defence organisation.

Earl Howe:
That is so true. When people feel under serious stress as was clearly the case in this tragic incident I think that it's human nature to almost close off and not seek help. There's no easy answer to this, I can blithely say to you that there should be a culture of support and help within NHS England. That is above all what we want to see in the NHS, not just in relation to dentistry. NHS England is there to hold the system to account, but it is also there to support and improve quality and generally make for a healthier climate in the NHS devoid of bullying. Now, when somebody gets under pressure, it is possible to feel very sensitive to almost anything that happens. And spotting the tell-tale signs of this is perhaps an art that not everybody in the NHS has, so yes, the message somehow has to go down throughout the system and if I can play a part in that I will to ensure that this general theme is emphasised, that of support rather than putting people under undue pressure when their circumstances are clearly ones in which they are suffering pressure from many directions.

Calderdale and Kirklees LDC:

The new contract is IT driven; what financial support for IT will you be giving practices in the future to fulfil your aims?

Earl Howe:
Well, I wish I could give you a detailed answer on that because the financial support to practices is not something that we have reached yet in our decision making. Until we know what the optimal system looks like and of course it has changed, software has changed, any system of remuneration recognising the cost of that can't be articulated or formed. So, I don't know, but this has to be in the mix because we know that the IT system will underpin the new contract is absolutely essential and we are determined that this new contract should be a success. The last thing we want is for it to fall on its face because it's unaffordable. So, those are the only broad answers I can give you at the moment. Maybe in a year or so I'll be able to give you further and better particulars.

Chair:
Thank you Minister. I'm afraid we have no further time for questions.

The future of associates in practice: general practice experiences from independent contractor practice and corporate dentistry

Michael Lessani, associate dentist in NHS and private practice

Michael began by stating his intentions to speak under the title, “Associates: an endangered species?”. Michael emphasised the benefits to working together as a single dental family of providers and performers, rather than working against one another in discussions about how the dental labour market should be managed. In relation to associate aspirations, he suggested that there appeared to be ever-increasing barriers to becoming a practice owner and that some associate dentists he knew personally, had already made the decision to move into a different profession and had left dentistry all together. Michael noted the apparent over-supply of qualified dentists, highlighting both domestic production of dentists and the rising numbers of skilled migrants, as critical factors having a bearing on the supply side of the labour market. He referenced a conversation with an official of the Department of Health, during which it was suggested to him that newly qualified dentists did necessarily wish to work full time. He disputed this assertion, stating that this was not his experience and that he did not believe many qualified dentists wished only to work part-time. He made it clear that, in his experience, the vast majority of dentists sought full employment with many aspiring to work at a single location.

Michael also commented on the rising costs of further training and the impact on ambitious young dentists wanting to build their career and develop their skills. He suggested that any new requirements for additional training would place a significant burden on the costs of training, pushing a career choice of dentistry even further out of reach of some of the lower socio-economic groups.

Michael stated that the BDA’s Young Dentists’ Committee was anxious to maintain the opportunity for associates to practise as self-employed professionals. Michael noted concerns about the difficulties that related to becoming a practice owner. Increasing competition, the poor economic situation, high costs of living and the increasing number of corporate owned practices were all making it more difficult to buy a practice and run it profitably. If an associate could purchase a practice then they would come into competition with dental corporates for tenders, and their lack of resources in comparison to corporates often placed them at a severe disadvantage, either perceived or real.

Associates, often young dentists in particular, were becoming the victims of a 'race to the bottom' for low pay. As jobs were becoming more difficult to find, practice owners could rely on prospective associates under-bidding one another on the UDA rates they would accept. Michael felt this was damaging, both for associates in the short term and for the profession at large in the longer term. He hinted that decreased pay for associates would ultimately undermine pay across the profession.

Additional concerns that Michael described included how best the profession might be able to ensure that younger dentists receive adequate exposure to clinical situations to allow them to progress to the proposed 'level two' competency. Simply paying for courses was not felt to be a sustainable option, as associates faced greater student debt at graduation and reductions in pay. It was felt that it was more important for this sort of personal and career development to be taking place as part of their work, rather than as part of chargeable career development course that could only be accessed outside of the workplace. Many younger associates were keen to gain the experience of running practices and there should be more opportunities made available for this. Such opportunities were likely to not only improve skills, but to increase attachment to the practice. Concerns over the impact that direct access could have on the job market for associates were very strong.

Michael concluded by asking the profession to unite and join the debate about the most effective way forward together. He thanked the Chair for his invitation to present and said that he looked forward to the discussion during questions later.

Justin Ash, Chief Executive, Oasis and representative of the Association of Dental Groups and Dr Kaushik Paul, GDP and specialty dentist in oral surgery, Rodericks

Justin explained that he was representing the Association of Dental Groups but that he would talk about the position of Oasis as CEO, as that was the company that he knew best. He spoke about the experience of Oasis in managing associates, noting that they employ 850 across more than 200 sites. He described his varied background, stating that his area of expertise was in running multi-site businesses, having worked previously in the fast-food sector for KFC and in the pharmacy sector for Lloyds.

He described how every year for the last few years, there has been a one percent rise in the number of associates working for corporate dental practice. He emphasised that the objective for dental corporates was to offer whatever would attract qualified dentists into their practices. He said that the total figure for dentists practising in dental corporates currently stood at approximately nine per cent of GDPs. Justin suggested it would, therefore, take a long time for the market to become 'dominated' by corporate practices. The overall percentage of dental corporate market share was relatively small and he anticipated it levelling out at a roughly equal share of independent and corporate practice in

future. He estimated independent practices would always constitute *at least* half of the market.

Justin reported that, at Oasis, the number of female associates was growing year on year and, furthermore, the population of associates was extremely varied. In relation to training, 66 per cent of the Oasis workforce is UK trained and this proportion is also increasing. He noted that many practice owners sell their practices not simply to release equity, but also to return to practice as associates, in order to avoid the stresses of practice ownership, particularly for those nearing the later stages of their careers. He stressed his opinion that the future looked extremely positive for good associates. He considered associates a precious resource.

Dr Paul from Rodericks also spoke briefly on his experience of working as an associate within a dental corporate. He understood one of the key benefits brought to associates by corporate dentistry, was the flexible career development structure which most offered. In his experience, dental corporates were often keen to invest in their associates and support them in their clinical development.

Questions from the floor:

Q – Michael, should the BDA protect minimum terms and conditions for associates (i.e. to protect a basic UDA rate for associates)?

Michael Lessani:
Things like this are appealing in principle but difficult to achieve in practice. It could quickly become a 'race to the bottom' and so, things like this are usually best addressed as issues of professionalism between associates and practice owners. I will take that back to the Young Dentists' Committee for further discussion, thank you.

Q – Justin, you mentioned career progression. Practices need infrastructure as well as clinically trained staff. Do Oasis practices provide sufficient resources to support trained dentists in carrying out advanced care?

Justin Ash:
This is a question about whether everything should be offered everywhere. We are currently looking at what will suit our business most appropriately. We do support our dentists to be able to practise their particular dentistry in a well resourced treatment delivery setting. We could do more to support our associates in some situations and this is something we are looking at.

Q – Justin, some dental corporates are considered to be exploiting associates and this is tarnishing the overall brand of corporate dental practice. Could the Association of Dental Groups have a code of practice to ensure high standards are upheld across the member companies?

Justin Ash:
Protecting the reputation of dental corporates through higher standards is the purpose of the Association. To this end we are drawing up a code of practice for exactly the reasons you outline. Although the picture you paint is not one which I recognise in relation to Oasis practices, I am

concerned about the damage that some corporate practices do to the reputation of corporate dentistry.

Q – Justin, what impact will 'Direct Access' have in Oasis practices? Have you considered payment mechanisms for associates under a new 'capitation' based contract?

Justin Ash:
We will support access to dental hygienists and therapists as this has been shown to have no effect on access to the dentist. We have no plans to reduce the number of dentists. We are running six pilot sites and everyone is very enthusiastic and believes the models being tested to be superior to UDA based contracts. However, no final decisions have been taken on how payment in a new system will work and, as yet, it is simply too early to tell.

Q – Michael, what has happened to the progress of the private dental schools?

Michael Lessani:
The licence has been rejected by the Privy Council. I have heard rumours of something developing in London.

Q – Michael, a question about one of your slides; you mentioned that universities have a responsibility to prepare associates for a realistic view of the working world. Recently, the question about whether deaneries should be funding and supporting additional training for associates following foundation training?

Michael Lessani:
DF training is fantastic and that is what makes it so popular. The qualification process at university should ensure that any graduating student is fully competent for safe practice. This is what we must focus on, I believe.

Q – Justin, the corporate model seems to be one of never-ending expansion and ever-changing management/ownership. I cannot see the model you describe when I look at Oasis practices but rather I see a failing business model struggling to turn a profit and relying largely on private equity investors.

Justin Ash:
Our dentist leaver rate used to be about 23 per cent, which is far too high. Now though, it is about 9 per cent, as we track it weekly. Of course, we want to hang on to good dentists, but most of the leaving figures come from dentists from overseas who are choosing to return to their home countries. In terms of the business model, our economics are not magic but look startlingly like the business models of independent practices.

Q – Justin, do you think it's easier to motivate associates on a fee-per-item basis or on a UDA basis?

Justin Ash:
We do UDAs because they exist but I am enthusiastic about the pathway model currently being piloted and the opportunities that it offers to enable associates to focus on the most appropriate treatments for patients, at the most appropriate time.

Q – Michael, as the head of the Association representing associate dentists, are you not concerned that the pressure on the pay of associates (via the value of UDAs) is driving down the calibre of those seeking to become dentists? How can you stand up and claim to represent associates but not advocate a minimum terms contract for associates?

Michael Lessani:
Of course, we want to see a good level of support for all associates out there. We have made a decision to get out there and engage with other professional meetings such as this one. I, personally, would like to see a minimum standard but I worry about this 'race to the bottom'. In order to achieve this though, we need a groundswell of support within the profession.

Q – Justin, you would now be hard pressed to find an independent NHS-dispensing pharmacy. Do you see dentistry going the same way?

Justin Ash:
Dental practices are very different businesses to pharmacies. Pharmacies operate on a very different business model from dentistry. The dispensing of pills is a market in which bulk-buying and scale can make an enormous difference. Dentistry is a service however, and this means that there will always be a greater plurality of providers in the market. I do not see the market going beyond a 50/50 split.

Questions for NHS England, David Geddes, Head of Primary Care Commissioning, NHS England

The Chair thanked David Geddes for taking the time out of practice to attend the LDC Conference and respond to questions from LDC representatives from across the country. The Chair invited questions from the floor for David.

Q – Please can we have an update on the payment of levies? What will happen to our recognition at the end of this six month limbo period?

David Geddes:
All I am able to do is apologise for the lack of payment thus far. I believe there has been a problem between the collection of levies and the payment to LDCs which has also occurred with some LOCs. I had hoped it would have already been sorted but I understand things should be resolved within the next week. Regarding the transition period of six months, some LRCs were quite small and so we are taking the opportunity to ensure LRCs link effectively with each of the Area Teams so that they can efficiently manage their relationships. Over the six month period, recognition will be arranged and agreed with the respective Area Team for each of the LDCs.

Q – I find myself in a very awkward position: I work in Chester, which is in Wales, but the referral pathway for our secondary care has been moved from Liverpool to Cardiff. This discriminates against patients locally and, of course, they say that they pay taxes to Whitehall and therefore cannot understand the situation.

David Geddes:
The boundaries for Area Teams are determined by the boundaries of CCGs. I will need to explore this specific case with Barry Cockcroft.

Q – David, could you tell us what community care is going to be commissioned from primary care in England? And what about treatment for school children? At the moment we are only able to claim UDAs when we treat school aged children at our practice. In addition, will there be some sort of equality across the country in terms of the provision of endodontic treatments, geriatric treatments and periodontal treatment, when we make referrals. At the moment it's a complete mess!

David Geddes:
I will need to unpick some of that with you. First of all, when you talked about community dental services, I expect you are talking about specialist services as well as the community service. Actually, there are real opportunities here, as NHS England will be responsible for commissioning all dental care, apart from maxillofacial surgery, because of its more medical nature. This will be commissioned

by the CCGs. The dental budget is about £2.4bn and of that, about £600m is used to commission secondary care services. I think there is a recognition and an opportunity to shift care from secondary into the community (either general dental services or specialist services). It will be commissioned on the basis of equality of access and good outcomes for patients.

Q – I sit on two LDCs; one was told that, in order to arrange for the payment of levies, they would need to agree a common levy amount for collection across the patch. I cannot see anything in the legislation or in the NHS England SOPs which would point to this being an agreed way of operating. Can you confirm that this is not necessary?

David Geddes:
We have considered how we can manage the administration and collection of these levies more efficiently. We are in discussion with the BSA over how the levies can be collected most efficiently. We are looking at what we can organise with the responsible bodies, which will improve the way in which they are collected. As yet though, no decision has been made.

Q – We have a meeting with our Area Team this week. We will be discussing the occupational health service with them as we have found it increasingly difficult to get staff the necessary treatment and inoculations recently. One suggestion was that the funding for the service had been lost in the transition; another was that the money had moved to CCGs. What are you able to do about the situation?

David Geddes:
I do not think the CCGs have taken it. The transformation from 152 PCTs to the 27 Area Teams was never going to be an easy task. The political imperative was to ensure that CCGs were functional in time for the transition. It has felt quite rushed. The guidance regarding occupational health was not terribly clear and so some PCTs aligned the occupational health service funding to CCGs, some aligned it with Area Teams. Most chose to align it with Area Teams but – because of the historical variation in provision across PCTs – we now need to look to see what an affordable and sustainable solution will be for the NHS. We have said to Area Teams that, if you have capacity to manage the existing services, please continue to provide them until we issue further guidance. This should be made available later in the summer (July or August time).

Q – My question is about the Individual Funding Request (IFR) route. There seems to be a lot of confusion in our area about this and patients are struggling to get an answer. Could you clarify please?

David Geddes:
We have 10 Area Teams commissioning these services and 4 Area Teams (one per region) run the IFR process. We can talk this through in more detail at our regional event which we are holding over the summer. We have written to Area Teams to make them aware that

previous local thresholds for referrals must not be applied to IFR processes, as we are now a national organisation.

Q – My question refers to your letter about LDC recognition and levy collection. Will recognition continue beyond the six month period mentioned in the letter? I found this rather ambiguous.

David Geddes:
Yes! There is absolutely no intention to refuse to recognise LRCs beyond this six month window. This period just provides the time for us to work out the appropriate administrative mechanisms for managing LDCs within the future NHS structure.

Q – My question is about the pilots. David, the dental contract pilots have played a big part in today's discussions and I understand that they remain the responsibility of the Department of Health. You, at NHS England, are responsible for managing the current contract. Where are we in terms of ensuring consistency in the management of NHS dental contracts? Are you going to prevent the 'excesses' of former PCT management practice?

David Geddes:
This is one of the greatest challenges we face as NHS England. You must have that assurance that you will be treated the same, whether in Cornwall or North Yorkshire or wherever. The challenge is to ensure that rules are consistent but that there is an allowance for local sensitivity to be reflected in the NHS management locally. In addition to this, there is the importance of working towards eliminating national inequalities in health outcomes across England. NHS England will be performance managed on this issue, in particular.

Q – Earlier today, LPNs were discussed and the Conference agreed that LPNs must have LDC representation with full voting rights. Do you have a view on this?

David Geddes:
The single operating model for LPNs is just about to go to the Executive team at NHS England for sign off. We have had a discussion about it and I think it is really important that LRCs are involved in their respective LPNs. If we were to restrict LDC involvement in these bodies, we would be reducing the potential for them to attract the best clinical leaders. I know there have been concerns about possible conflicts of interest but the issue is not one which should preclude LDC members from involvement with LPNs, where any such conflicts of interest are clearly noted. There is no more of a problem than a GP sitting on a CCG; in fact, perhaps less so. People must understand how these conflicts must be appropriately managed. LPNs face huge challenges as they cover enormous geographic areas and have very limited funds available. Such work though, presents a great opportunity for clinicians and I hope they are able to make the most of it.

Conference motions

The following motions were passed at LDC Conference 2013:

Mick Armstrong, Wakefield LDC
Conference is saddened and dismayed by the tragic suicide of a dentist who felt harassed and bullied by the NHS. Conference wholeheartedly supports the BDA call for an independent inquiry and urges the Government to make it clear that bullying has no place within the culture of the NHS.

Jason Stokes, Norfolk LDC
This Conference believes any moves to increase the NHS retirement age for dental performers should be linked to an independent evaluation of age related performance. Any performers suffering from age related changes should be allowed to take their full NHS pension at this point - and not forced to continue working to the detriment of their patients, their team & themselves.

Nick Stolls, Norfolk LDC
This Conference believes that negotiations over future dental contracts should be undertaken by an alternative organisation than the Department of Health.

Ian Gordon, North Yorkshire LDC
Conference calls on the GDPC to offer robust objections to many aspects of the proposed pilots, especially where it is clear that patient care will be more determined by computer algorithm than by clinical judgement.

Jonathan Randall, Hertfordshire LDC
This Conference demands that GDPC be re-instated as an autonomous committee of the BDA. The decisions of GDPC must not be subject to approval by the BDA PEC.

Richard Liver, Shropshire LDC
This Conference believes that all performers must be provided with a secure NHS network email address.

Ian Gordon, North Yorkshire LDC
This Conference demands that superannuation benefit is returned to all FD trainers, who are themselves superannuable contractors.

Ian Gordon, North Yorkshire LDC
This Conference demands a full independent investigation of, and an explanation from the DH for, the removal of Seniority Pay.

Ian Gordon, North Yorkshire LDC
This Conference calls for adequate funding of dental LPNs.

Eddie Crouch, Birmingham LDC
This Conference believes that all dental LPNs should have LDC representation with full voting rights.

Ian Gordon, North Yorkshire LDC
This Conference calls for the national recruitment process for Foundation Dentists to be halted for the 2014 intake, so that genuine concerns about whether the current process is fit for purpose can be addressed.

Dave Cottam, Birmingham LDC
This conference demands that all newly qualified UK trained dental graduates should be offered a FD placement in their graduation year.

Jim Lafferty, Sheffield LDC
Sheffield LDC proposes that the Annual Conference of Local Dental Committees make annual award or awards to recognise the unsung heroines and heroes of local dental committees. We propose that the Agenda Committee are tasked with organising the awards for first presentation at Conference Dinner 2014.

Eddie Crouch, Birmingham LDC
This Conference believes that the lack of data exchanged with GDPC from the pilot practices and the transparency of the processes through which it has been supposedly collected means the profession can have no confidence in any drafted contract arising from the process.

Mark Wilkins, Nottinghamshire LDC
This Conference believes it is wholly unacceptable that dentists and their staff are not afforded the same safeguards and protection against violent and abusive patients as our general medical colleagues. This Conference therefore demands that NHS England make guidance available to area teams to provide a suitable alternative treatment setting for these patients so that they receive the care they need.

Shamique Ismail, Hertfordshire LDC
Conference demands that clauses which forbid a dentist from implying that private dentistry may be better than NHS dentistry be removed from NHS GDS contracts.

Paul Weston, Worcestershire LDC
Conference calls for NHS England to clarify its position on current UDA values and to formulate a strategy to lift low value outliers with a minimum value for UDAs.

Fiona Sutherland, Hertfordshire LDC
The current levels of remuneration do not provide for a comprehensive NHS dental service for patients. This Conference demands that if the Department of Health wishes to provide a fully comprehensive high standard of care to those who seek it, the Government must fully fund NHS dentistry in any new contract.

Eddie Crouch, Birmingham LDC
This Conference demands GDPC reject any proposed new dental contract that time limits general dental service contracts.

Eddie Crouch, Birmingham LDC
This Conference requests GDPC and BDA actively campaign for non signing of mandatory service contracts that impose time limits.

Eddie Crouch, Birmingham LDC
This Conference demands that funding allocations for primary care dentistry pre 1st April 2013 are returned to Area Teams to assist improving services for dental patients.

Bruce Pearson, Devon LDC
Devon LDC demands NHS England takes an approach to commissioning based on ensuring high quality dental services for patients, rather than those that are simply the cheapest, particularly when dealing with large dental corporates.

Peter Tatton, Hertfordshire LDC
The recent amendments of HTM 01 05 clearly acknowledge the failure to use evidence-based information in the drafting of the original document. This Conference demands that HTM 01-05 be further updated, using only information for which there is a proper evidence base.

Marion English, Hertfordshire LDC
This Conference demands that all inspections of dental surgeries only be carried out by qualified dental professionals, and that the inspections focus as much on clinical dentistry as they do on the relevant paperwork.

Eddie Crouch, Birmingham LDC
This Conference deplores the decision of the GDC to accept direct access to DCPs without an adequate risk assessment on patient safety. Conference therefore calls on GDPC to urgently discuss professional concerns over patient safety with the GDC, in the context of the new decision on direct access.

Jonathan Randall, Hertfordshire LDC
This Conference deplores the appointment of a non-dentist as the Chair of GDC. We ask the Appointments Committee to reconsider urgently, and to appoint a dentist as Chair of the GDC.

Ray McNamara, South Cheshire LDC
This Conference believes we should once more have a national health service. Conference therefore demands that the Government immediately tackles the inconsistencies in funding, commissioning and service provision for patients, currently persisting across the country.

LDC Conference 2013 Election results

Chair Elect for Conference 2015	Jonathan Randall
Honorary Treasurer of Conference	Tim Harker
Two Honorary Auditors to the Conference	Brett Sinson and Clive Harris
Conference Representative to the Agenda Committee	Stuart Allan
One Representative to the GDPC	Jim Lafferty
Representative to the Board of Managers of the British Dental Guild	Howard Jones

The Chair closed Conference by noting the pleasure he had got from chairing the Conference. He thanked everyone for attending and playing their part in representing the profession.

The Chair Elect thanked Conference for the honour of chairing next years' Conference and said that he was looking forward to welcoming representatives to a great Conference in Manchester.

Conference Chair, Richard Elvin, hands the Chain of Office to the new Conference Chair for 2013/14, Tony Jacobs.