LDC Conference 2015

Held at the Grand Connaught Rooms London

Chaired by Dr Jonathan Randall
12 June 2015

CONTENTS **PAGE**

LDC Annual Conference

Agenda

Friday 12 June 2015 at The Grand Connaught Rooms, London

Chaired by Dr Jonathan Randall

08.30		**Registration and networking, coffee and exhibition**
09.15	1.	*Chair's opening address*
09.25	2.	*An update from Dr Henrik Overgaard-Nielsen, Chair of the General Dental Practice Committee (GDPC) of the BDA* Questions from the floor
09.45	3.	*Conference motions*
11.00		**Networking, coffee break and exhibition**
11.30	4.	*Presentation from Dr John Milne, Senior National Dental Adviser, Care Quality Commission and Sampana Banga, Head of Dentistry Inspection, Care Quality Commission.* Questions from the floor
12.00	5.	*Presentations on the Dental Activity Review Programme* *Carol Doble, Head of Dental Services NHS BSA* *Paul Gray, Senior Clinical Adviser NHS BSA* *Sarah McCallum, Dental Activity Review Programme Lead BSA* *Carol Reece, Senior Programme Manager, PCC, NHS England* Questions from the floor

12.45	6.	*Report of the Honorary Treasurer to the Conference and accounts for the year to 31 October 2014*
13.00		***Lunch break and exhibition***
14.00	7.	Standing Orders
	8.	*Elections:*
	i.	Chair Elect for Conference 2016/2017 with nominations taken from the floor (two minutes will be offered to candidates to make an election address to Conference prior to the vote)
	ii.	Honorary Treasurer of Conference with nominations taken from the floor
	iii.	Two Honorary Auditors to the Conference with nominations taken from the floor
	iv.	One Representative to the Conference Agenda Committee (who is not a member of the GDPC at the time of election) with nominations taken from the floor
	v.	Two representatives to the GDPC with nominations previously submitted
	vi.	One Representative to the Board of Managers of the British Dental Guild with nominations taken from the floor
14.15	*9.*	*Presentation by the British Dental Guild*
		Presentation by the Dentists' Health Support Trust
		Presentation by the BDA Benevolent Fund
14.30	*10.*	*Conference motions*
15.15		**Networking, Coffee break and exhibition**
15.35	11.	*Contract Reform Policy update from Helen Miscampbell, Department of Health followed by Q&A with a panel consisting of Dr Serbjit Kaur (Acting Chief Dental Officer), Carol Reece (Senior Programme Manager, PCC, NHS England), and David Glover (Department of Health)*
16.05	12.	*Conference motions*
16.25	13.	Induction of new Chair 2015/2016
16.30	14.	Closing remarks from the newly inducted Chair of LDC Conference

Conference speech, Chair of Conference, Dr Jonathan Randall

Welcoming delegates and guests to the 64th annual pre-conference dinner Jonathan Randall reflected on a challenging year that had seen LDCs work together more closely than ever before.

He used his opening words to thank event sponsors particularly Denplan as Platinum Sponsor and Dental Elite for their support as well as the BDA teams which had helped with the organisation of Conference. He thanked the LDC Agenda Committee of Stuart Allen, Shareena Ilyas, Leah Farrell, Tony Jacobs, Nick Stolls, John Milne and Henrik Overgaard Neilson for their contributions and support. Special tribute was paid to Tim Harker, Conference Treasurer over more than a decade:

'Tim Harker has been of invaluable help not just to me but to many past chairs.… Without his help and encyclopaedic knowledge of contracts, Standing Orders and all the other minutiae I would have struggled to survive the minefield of conference. Agenda Committee's loss is the BDA PEC's gain'.

He concluded his introduction by thanking his wife, Christine, for 'staunchly standing by and supported him for the last two years' tolerating conversations littered with a 'veritable alphabet soup of acronyms'.

Dr Randall reflected on his days at dental school and on the continuing influence of The Royal Dental Hospital on the profession:

'As with last year's chair of conference Tony Jacobs and my good friend and classmate Jerry Asquith along with a surprising number of conference delegates - I qualified just down the road from here at "That Place above the Golden Egg Restaurant" or The Royal Dental Hospital as it was more formally known. The Royal was the first Dental Teaching Hospital to have been founded in Europe and remained the UK's only independent teaching hospital until it closed its doors for the last time 30 years ago.

Students were taught in an independent environment free from the tag of being "Doctors who do teeth" - we were encouraged to be independent Professional Dentists first and last. Maybe that has something to do with why when I look around this room I see so many of my contemporaries still striving to make a difference, still working at the heart of dental politics – either that or the Staff at the Royal deliberately recruited a particularly stroppy group of students to irritate the dental establishment for years to come when they saw the writing on the wall regarding closure!

Dentistry to my mind is all the better for that independence, it encourages a caring and entrepreneurial spirit that makes dentistry in the UK one of the most effective areas of health care provision. These are our businesses, our patients and it is our skill and professionalism that has delivered one of the largest increases in health care benefits of any part of the health service in the last few decades.

In his BDA Presidential address this year, Nairn Wilson said "Dentistry, in my opinion, is best delivered when part of integrated healthcare - treating people not just teeth". I wholeheartedly agree with that statement however, integration of dentistry into healthcare cannot be at the expense of our professional independence. Once lost independence, as our Scottish friends will tell you, is a very difficult thing to regain. However, if we are to remain an independent profession we must be prepared to act like professionals and demand our right to be treated as professionals by those that seek to regulate us. Whether it is our patients, the GDC, the CQC or the Department of Health we must act in a

professional manner at all times and in return for that commitment we must communicate effectively with those we deal with'.

He reflected that when he took over the role of Conference Chair, just after the 'disproportionate application of GDC regulation epitomised by the ARF hike', he had been advised that getting dentists to work together was like 'herding cats'. He had been pleased that the last year had proved those statements less than accurate and thanked all those involved:

'Twenty-eight LDCs had worked together to agree a motion for the special conference held in December. That conference had been attended by 89 of the 96 LDCs and passed a unanimous vote of no confidence in the GDC. The repercussions of that conference rippled out and were picked up by both Parliament and the Health Select Committee. All this came about because you, the LDCs, started communicating better'.

He also emphasised the contributions of a 'determined and focused BDA providing a consistent and clear message. Recent press and TV coverage regarding the raising of the Sugar Tax and the current BBC "Truth about Teeth" programmes has given dentistry some much needed positive spin'.

'The challenge to our profession is to maintain that focus and to keep the communication channels open. This is where I believe LDCs strength lies'.

In this regard, he stressed the importance of the discussions at Conference highlighting a packed programme of presentations and motions:

'Change and particularly regulatory change is as ever on the agenda. The motions that are down for debate will direct GDPC for the coming year in their negotiations with all our regulators and I hope to hear robust debate on a number of topics….

We must be prepared to exchange honestly held views without fear of repercussion'

He also urged LDCs to continue their awareness-raising campaigns: 'We find ourselves at one of those unique points in the political calendar – we are 35 days into the first 100 days of a new parliament and for once with a majority party government. The first 100 days of any parliament is when policy is set for the next 5 years. If we wish to build our influence now is the time to be meeting with our MPs… And the messages we need to deliver?

Firstly, that dentistry needs to be returned to the forefront of the health debate.

Secondly, that dental regulation needs to be fair and proportionate.

Thirdly, that any new dental contract must be clear and unambiguous for both patients and dentists'.

He finished his speech by thanking all of those that made up the wider LDC Conference for electing him the 64th Chair of Conference and looked forward to the challenges of Conference itself:

'It has been a challenging year but a rewarding one and as Bill Allen reminded me recently, I am only the third chair to have had two conferences in a single year. Along with David Lester and Bill Allen I have had the honour of chairing a special conference so you would think I would have no worries about tomorrow when we meet again in this very room for Conference 2015. However, if as Harold Wilson once said – "a week is a long time in politics "and four days is a long time as a FIFA President then I can assure you that the last

two days as LDC Conference chair is a lifetime given your ability to think things up at the last minute! ‘

LDC Conference Awards

This year in a change to the usual format, the Conference Dinner saw the introduction of the inaugural LDC Conference Awards to the unsung heroines and heroes of the dental profession.

The LDC Awards this year were “in memoriam of Richard Thomas”. The Chair spoke of the contributions of a man known and admired by many of those present:

‘Richard joined the Federation of London Local Dental Committees (LDCs) as Secretary to four LDCs in 1998. He worked hard to ensure they had the correct governance procedures in place to support all their work. He brought to the London Federation his wealth of experience and knowledge of the business of dentistry, regulatory issues, contractual details, and many other things that concern dentists. He gave invaluable advice and support to dentists and practices. As a result of his beyond-the-call-of-duty approach to his work, the Federation has grown both in the number of LDCs involved and in what it is able to provide to the LDCs. The Federation is now a powerful voice, speaking on behalf of dentists in London’.

The aim of the awards as defined in the nomination guidelines, was to recognise those colleagues who have voluntarily served their LDC in an honorary position of Chair, Secretary or Treasurer, and had not gone on to national or other elected roles in the profession.

As the Chair put it: ‘these awards recognised colleagues who go that extra mile, are prepared to offer help to less experienced or less fortunate colleagues and have done so for many years without any thought of reward’.

The four award winners in this inaugural year were

- **Martin Miller nominated by Croydon LDC**
- **John Kocierz nominated by North Staffordshire LDC and South Staffordshire LDC**
- **Bill Field nominated by Dorset LDC**
- **David Eley nominated by Derby City LDC**

The citations for the award winners from their LDC colleagues are reproduced here in full:

Dr Martin Miller

Martin has served continuously and diligently on Croydon LDC for the past 40 years. He has also served with our local BDA since 1971, with periods as chairman and secretary and was Southern Counties Branch President in 2005.

He has been Postgraduate Trustee at Croydon University Hospital since 2007, and the LDC have been instrumental in improving the clinical skills room by encouraging local GDPs to “put something back” in the form of personal donations.

Martin was a founder member of Croydent, our emergency dental service, which was so successful that it is now the main hub for SW London.

Since 2006, the close links formed with our PCT have been of immense benefit to local GDPs who found themselves struggling with the new contract, and Martin was tireless in facilitating this dialogue. Many cases which would have resulted in breach notices in other areas were resolved by negotiation.

More important than a list of "positions held" is the pastoral role of the LDC. Martin has created a climate where the LDC is approachable and many colleagues who have been in need over the years have benefitted from a sympathetic and supportive visit from LDC members.

Dr John Kocierz

John has been a welcoming face for local dentists in the area for the last 30 years – 25 of these spent as Secretary of both North and South Staffordshire LDCs. He has been a constant throughout turbulent times; been accessible to those in need, kept everyone thoroughly informed about both the business and regulatory sides of dentistry and now as a medico-legal advisor remains available in times of desperate need. John has always been a knowledgeable, thoroughly reliable, non-judgemental and unendingly supportive colleague as well as a good friend to so many of us over the years, quietly going home to his very understanding and much-loved family each day, often without any thanks from those he has helped.

John is a man with a massive heart, unlimited patience, a wicked sense of humour and something of a penchant for a fast car. He is truly deserving of this award.

South Staffordshire LDC also nominated Dr Kocierz:

John Kocierz has served the LDC for many years as a member and then as Honorary Secretary. He has been a constant support, first point of contact and friend to many local practitioners as both an executive of the LDC and a local adviser for Dental Protection. It is to his credit that the LDC has a Pastoral Advice and Support Scheme within the area to support colleagues through times of concern and as a caring individual John will always "go the extra mile" to help anyone. For many years John has been the link for practitioners with NHS bodies locally, explaining developments in times of change and acting as an intermediary. His foresight with NHS changes guided and developed the LDC to maintain its standing and credence with local NHS structures. John continues his support for the LDC and colleagues locally since his retirement from general practice with his involvement running BDA Section Meetings and is a true un-sung hero of the Staffordshire area that befits this award.

Dr Bill Field

He has been nominated by Dorset LDC for his work as Treasurer and Clerk where he has given 55 years of service.

Bill qualified in 1956 and was first elected to the LDC in 1960. Since this time Bill has served almost continuously on the LDC in all roles including Chair, notwithstanding retirement from practice in 2009.

Bill has generated a unique position within the committee, beyond that of current clerk. By virtue of his experience, Bill has gravitated towards the role of honest broker, helping

resolve disputes. Committee work can be eventful, and Bill was unelected in response to a body of opinion believing that young blood should be marshalled for potential combat with the then new PCTs. Sadly, it transpired that the new “combatants” felt unable to step into Bill’s shoes, prompting a recall to duty, which was graciously accepted.

Bill’s faultless understanding of our constitution, combined with exemplary attendance at meetings, has served to deliver a formality and set of values, which in no small part has contributed to the survival of the Dorset LDC in the face of amalgamation of a number of LDCs in the Wessex Area Team geographic footprint. This committee believes that Bill’s contribution to his LDC from 1960 may well be unique within the annals of any LDC.

Dr David Eley

Derby City LDC nominated Dr David Eley their Current Chair, former Vice-Chair and postgraduate representative.

Dr Eley has been a member of the LDC since being voted on in 1991 whilst an associate.

He has been Chair for the last four and a half years, previously serving as vice-chair and postgraduate representative.

As a result of being on the LDC he has served on various committees, these included the FHSA Service Committees, and the Oral Health Advisory Groups, and he was currently on the East Midlands Regional LDC, Primary Care Panel, LPN (including Task and Finish Groups), Performance advisory/screening Group, Performers List Decision Panel Deputy. He and the secretary meet regularly with the Area Team.

He is a former VT trainer and for 9 years an examiner for DGDP (UK) now MFGGDP, having examined nationwide and abroad.

Conference Motions

There were 46 motions taken at LDC Conference, three of these were administrative motions. Of the 43 motions voted upon 40 were passed and three of these were unanimous. The motions that failed are not included though the original motion numbers remain for reference.

The following motions were passed by Conference:

Motion 1 Norfolk LDC

This conference demands that any changes to the GDC complaints management process that result in a reduction in GDC activity will have a corresponding reduction in GDC ARF levels. 94.6%

Motion 2 Northamptonshire LDC

This conference demands that the profession should elect who leads the GDC.
Unless we are allowed that professional input, we call that the government should fund the General Dental Council from taxpayers' money

Motion 3 Merton Sutton and Wandsworth LDC

This conference demands that, in addition to other cost saving measures that might be taken, the practice of renting central London premises for GDC hearings should be ended and those hearings should be held outside London at the cheapest suitable venue.

Motion 4 Merton Sutton and Wandsworth LDC

Conference demands that the Chief Executive surrender the pay awards she has received over the last three years because of GDC failings under her leadership. Conference

believes this would be a suitable way for her to demonstrate a renewed personal commitment towards the rebalancing of the books at the GDC.

Motion 5 Lincolnshire LDC
This conference calls on the General Dental council to form a new General Dental technician, therapist, hygienist and nurses' council and retain the General Dental council to regulate Dentists.

Motion 6 Cornwall & Isles of Scilly LDC

This conference recommends that the BDA should engage with the GDC to ensure that only charges related to the patient's complaint should be pursued. Where issues are historical, of more than 7 years, and are not of relevance to the presenting complaint they should not be considered by the GDC.

Motion 7 Northamptonshire LDC

This conference demands that the GDC no longer publish charges against dentists in advance of hearings.

Motion 8 Norfolk LDC

This conference proposes that NHS England and the GDC cannot investigate a complaint (except in exceptional cases involving risk of ongoing patient harm) until evidence is provided that recognises local resolution at practice level has been attempted.

Motion 9 Cornwall & Scilly isles LDC

This conference believes that misconduct cases based on inadequate consent forms are unfair on dentists, as they are being held accountable to an unachievable target, and unfair on patients as they are not being given nationally recognised consent forms covering the relevant areas of consent. This conference recommends that the BDA engages with the GDC to produce consent forms that overcome these issues.

Motion 10 Trafford LDC

This conference urges Indemnity organisations to take a more sympathetic view in dealing with dentists who have made mistakes. Such dentists should not be thrown to the wolves i.e refused further cover other than in the most extreme cases.

Motion 11 Trafford LDC

This conference asks that only a dentist who treats patients is given the title "clinician"

Motion 12 Norfolk LDC

This conference expects that all premises providing primary dental care should be required to register with the CQC

Motion 13 Northamptonshire LDC

This conference deplores the overwhelming weight of "red-tape" and Inspections forced upon GDPs none of which measures Good Clinical Dentistry.

Motion 14 Northamptonshire LDC

This conference calls for the resources wasted on ‘red-tape’ to be used for the re-introduction of Dental Reference Officers to replace the DQOF, FFT, and CQC.

Motion 15 Northumberland LDC

This conference believes that confidentiality and security of data is a well- established aspect of a dental professional's role, but that the IG Toolkit, as currently mandated by NHS England, is far too onerous and wide-ranging an instrument for the needs and risks of a dental practice. We ask that the Department leaves enforcement on data security to the other bodies already regulating compliance.

Motion 16 Northumberland LDC

This conference urges NHS England to adopt a greater degree of flexibility in relation to small practices in rural areas closing for dentists' and staff holidays.

Motion 17 Bexley and Greenwich LDC

.....Conference demands changes to ensure that indicators do not discriminate against smaller practices, that indicators are relative and not absolute and that real clinical quality is monitored in relation to contract performance management.

Motion 18 Bury and Rochdale LDC

This conference demands that the dental charges regulations and statement of financial entitlement regulations (SFE) are clarified with a published narrative to avoid differences in interpretation which result in under claiming and consequent loss of income for clinicians

Motion 19 Barnet LDC

This conference demands that the Department of Health withdraw the requirement to carry out the FFT. 94.10%

Motion 20 Birmingham LDC

Stress levels are now dangerously high for primary care dentists. Conference demands that GDPC take a firmer line with the Department/CQC/GDC in defence of the profession.

Motion 21 Birmingham LDC

The development of the Commissioning Guides has excluded a proportionate representation of primary care providers and are therefore not fit for purpose. Conference calls for an immediate quashing of these pathways documents and a fresh start made engaging with parties reflective of the profession

Motion 22 Norfolk LDC

This conference calls for clarification of the expected publication date of the vulnerable people in dentistry task group led by Janet Clarke. This conference is disappointed that the report has yet to be published as this would help with the development of the forthcoming commissioning guides for domiciliary services, dental care in care homes and dental care in prisons.

Motion 23 Wakefield LDC

Conference believes that dentists need adequate time to deliver quality care and prevention that enables patients to improve their oral health. These principles should not be sacrificed by chasing unrealistic activity targets or unsafe patient numbers.

Motion 24 Birmingham LDC

Conference demands that GDPC engage in dialogue with the new CDO to redress the significant inequalities that now exist in NHS Dentistry as a result of the Contract championed by her predecessor.

Motion 25 Manchester LDC

This conference deplores the prototype dental contract as a regressive development.

Motion 26 Lincolnshire LDC

This conference calls for some of the prototypes to be on a full capitation model thus dispensing with the discredited and despised UDA system.

Motion 27 Milton Keynes LDC

This conference insists that there is satisfactory protection for those pilots who have not been offered a prototype and have to return to the GDS contract.

Motion 28 Merton Sutton and Wandsworth LDC

This conference insists that the NHS fee uplifts must fully compensate dental practices, to reflect the additional costs to practices for the implementation of new regulations, including the Friends and Family Test.

Motion 30 Birmingham LDC

Conference demands GDPC negotiate a level playing field for primary and secondary care so that there is equality of monitoring, accountability and transparency so that primary care providers are not unfairly disadvantaged.

Motion 31 Lambeth Southwark & Lewisham LDC

Conference calls for primary care dental providers to be much more closely involved in local child oral health promotion efforts and increased NHS funding to support many more children being treated in primary care.

Motion 32 Ealing, Hammersmith and Hounslow LDC

This Conference demands, and calls upon, NHS England to increase the number of paediatric specialists available for GDPs to refer to, to end the crisis in children's oral health.

Motion 34 Croydon LDC

This conference demands that urgent action is taken by the NHS Business Services Authority to end the levy deductions being made from Dental Foundation Trainees and from the contracts held by their trainers.

Motion 35 Lincolnshire LDC

This conference calls on GDPC/BDA to seek change to the LDC levy collection so that all providers pay a statutory levy and the information process is examined and improved.

Motion 36 Hertfordshire LDC

This conference insists that the Department of Health clearly defines the differences between mandatory and advanced mandatory dental services.

Vote Motion 37 Northamptonshire LDC

This conference regrets that the Department of Health refuses to provide any meaningful guidance on what treatments GDPs should provide on the NHS. This conference demands that the profession no longer wait for the Department of Health to do this and produce a definition of the scope of NHS practice for itself.

Motion 38 Hertfordshire LDC

This conference insists that all boundary limitations be removed from AMS contracts.

Motion 39 Northamptonshire LDC

This conference demands that the LDC be given powers to appeal against the responses commissioners have given to patients who ask them what treatments their dentist should be providing on the NHS.

Motion 40 Trafford LDC

This conference deplores the lack of provision for anxious patients within the commissioning system. Such patients often have massive needs, and as is the case with all high needs patients, they are completely let down by the UDA system

Motion 41 Birmingham LDC

Local Professional Networks and the associated Managed Clinical Networks are failing for a plethora of reasons. Conference therefore demands that GDPC challenge the Department on the fallacy that is 'Clinician led commissioning'.

Motion 42 West Sussex LDC

This conference believes that any managed clinical network (MCN) must have adequate funding supplied from NHS England.

Motion 43 Trafford LDC

This conference deplores the imposition of a centralised “referral management system" on many unsuspecting GDPs.

Administrative Motions/ Changes to Standing Orders

The following motions were carried:

Two-day conference

This conference approves that LDC Conference 2016 be extended to two days on a one year trial

Change to calculation of Conference Fund methodology

All Local Dental Committees entitled to be represented at the Conference shall contribute to the Conference Fund, at rates to be proposed from time to time by the Conference Treasurer and with the approval of Conference, with each Local Dental Committee's contribution being in proportion to the GDS contract value of the LDC electoral area on September 30 immediately preceding the Conference.

An amendment to the Standing Orders was also proposed to allow live reporting but this was not passed:

This Conference approves live reporting, including by video feed from the Conference chamber.

An update from Dr Henrik Overgaard-Nielsen, Chair of the General Dental Practice Committee (GDPC) of the BDA

Henrik Overgaard-Nielsen started his first address to LDC Conference as Chair of the General Dental Practice Committee by thanking his predecessor, John Milne, for his hard work for the past six years as Chairman of GDPC.

He began his presentation on the Dental Contract Reform by outlining some of the details of the prototype activity planned by the Department of Health.

He told delegates that the plan was to have around a hundred practices in total, going live from 1 October on a staggered basis i.e. with pilot practices moving into prototypes from that date. From April 2017, the Department would be scaling up and stress testing with April 2018 as the potential start of full roll out.

Sixty-three of the ninety-two pilot practices had been offered an opportunity to move forward into the prototypes. Five of the pilot practices had not applied and twenty-four had been refused the chance to go forward mainly due to access problems as those practices had lost more than 20% of their patient numbers prior to being pilots. Twenty-nine practices would be returning to UDAs from being pilots. He expressed his concerns about the implications for these practices:

'I'm not going to go into all the details about why these practices are having problems. But, in my personal opinion, I think these practices have been given a bit of a raw deal. They have tested the system, now they are kicked back into UDAs, and it is going to cause quite a few of them financial difficulties'.

He explained that for both Blend A and Blend B the capitation and the activity part of the prototype would relate to 90% of the contract value. Capitation related to the number of patients seen in the past three years. An over delivery of 2% would be allowed, with under delivery up to 10% will be clawed back.

'And the reason for this risk, increased risk for the prototypes is that the Department of Health believe that that will give us a more realistic testing of the system because obviously when we get to a national roll out you will in effect have a 100% risk on these issues'.

He explained that prototype practices would be allowed to over deliver on capitation but not on quality, which meant that those that had under delivered on activity could offset this by registering more patients. However, the opposite would not be the case - a shortfall in patients could not be offset by doing more treatment on existing patients. He said that activity levels were still being discussed and that GDPC was pushing very, very hard for the Department of Health to 'acknowledge that the pilot practices did less activity' because of the measures and the pathways that were introduced. GDPC negotiators were trying to convince the Department of Health that the activity levels for the pilots when they move into prototypes should be the activity levels they had at pilot level.

Another decision yet to be made was which practices were to be A Blend and B Blend. Negotiators had tried to convince the Department of Health that it should test more Bs than As but the Department had decided to test approximately the same amount.

There was an awareness that some pilot practices, if offered the A blend, would be likely to go back to UDAs. Also that some UDA practices would not take up the opportunity to become prototypes if offered A but the Department still expected to get a hundred prototypes.

Another key factor was activity levels. GDPC had argued against setting activity levels too high. Whilst the Department's answer was that setting levels too high was not a problem because practices could take on more patients to offset it, this argument did not hold true. Firstly, practices 'generally did not have a long waiting list of people waiting to get into the practice' and 'secondly, and more importantly, the reason why pilot practices are doing less treatment is because they spend their time doing prevention'.

'..what the Department of Health needs to understand is that when you do prevention that is actually an activity. So, if you are looking after your patients you're making them more dentally fit and you don't need to do as much treatment. That takes time as well so you do not have time to register more patients.'

He reminded delegates that the starting point with the Department had been 'capitation, registration and quality.' That was the reason why the pilots had no activity target. GDPC had not changed its mind: the desire to introduce activity targets had come from the Department of Health. The problem with the pilots was actually not the activity it was that some of them lost access.

'But the reason when you want to increase access ….to then ask practices to do more activity on the patients they've got… the logic escapes me on this one. There's no logic to it, it doesn't add up and what we need and what we are pushing for is obviously 100% capitation'.

He reminded delegates that Blend A related to Band 1 as capitation and Band 2 and 3 on UDAs. As percentages between capitation and activity in the prototypes would be individually measured, the outcomes would be different for different practices. When it came to the point of a national roll out those percentages would be set nationally - which meant that non-average practices could have problems. The other issue was that, at national roll out, capitation values would be equalised - meaning that there would be winners and losers 'which means that we will need MPIG, a Minimum Practices Income Guarantee. And in my opinion we need that for as long as we can get it'. For Blend B, Band 1 and 2 related to capitation and Band 3 related to UDAs. At BDA conference, Jimmy Steele had said that Blend B was much closer to his original vision in his 2009 report.

'And GDPC agrees that B was much better than A but GDPC want full capitation and no UDAs. And unfortunately, that is not tested at the moment'.

Referring to a slide from the Department of Health about the full capitation approach, he highlighted some of the stated props and cons: 'the pros are that it can be used to increase access and incentivises delivery of preventative care which I agree with and I think that's very laudable.

The challenges, well one of the challenges is to get the ratings and bandings right for everyone. That I agree with as well but that's a problem whether you have a Blend A, B or full capitation approach'.

As for the risk of appropriate treatment not being delivered i.e. under treatment, the pilots had shown that patients were actually getting the treatment that they needed. Whilst GDPC had argued for 'boots on the ground … some DROs there to check patients' the idea that there was a huge risk of under treatment was simply not true. He was similarly unpersuaded by the other arguments made:

'And then it says those treating more NHS patients may be disadvantaged. I do not understand that because treating more NHS patients we need to be paid more how that

can be a disadvantage I'm not quite sure. What they could do would actually be to just remove the cap on the contract and let everybody register as many NHS patients as they wanted. The worst-case scenario of that would be that we would end up seeing a bigger part of the population than we see now. But I thought that was the whole purpose of this whole exercise'.

'And then I have to say that the last one, the risks to PCR as this treatment is delivered. That for me takes the biscuit. To design a system based on how to collect a tax, the Patient Charge Revenue (PCR), is simply completely unambitious. It cannot be allowed to continue. Pilots showed the patients were happy, dentists were happy and all the treatment needed was carried out. The only problem was that some practices lost access. The Department's solution to ask all practices to perform more treatment on the same patients is quite simply ridiculous. And if we are unlucky we'll end up with something like this again'.

Dr Overgaard-Nielsen's slides can be downloaded here:
http://www.ldcuk.org/documents/archive/2015/162-2015-contract-reforn-slide

Questions and comments from the floor

Q1: Concern was expressed that even though some pilot practices suffered from clawback because they didn't have the anticipated patient numbers the prototypes were going forward on the same basis.

Chair of GDPC: I think for the pilots going into the prototypes, the expectation from the Department of Health is that they are on a projectory to get to 100% of their patient numbers within a two-year period. So, some of the pilots that are going in will have fewer patients now than they had before they became pilots. The ones that had been refused to progress into pilots are the ones with less than 80% of the patients left there. I don't have

the exact figures on how many of the practices affected did have the 2% clawback – though I would say it was probably the majority of them. There are also a few pilots that actually have more patients now than they had when they became pilots. But those are the minority.

Q2: A question was raised as to whether there was a possibility that the reform may not occur at all.

Chair of GDPC: The Department still said that it had an appetite for the reform. In his personal opinion, however he had problems seeing GDPC agreeing to a Blend A system. 'The idea of having capitation based for doing the check-ups, the whole purpose of capitation is that you get your patients more prevention and therefore need to do less treatment. But to do capitation on the check-up side and then say, but you have to do the same amount of treatment, because you're going to be paid on activity on that is just, I mean, it doesn't add up'. Blend B was better but GDPC was pushing for capitation. As far as he was aware, both the Department and the politicians were still interested in going forward.

Q3: There were a number of questions as to whether a return to the Dental Reference Officers system was likely. Concern was expressed that quality assurance was based on paperwork, which was not the way that many felt that the profession should be going forward.

Chair of GDPC: I would hope that some sort of DROs would come back. If there was to be a capitation based system it was, in his view, important that there was somebody there checking it clinically though exactly who this was to be and how and who was going to pay for it was a matter for further discussion.

Q4: A question was raised about the implications of the suggestion that the cap on the number of patients registered be moved – the concern being that this might lead to position in the 90s when dentists registered too many patients and then had their fees cut. The Government was unlikely to change its position on wanting a cap on spending so that they know going forward how much dentistry is costing them.

Chair of GDPC: His argument with DH had always been that if you have a capitation-based system, if a patient moves from one practice to another it would not cost the Treasury more because the money would follow. 'And I think that's the sort of competition we're used to as dentists. The only problem they are going to face … is if we register more patients. But, that is the whole purpose of this exercise - action to get to more patients and get more patients dentally fit. However, obviously the Department of Treasury don't want to hear that. At the moment, we are only registering about 56% of the population in any two-year period. So, you know, there is a problem there and we need to do something about it'.

Q5: There was a question as to how the Patient Charge Revenue would work in Blend 2.

Chair of GDPC: A very good question, but an area which had not yet been decided. He personally had argued, since the start of the process that the National Steering Group for Contract Reform needed to discuss how patient charges were going to work but was told that there was a need to wait for the pilots. However, the steering group had not gone forward with discussing patient charge revenue at all.

'My problem with it is that it looks like it's the Treasury that want the PCR and the only way they can see it is by having activity in there that they can charge patients for. I think that is the wrong way of designing a dental system. We actually need to start with oral health and then work backwards from there. And if they do need five or six hundred million in patient

charge revenue they need to come up with a way of doing that'.

In his view 'we need to start designing the system first and then decide the patient charge revenue afterwards'.

Q6: The final speaker expressed his serious concerns about the type B Blend of capitation given the limitations on the budget.

Dr Overgaard-Nielsen re-emphasised the need to start with what you want which is oral health and prevention for the population and then work backwards from there.

Presentation from John Milne, Senior National Dental Adviser, Care Quality Commission and Sampana Banga, Head of Dentistry Inspection, Care Quality Commission

Slides can be found at:

http://www.ldcuk.org/documents/archive/2015/165-2015-cqc-update-slides

'And so although I've moved from being GDPC Chair to the CQC, I'm still in practice in dentistry, I'm still working in a practice that's providing the majority of the care through the NHS. So I'm still suffering many of the things that you are suffering from including a small amount of fear that the CQC might phone me up and tell me they're coming in a couple of weeks.

So, what is the CQCs role? Well, Alastair MacKendrick told us earlier that its role was clearly to ruin his life and I'm looking forward to ruining his life. Nothing would give me greater pleasure. But Alastair raised an interesting point. He more or less said ..there is too much of the red tape, there's too much rubbish.

And he raised an interesting question about whether the CQC might actually begin to cast an eye over clinical quality? Eddie said, no, because we'd have to pay for it but there may be a discussion to be had there.

It's ironic, really, it's ironic, I think, that I started working for the CQC because I can remember not very, very long ago, going to see the Minister on behalf of the profession and saying, we want nothing to do with this body. They'll be absolutely useless in terms of looking after dentistry. We don't need it. I was in the Minister's office, Earl Howe's, making those very points on our behalf and he listened politely and, of course, said no.

Only two or three days later they announced the Health and Social Care Act which effectively abolished the PCTs and, with it, the oversight role of dental practice, particularly within the NHS. And, I think, one of the interesting things about the CQC is the CQC hope to be an agent or a catalyst for improvement of patient care and I guess that, that's something we could all pretty well sign up to.

The CQC does a massive job over healthcare regulation, hospitals, private hospitals, GP practices, care homes, domiciliary services and loads more and so it is a big organisation.

So what's the CQC about? It's about registration of all sorts of locations, as I have said, dentists and all sorts, of which we're one. And I think I've got to say at this point, because loads of people nobbled me at dinner and said, John, really glad you've gone to the CQC because you're a dentist like we are and then you said, but you've got to sort it out.

And you also said to me, do you know, lots of people said, I'm having problems with my registration. I want to do a 24-hour retirement. It's proving a nightmare. I'm wanting to sell my practice. I'm wanting to make changes to my partnership. And, you know, these things, we're not getting them right. And I'm happy to say here that the CQC needs to improve particularly around the area of registration so I'm just acknowledging that at this place.

At the moment the CQC is not rating dental practices. You might have a view on that whether they should or whether they shouldn't. I argued against rating dental practices and I think I'm still in that place at the moment but you might have different views.

The CQC started to change probably two and a bit years ago and in my previous role I was quite happy to say to the CQC, come on, you're not getting the stuff right. You need to change. And one of the things that I noticed over the last couple of years was that CQC were listening and the CQC were changing.

And there's a reference group that the CQC host and it has people from the British Dental Association – I was doing it as GDPC Chair – members from the corporate bodies are there, people from the Faculty of Dental Surgery, and there was collective work going on to actually help the CQC design and modify its inspection routine to make it more fit for purpose. And these things that are on this list, I think, came about from that collaborative and constructive working.

So the CQC is doing things differently from this April. There are specialised inspection teams. The vast majority of inspections, when they happen in a dental practice, will have an inspector from the CQC but also a specialist advisor who, more often than not, will be a dentist. We called for that in our criticisms in the past and CQC have responded.

CQC will involve people in the inspections gathering information from patients and so on; that just, I think, make sense. The inspections will – there will be fewer of them, only 10% – but they will be in more depth and they will take a bit more time. And, again, you might have a view that 10% is too few. Some of you might think it's too many but interested to hear your thoughts in the questions.

So the CQC, we see ourselves as an agent of improvement and if you're not aware of this booklet – it's called the Dental Provider Handbook – it's available on the CQC website. You all need to read it because it gives you the background as to the way CQC is thinking and how it regulates and looks at practices.

One of the things that we're quite keen to do is actually celebrate when we find something good and so you will see developing over the next year or so, examples of what we call Notable Practice. There a reference group meeting next week and we'll be discussing Notable Practice because actually – I'm looking at, you know, one of my colleagues from Wakefield, Joe over there – he might think his practice is utterly wonderful and it's really notable and I might think it's pretty average.

Actually, Joe, it is pretty good. But, in a sense, what is notable? What does it mean? Would we all recognise it as being good? And I think, as a profession, we need to own these things and there are some interesting discussions going on at the moment about standards from the Faculty of General Dental Practice and the way their standards are interpreted by the regulatory bodies such as the GDC or maybe even the CQC's inspectors and special advisors as they go around. So we need to have some interesting discussions about standards.

So the key questions are: is it safe? Is it effective, Is it caring? Is it responsive? Is it well-led? And you can see the information on the slides. Do you know, I don't care whether the red mop is next to the green mop, which has been one of the things that's been criticised in some of the inspections in the past. You know, I'm not bothered but what I am bothered about is whether the practice is safe for my mum or your mum or a member of your family?

I'm interested whether the care that's given by the practice is effective, whether the environment is set up to enable people to get a good care? I'm interested whether the dental practice is caring? Although it cares for my mum when she turns up and sees her treatment and her care as part of a holistic process not just a means to gather UDAs.

I'm interested that practices are responsive, that they'll change depending on the needs of the individual patients who are coming there? And, equally well, I'm interested to know whether the practice is well led so that everyone's involved in collectively making the experience for patients good and the care for patients to be good; something that we would be happy to receive.

And we sometimes get a bit bogged down in the nitty-gritty detail about whether you've got absolutely the right emergency drug. Well, those things are important and if there are loads of things that are wrong in that sort of area, you'd expect CQC to want you to do something about it.

This is an interesting one because it's one of the new changes. CQC have got this fit and proper person requirement. Well, I know all of you are fit and proper people to be participating in our profession but increasingly the dental world's becoming corporatised. And I've heard – in my previous role – I've often heard young dentist in particular say, I can't use this impression material, I can't use this instrument for root-canal treatment, because the corporate body that I work for say I've got to work in that particular way because it's cheaper and it's more profitable.

So if the CQC come and find that care is less than adequate does the responsibility lie with the practice manager or does it lie with the directors of that particular organisation? Again, I'd be happy to hear your views but I think the way the regulation is structured means that, actually, responsibility for the culture, leadership and organisation of dental practices lies at the top.

And this is another new one: the duty of candour. And it's about good communication and empathy and speaking with patients when things go wrong. And I think it's the right professional thing to do and I think we should actually, welcome that. So when the CQC come knocking on your door they'll have got several sources of evidence. Before they come they'll probably speak to the area team, they'll listen to what patients say, they'll probably ask whether you've had any complaints and how you've dealt with them, they'll look at local and national data and they'll talk to lots and lots of people. And the idea is that they get a holistic view of what's going on in a practice.

It won't surprise you to know that there are people who get irritated with a practice and say, I'll make their life a misery, Alistair. I'll dob them into the CQC about something and the CQC have got a responsibility to investigate. So they roll up and they find everything is hunky-dory. And so the CQC tends to look at the information that's coming in, in a whole.

This next slide just shows how we got to the changes in the way CQC looks at dental practices, through from last August with a consultation exercise, reference group were involved, through to the changes that were piloted between November and April and they're going live now.

So what you can expect from an inspection? A couple of weeks' notice before.. you will be sent a letter. They'll say, we're coming in two weeks. It used to be a couple of days. Again, those changes came through, I think, from speaking with the profession and it is an example of CQC being responsive. And on the day the CQC people will come round and they'll say, tell us about the care you give.

And it's an opportunity, I think, for the practice just to say, well, we think we do this well. We think we're pretty good at this because of A, B, C and D. We think we're safe, effective, caring, responsive, well-led, all of those things and, you know, here's the evidence to show it. And so the people from the CQC will then talk to staff, and talk to patients to see if it all

stacks up. But the overwhelming starting point is the assumption that the care that's being delivered is good.

And then, at the end of the inspection, the people who've come on it will have a chat with you about what they found. They'll say whether they think you need to make any changes. They'll tell you if they think there's anything serious that they've turned up and then they'll publish it on the website.

And the report addresses those five areas of safe, effective, caring, responsive and well-led. So they'll say we found this to be safe or we didn't find it to be safe for this reason. And if changes need to be made you'll hear what they're going to be.

Take a look on the CQC's websites at some reports of the practices that have been published. So the ones from December through to April, there's probably about 50, 60 of them, have a look at them. The good, the bad, the indifferent. Just have a look. It'll give you an idea of what's going on.

I'm just going to do one more slide before we move on. In my previous role I was very critical of the stress that practitioners find themselves under because dentists can find themselves under investigation from the GDC, from the CQC, from the area team, from lots of different organisations. And we're aware of that at the CQC and, actually, we want to do something about it.

So CQC is doing some work on what's called the ‘Future Of Dental Regulation Programme Board’. It doesn't run off the tongue terribly well but that's a collection of all the organisations who, in a regulatory capacity, are working within dentistry. So we're recognising there's this problem of duplication. There is the problem of double, triple or quadruple jeopardy and we think we need to do some work together to reduce that.

It's in its early stages but from what I've heard people saying, from what Alistair was saying about his big pile of red tape, actually, I'm just saying to you now, we're aware of the issue and we're going to have a crack at it. So how does it all work in practice? Sam Banga is our head of inspection and he's going to come and tell us.

Sam Banga, Head of Dentistry Inspection, Care Quality Commission

It is really important that we make contact with you at a local level and if there's anyone out there that would like us to come down to any of your local LDC meetings etc, to speak about the way we regulate and also to hear from you some of your experiences of regulation we would be more than happy to do that.

What I want to address just for a short while is building on what John was saying, some of our challenges and the way in which we are trying to act in partnership with the local regulatory community.

We've heard a lot this morning about some of the pressures that dentists are under, not just from us but from GDC and NHS England. And one of our biggest challenges at the moment is to make sure that the approach that we take, when we find practices that are struggling, is joined up. There seems to be, just building on what John's said, a long queue of people ready to give a practice a kick but there's nobody there to give them a lift. And what we're doing is working really hard with NHS England, especially, to try and encourage some form of supportive network for practices where we find that there is a potential for remediation but there is the absence of support.

And building on our experiences over the last twelve months, we think that's crucial because there is undoubtedly, on the basis of our experience, a group of dentists out there who have, for whatever reason, become isolated and really need to re-engage with a system of support. And we've heard, obviously, this morning some resonances to that.

One of the things I wanted to give an example about was the way in which we'd approached an example of this in Bristol where, after an inspection, we did find a lot of challenges within the practice and we were concerned, so concerned, that we needed to take urgent action because we did genuinely fear for the care and welfare of people using that service; John's mum, my mum, you know, your relatives, your friends, your colleagues.

One of the things that we weren't clear about, however, was whether or not the dentist was capable of putting right the deficits that we'd identified and one of the things we then tried to do was to solicit what support maybe available for that dentist should we suspend the practice.

So what I spent was 24 hours, basically, on the phone trying to get in touch with a local agency, either the NHS or the national team, the educational area team, to try and find somebody to support the dentist, because after having spoken to the dentist I was convinced that she was willing and able to change, as a result of which shutting her practice down would not be the right thing to do. The right thing to do would be to give her a suspension and a period of time within which to get it right. But she needed support to do that.

Scrabbling around, I think that the last thing that I would have expected to do was to call the BDA but we do have an open dialogue with a colleague from the BDA. And so I gave him a ring, talked about the situation and I have to say that the only agency that was prepared to respond in order to support that individual, to get themselves back on track, was the BDA. In my conversation with her she had mentioned their name and I decided to put that to the test.

It was a Friday and I think that that is something that we were really, really concerned about. What we didn't want was this individual dentist going into the weekend with this hanging over her, without anybody available to put an arm round the shoulder and to help her work through.

I have to say that I would consider this as a success and the reason I'm giving this example isn't to say how great the BDA are – though they and they were particularly great in this situation – it is to say is that with that bit of support, we suspended the practice for a month initially, thinking that we would probably have to suspend for another month. Within two weeks the dentist had given us a call back, asked us to come back and re-inspect and that afternoon we re-opened.

With that kind of support the practice is able to continue. With that kind of support the patients are able to benefit from a continuity of service and that is the type of system that we talk about when we talk about encouraging improvement. What we want to do is to encourage practices to continue to provide the good services that they are doing for patients. Where we find that they're either incapable of or patients are at risk, clearly we need to act, but we only need to do that as a last resort. What we're trying to do is to work in partnership with the local economy to reduce the pressure and the stress of dentists but to increase the effectiveness of dental provision.

And listening to yourselves, participating in conferences such as this and also benefiting from the advice of dental colleagues that we engaged to support us on our inspections, will hopefully get us to that place. As John said, we're not perfect. We wouldn't, at all, claim to

be, especially on the registrations side. The way we work, I'm not going into too much detail. It's slightly separate between inspection and registration.

In inspection, these are the changes that we're talking about and we're now, internally, moving these changes into our registrations side to make sure that they are as effective as we hope our inspection side is. So I don't want to overdo it because we do have other colleagues coming here but I did want to say thank you for, inviting me here. I'm very pleased to be here. Also just to say, keep talking to us because what we're trying to do is to help you improve.

Clearly we are a regulator. What we don't expect is to be liked by the profession but what we would want to be is respected and we appreciate that in order to be so we need to be open and transparent and honest with you about what we're trying to do.

Questions and comments from the floor

Q1: In the slide, John, that you put up initially, which talked about the role of CQC, it was 'monitor, inspect and regulate'. It was 'ensuring that practices meet fundamental standards'. I was at a debate at which Mike Richards… was saying when he was asked about ratings that the only reason they haven't introduced ratings is that they don't yet know quite how to do it. Is this something that we can then expect to have and that practices, very, very different practices that do satisfy these fundamental standards are going to be compared against each other or is this mission creep?

JM: Well, in the debate about ratings, people were split. People, many people, actually think ratings are a good idea because they can then be used as a marketing tool. But when only 10% of the profession are being looked at, it seemed a little bit unfair that your practice can have a rating of 'requires improvement' or maybe 'outstanding' and 90% of the practices don't have the marketing benefit of that. So while that debate is going on, that's why ratings are not being used.

And I think it's actually quite rational to do it that way. I'm not disagreeing with my colleague, Sir Mike Richards, but there is a sense in which it's either ratings for all or ratings for none. And if there are going to be ratings for all, my personal view is that they've got to be the right ratings, they've got to stand up, we've got to believe that those rating judgments are sound. Sam?

SB: Absolutely right. Professor Sir Mike Richards is our chief inspector for hospitals. We work in the directorate that's led by the Chief Inspector for primary care, Steve Field, who happens to be a general practitioner. Absolutely support the point that John was making in relation to the 10% issue. There isn't, at all, the view in CQC that we're going to increase significantly the number of inspections that we are or I am going to undertake.

What we're doing is starting off from the premise that dentistry is providing safe, effective care and the 10% that we're inspecting is a balance of risk and randomly selected locations. There isn't an intention that we move that significantly towards a number that would justify us rating.

So clearly there isn't any mission creep but there is clearly an issue that, as John has highlighted, that if we are going to rate it will need to be from an inspection basis of significantly more than 10% and, just to use the phrase that I think that John helpfully used, 'it's ratings for all or it's rating for none'.

Q2: A question for Sam and John. Do the CQC look to carry out record card inspections or, indeed, any clinical assessments in the near future?

JM: Interesting question and it's a debate that's beginning to arise through the new inspection programme. In many ways some people feel that if you do have a look at record cards in practices it gives you a bit of a snapshot of whether consent is being handled properly, whether medical histories are being adequately taken to ensure the safety of patients and so on.

Some people have felt that, maybe, CQC should be looking at clinical care, and as I said earlier there is probably a debate to be had about that and a debate to how it might happen. CQC doesn't look at clinical quality per se in other areas. It doesn't check that your hip replacement has been done adequately and to a good standard. What it checks is: is the environment conducive to deliver quality care?

So it's an interesting debate that's been brought up this morning. I don't think the CQC has got any plans to do any of that but the CQC, as I mentioned earlier, is responsive. And so it's an interesting idea. We're listening to it. I'm sure NHS England are listening to it. In the light of what was said about contract reform and the conference here is saying, we actually need some clinicians to look in patients' mouths to see whether the clinical care that's being given is good enough. And particularly, if we did have a reform contract that was heavy on capitation, in particular to make sure that there's no neglect of patients.

So it's an interesting argument, particularly within the context of reform and, I think, the conference has given us a lot to think about.

SB: So we do look at a very small number of records on inspection but, as John said, that's only to, corroborate the patient journey. It's not at all to look at the clinical aspects of care. It's just to understand the dialogue, effectively, that takes place between the dentist and the patient.

Also, that gives me an opportunity to clarify a point earlier. As John said, 99% – I mean, I would like to say 100% but you can't ever be that certain – but 99% of all our inspections will be conducted between an inspector and a specialist advisor and that specialist advisor will, most often than not, be a dentist.

That is the case, so currently, every inspection that we undertake should have a specialist advisor alongside it unless the inspector is confident enough about the environment in which they're walking into, to not take one with them. If they don't take one with them then we'll want to know why but they will also need to have access to a specialist on the phone in case anything crops up whilst they're there.

Presentation on the Dental Activity Review Programme from Carol Doble (Head of Dental Services, NHSBSA), Paul Gray (Senior Clinical Adviser NHSBSA), Sarah McCallum (Dental Activity Review Programme Lead, NHSBSA) and Carol Reece (Senior Programme Lead (Dental), NHS England).

Slides can be downloaded here:

http://www.ldcuk.org/documents/archive/2015/163-2015-dental-activity-review-slides

Carol Doble: Good morning, everyone, and thank you for having us here today. We were invited to speak on a specific area that we're working on at the moment, which is a dental activity review on 28-day re-attendance. So we're going to zone in specifically on that but I am going to introduce us as a whole and what we do and make the point, really, that this is not a new activity for us. This is very much what the NHS Business Services Authority has been doing ever since the new contract came in 2006 for the NHS.

In terms of where this programme started, it all had its roots back at a report that was produced by NHS Protect, which I don't know how many of you are aware of. But they carried out a dental contractor loss analysis which was based on 2009/2010 data and they published it in 2012. And this was estimating what they term – and you've got to bear in mind this is NHS Protect's words. This is very much their lens, if you like, on the world – they were talking there about 73.2 million per annum based on assessment of resolved treatments, as potential suspected contractor fraud.

Now, I know that's a very emotive word and that's certainly not a word we are using in context to this 28-day re-attendance so I can reassure you on that. What their report was looking at was quite a wide range of issues. So they were looking not just at the re-attendance or 'splitting issues', as we have called it, they were also looking at areas such as up-coding, they were looking at areas where fictitious patients, patients that hadn't actually turned up for appointments but the UDAs were being claimed so we're looking at quite a wide range.

Now, what we have done in subsequent analysis is we have re-looked at the data and we've looked specifically at the whole issue of splitting re-attendance within 28 days and we're valuing that between 52.4 million and 63.5 million. What we are not saying, and I can't help but emphasise this, this is not all inappropriate by any means. We're not saying that. What we're saying is this needs to be looked at and Sarah, when she comes on to talk to you, will show exactly how we've approached this. But this is just to give some idea of the scale and the magnitude of what we're looking at. So we would do that as a normal course of action in terms of assessing whether it's worth us looking at it in more detail. So that's why that valuation is done.

Subsequent to the NHS Protect report, ministers got very interested. As you all know the NHS is under huge pressure financially so ministers, NHS England are all looking at ways in which we can try and make the money go further, try and treat more patients, give more effective care for the same or, hopefully, less money. So they were very focused on this. NHS Protect went to frequent meetings. We also attended, NHS England attended, DH colleagues attended and what that resulted in was a business case that we all put together which showed what we could try and do to tackle some of the issues that have been raised in NHS Protect's report.

And that's why we and our colleagues are focusing on the 28 days because it's very clear in the data where it's happening, it's unambiguous and it's something we felt that if we start

that programme we can look to see if there are any other areas of concern that might result out of the detailed work we do. So that's why we picked that.

In terms of the programme of work it is very much owned by NHS England and Carol Reece from NHS England will come on at the end of our preesntation to talk about it being a joined-up exercise and it's very much sponsored by them. The reason we're standing in front of you is we're the guys who are actually executing this programme so we can talk about the detail for you.

It's very early days for the programme and we did explain this when we had the invite, that we can't talk about a lot of the detail of what will happen once we get into the programme, hence I'm talking through the background. We're talking about why we're focused in on 'splitting' and what we're actually doing to approach it. So we can talk about the first few steps that we're going to take which hopefully will clarify things to any of you that are aware of this and aren't sure what's actually happening.

I also wanted to just give us a background of what we do already and what we have done since 2006 and obviously those of you who knew us before that as the Dental Practice Board, you know we used to do it under the Dental Reference Service. So we have a clinical service. There are 12 clinicians headed by Paul who'll be speaking in a minute and that team carry out a wide range of activities.

We've adopted a risk-based approach. So what we have done is worked closely with our statisticians and our analysts to look at data, to look at the patterns to see if there's any reason for us to look at any particular issue in more detail. And then our clinicians will take that on as individual cases, or they might look at particular exercises we might run where we're seeking more information on a particular activity. So our clinicians are very much at the heart of all this and they're leading a lot of the areas that we're looking at.

So they will range from, as I say, working at the risk model end, so looking at how do we try and pore through our data to look at the areas that need a bit more investigation. And then once we've done that we'll actually have cases and the guys work on about 340 cases a year. So we will look at specific cases and that might mean calling record cards in. It might involve patient exams. Not always. It depends on the nature of the issue. And after that activity, if there's a case there, the evidence points to there being a case, we will provide a report to colleagues in NHS England and then they will take that forward through their various commissioning activities.

In tandem with that we also have general contract monitoring that we do and that's where, again, we're just trying to claw in a lot of data. So we go for a variety of sources. Obviously the FP17 and the activity data that you all submit is primary source material for us. But we also add into that information we get from patients. So we conduct patient surveys every year. There's about 300,000 to 400,000 of those we do a year. We're looking at ways we can try and increase that because I think we're all saying the patient voice is an important voice to be heard. So we're looking at how we can increase that.

We also do checks on patients as well so where patients are claiming exemption from paying for treatment we are picking them up where they don't actually have that exemption. So we are then obviously charging them for the treatment they should have paid for in the first place plus they do get a fine because they should have paid for it in the first place and didn't and it's a deterrent factor in order to achieve that.

We also have produced a lot of reports. Since 2006 our team of analysts and statisticians have pored through the data and have, in conjunction with NHS England, produced a whole range of monitoring reports that help the commissioners manage contracts. And we have

also done reports as well that we are sharing more and more with yourselves as well. So the Vital Signs, for example, is a typical report that we have developed from the data to try and help everyone focus in on the areas that they should be monitoring or areas where they're a bit out step with their colleagues. So those are the kind of things we've been working on.

But in everything, what we're trying to do, is to look at those unusual patterns and the next slide I've got is an example of a review we did back in 2013, which is looking at Band 3 treatments on children. So what we were looking at there was the incidence of treatments that we're carrying out on patients and claimed as a Band 3 and there were 72,000 courses representing 0.7%. So, for us, that was a significant trait in the data so we then explored it by identifying 383 contracts that we then got more information on. And we reviewed the responses. Our clinicians looked at them and 81% of those had a concern which was then raised with the area teams.

And the important point I want to make on this one as well is that a lot of what we're trying to achieve here is behaviour change. It is not about wielding the big stick, it's not about trying to get loads of dentists, you know, back through the contract process, etc. This is all about trying to get dentists to, kind of, work in the way that the NHS feel they should be working, what the standards are, etc. So with something like Band 3 treatments, where we've asked for clarification or we've brought it to the attention of clinicians, we've seen a behaviour change.

So, from our perspective, that's as much as we're trying to achieve in what we're doing on 28 day re-attendance - behaviour change for the vast majority. We are only looking at taking action on the very extreme end where you're literally talking in the hundreds at most. So for the thousands of dentists that work in the NHS it really is not an issue. It is much more about tweaking behaviour. In some cases, it may be a bit more than tweaking but that's really what we're trying to achieve here.

Paul Gray, Senior Clinical Adviser NHSBSA then took delegates through a detailed case (see slides).

Sarah McCallum, Dental Activity Review Programme Lead then focused on the operational aspects of this Dental Activity Review - looking at the data, the volume of it and how it's distributed across contracts, moving on to look at the operational objectives and how the BSA intended to achieve these and ending with an overview of the timeline.

‘Previous analyses and assessments have shown high volumes of courses of treatment being provided within 28 days but they've been carried out on different periods going back to 2009/ 2010. This exercise we're focusing on 2014/2015 and that's where we're going to be focusing our attention. We've looked at the data and we've refreshed that and the good news story is that the rates have reduced. We've seen the volume of 28-day re-attendance claims reduced by about 17%, which is great news for the profession.

A large part of that is because some contracts have closed. Another, we are also seeing a general trend for a reduction in these 28-day re-attendance claims. But there are still significant volumes within the dataset and we do need to remind ourselves that we're expecting this to be a relatively rare occurrence.

So in 2014/2015 there were around 760,000 FP17s that fell within 28 days of a previous course of treatment and this represents around 1.7 million UDAs. Now that's a lot of treatment, it's a lot of access, it's a lot of dental activity. It also represents around £43.5 million when we apply a £25 per UDA metric to that. So clearly there is a lot at stake here.

We're not suggesting that all of these are problematic but at the moment we don't really have a feel for how much is problematic and how much is genuine.

When we look at the spread of this data, we can see that the average rate for claims is 2.5% but that data is quite clearly skewed. What you can see is that less than a third of contracts have rates that are higher than the average and these have made 64%, nearly two-thirds of those 28-day re-attendance claims. So they're clearly skewing the data. So we might reasonably expect that a proper average will be well below the 2.5%.

What we do with our exercises is we identify where the largest element of activity is, where there's most likely to be a problem and we focus in on those contracts. We don't want to have a huge impact on everybody. We want to focus the resources where they're best placed. So we've identified 277 contracts – that's about 3.5% – who have the highest volume of 28-day re-attendance claims so they're in the top 500 nationally, and also where their rate is 3.75% or above. So that means that they're 50% or higher than the national average that we think is already skewed.

So we think this is a sensible approach, a sensible place to start. It's a reasonable number of contracts. It's in line with the volume of contacts we would typically look at with a dental activity review. We're also extending the exercise to invite a further 712 contracts and those are the remaining contracts that are 3.75% or 50% higher than the average or above, that didn't fall into group A. And we're going to invite them to have a look at their data, review their claiming and report to us if they're so inclined.

So we'll be happy to provide the data to any other contract. That leaves about another 7,000 contracts. Within that it's probably worth pointing out that there will probably be about 20% of the contracts nationally that are still above the average. So I'm sure that the profession, once they see these figures, will want to look at that data for themselves, look at their own contracts, look at their in-practice procedures and see whether they possibly have any issues or any behaviours that they want to change locally. But we're not intending to touch those contacts. This is going to be a light touch exercise. We want to engage and we want to provide the profession with an assurance that we are tackling the issue where it is most problematic.

So in terms of our operational objectives we primarily want to improve our understanding and raise awareness. The feedback from the casework, the feedback from the self-reports on the self-audits should enable us to improve our overall estimate of the risk landscape. We don't know at this stage how much of this is down to claiming practice, diagnosis, treatment planning, patient features, patient behaviours or something that's part of the contracts that we're not otherwise aware of. So this exercise should enable us to inform that estimate.

As well, as I said, we want to engage with the whole profession. We don't want dentists to be sitting there wondering if they're going to be next on the list. Everybody's going to be aware, very early on, what their figures are and whether or not they will be involved in the 277 that we will be tackling. We're hoping as a consequence of that engagement and that assurance that the profession will engage with us, they will understand the splitting issue and they will look and take that opportunity to view their figures and see what's happening.

Inevitably, there will be some instances where there is evidence of a pattern of splitting courses of treatment and where we do uncover that we will obviously have an obligation to recover those monies to the NHS.

So what happens next? We've got three phases to this exercise. The first phase is what I've described already where we write out to every single provider. So anybody who holds a

contract will have a letter telling them what their rates are, explaining whether they are within the 277 that will be asked to submit records for review or whether they're in the next tranche, where they have a high rate we're inviting them to self-audit and to report their findings to us or whether they're in the larger batch of 7,000. For most of those dentists this will be a letter for information only but all of those dentists are invited to request their data and we'll provide that to them so they could have a look at the data and whether there are any, sort of, skewed patterns within their practice.

The second phase moves onto the formal review where group C are asked to submit their records. All of those responses will be subject to casework and clinical review and we have a team of administrative caseworkers who are going to be supporting the Clinical Advisers' review of the records, the data and the other information. One of the other things we want to do at that stage as well is to start talking to some of the contract holders who have very low rates and there are a large number of contract holders with low rates. We want to talk to them to understand how this is achieved. Are there policies or procedures that they've implemented that enable them to ensure that they don't have an issue with this?

And then finally phase three. This is where we will extend the formal review phase to the group B providers where we haven't had any engagement and we haven't seen any change in their behaviour. So, again, it's about engaging, providing an assurance, providing an opportunity to look at what's going on within your contract and, if necessary, to implement policies and procedures.

The timeline around this. On Monday there's a message going or an article going in the BDJ, In Practice. It's a very short article but it just summarises this exercise. So your colleagues who aren't here today will know a little bit more about it if they don't already. We've also put a message to dentists on our own portal.

Phase one commences at the end of June. We will start sending out those letters to all dentists and they will come out within a two week period. So by the middle of July everybody would have received their letter. And at the same time, or as soon as that ends, we will start the phase two review, which is the formal request for records.

So really the main message is - it's part of business as usual. It's a dental activity review. A relatively small number of dentists will have an operational impact on them. We're wanting to engage with the profession so that everybody could look at their own data and provide an assurance that we're looking at this issue and that we're creating or hoping to help create a level playing field for those practitioners who don't have an issue.

Carol Reece, Senior Programme Lead (Dental) NHS England, then spoke on the NHS England view and involvement in this.

'NHS England do own this programme although we have actually delegated operational support to the BSA. So you will find that the letters coming out will come out via the BSA but very much with the involvement of NHS England and the knowledge of NHS England.

There are a couple of project boards that have been set up to provide assurance. NHS England do sit on those. And I think the important message here is that there's been lots of noise about some inconsistencies that have been happening across areas. Taking this approach, we're actually doing a unformed approach across the whole of England but also the important thing to say is that, actually, where there are individual cases that need further looking at, that will be done on a local level.

So we've got the national approach with some local level and local support for any inconsistencies that may be coming through there.

Questions and comments from the floor

Q1: You talked about understanding the landscape and part of the landscape is the confusion and lack of clarity about what to claim and when, for a practitioner when very often you have to make a snap decision when a patient comes in within 28 days, of what to do. My fear is that, actually, dentists, because they'll be scared of actually claiming something, that they will be just doing it and not putting a form in because they're frightened of triggering the response.

And the other thing is, looking at your top line of savings, there's 92.2 million that you felt was subject to fraud or whatever and by my calculations there was still 30 million to 40 million that we would class as not splitting and outright fraud. Well, I've got no qualms about claiming against patients who don't exist or dentists who are doing treatment that they're not actually doing.

But I know, you know, that the instance that was shown there was probably bad treatment planning but you can't say that all the treatment wasn't done and, you know, I think there's... we need some assurance that, actually, your patient behaviour will not actually lead to dentists doing treatment for the NHS out of their own pockets.

CD: I think in response to that, I don't think anything we intend to do is for dentists to be paying out of their own pocket. I think what we're trying to get across is trying to get some clarity around at what point do you actually claim for the course of treatments. And, yes, I think in a lot of cases it is quite vague but I think this exercise is trying to inform us of what is that clarity that's needed.

So what I would expect, for example, is ourselves in conjunction with NHS England will be issuing a lot of clarification, a lot of guidance on the back of this exercise that will prevent that but it certainly would be a totally unintended consequence if what you've described actually happens. It's not the intention of this. It's trying to get everybody working in the same way and I think Sarah used the term ‘level playing field’. You know, we are talking about a very small number that we're tackling here. The vast majority are doing absolutely nothing to worry about whatsoever in this regard. So I think we just have to keep the context that it is a small number we're looking at.

Q2: You gave an example of Band 3 courses of treatment in children. I just wondered if you'd done any analyses of what was in those Band 3 courses of treatment and whether any of it was orthodontics? Or interceptive orthodontics?

PG: Yes, there were some sports mouth guards were being made. That was quite a significant element which, as you know, isn’t appropriate to the NHS.

(Your conclusion was that this was a good result. I’m not sure that stopping interceptive orthodontics is a good result).

Q3: Thank you very much everybody. It's interesting the case you presented, Paul, was of a UDA value of over £38. I wish I got that. Some of the low rates, you haven't given any indication why, as yet, people are on low rates as opposed to over-claiming and I think some work needs to be done on that because I think an awful lot of practitioners are actually scared of claiming for something. So there does need to be more clarity and I think whenever your letters go out, I think you ought to be specific about what the rules and regulations are because I'm sure an awful lot of people don't understand that.

And I would like a request, please, to have more cooperation and communication with the GDPC. We're still waiting on the final letters that are coming out and what information leaflet you're going to provide and we have made a request but it's not been forthcoming as yet.

Q4: I've got a number of problems with this. I mean, the case that Paul was showing must be a very important case because it was exactly the same case that Barry Cockcroft showed us in January. So it seems like there are not that many of those cases. But apart from that what we were told in January was that this was an exercise to try and get hold of the worst ones only and he was talking about treating dead patients and things like that.

That all seems to have gone away and now we're just chasing all the dentists to try and get them, and I quote, reduce the number of claims over 28 days. The purpose of this, in my opinion, is not a question of reducing. The question is to get dentists to claim for the right number of UDAs that they're entitled to claim for. And, actually, I think it would be great if we could, from the BSA, have some clarity about what people can claim and not claim.. There are a number of, particularly young, dentists out there not claiming for the UDAs they are actually entitled to. And I find that... you might call it, Carol, 'an unintended consequence' but it's obviously a consequence of what you are sending out now.

I also think, there was something about sports mouth guards not being available on the NHS. That's not true. There were PCTs that specifically allowed sports mouth guards to be done on the NHS and claimed for as we started on this whole process. So that is simply not true.

You also said, Paul, that there was no assessment of why the denture was broken. That's not true but it wasn't noted in the file. There might very well have been an assessment before that. I think this whole exercise... I have to be honest with you, I'm actually steaming about this. I want you to come up explaining exactly all the grey areas about what we can and cannot claim for. And I think everybody here would love you to do that. The BSA need to ensure that we claim correctly.

CD: And I'll also add to that, we are actually trying to do exactly what you are asking for - to try and point out the areas - to get clarification to you all. So that is the biggest aim of this exercise is to get appropriate claiming.

CR: In terms of working with you that's one of the things that I'll be feeding through in the regional meetings that we have so I very much want to listen, very much want it to be a two-way dialogue and be open and transparent in the findings that we're coming across.

Q5: I don't understand why you're using volume as well as rate. Volume will naturally be greater in larger practices. So just to put it very simply, if you've got a practice twice as big, their volume will be twice as big. So why are you using volume as well as rate?

SM: We look at the volume as well because if we'd looked purely at the rate we could be picking up, in that initial batch of contracts, some very small contracts that simply have a high rate. So we've taken advice from our statisticians. It's a similar methodology. It produces similar results to a more complex outlier methodology but it's a much easier method to understand and for us to explain to colleagues and it gives that clarity. So people understand why they've fallen into that category. But volume is important because that's where most of the activity will be and the rate could include some very small contracts that aren't of such significance and aren't of such a priority.

Within the 500 highest volume contracts, I mean, there were 277 that fall within high rates. There are 223 that don't. So there are some very high volume contracts that don't have high rates. So they've fallen outside of that exercise. We're not picking just on the high volume contracts. We're looking at the combination of the two which gives a better view of issues as they fall.

Q6: This exercise is being carried out looking at the rates based on the providers. Where you identify the practices you're going to go into, could those rates then be split up into the performers as well because I think from a provider point of view it will be quite possible to have a performer within your practice who was doing a very high rate and everybody else was doing really well and I think you would need to know that information as a provider.

SM: Yes, we've prepared the data so there is a breakdown by performers so you can see where those 28-day re-attendance claims are coming from.

Q7: With the Vital Signs and the statistics we had a letter in our practice last year, a practice which was historically known as a socially deprived area-serving surgery and the statistics show that we had a very high percentage of Band 2s and 3s, overall, as part of that contract. Now I looked at this for about three days thinking that if I am so high above these rates, clearly I'm an outlier and if we don't correct these things we will be investigated and are the associates claiming in the right fashion? What transpired was, we actually had a very low percentage of Band 1s because almost everybody who comes through the door wants a tooth out, wants a filling, wants a denture and then we don't see them. We've tried umpteen times to get dental recalls but in my practice people do not come back for dental recalls. Now, I feel that the statistics I had, if only a 1,000 patients turned up for dental recalls in a year, all my statistics will be perfect according to NHS England. How do I fix that?

CD: I think one of the big points I hope you carry away today is we don't just look at the data. I think the biggest point we're trying to make is that the data only signals where there might be an area for us to look into. We do absolutely know that there will be circumstances like yours which give a perfectly valid and justifiable reason why you have high numbers of Band 2s and 3s. I don't think anything we said today contradicts that which is why we couple it with follow-ups, etc.

The data just gives us a starting point, that's all it does. The rest of it is around us actually talking to you, like getting your record cards in and talking to and getting more information on why your pattern is slightly unusual. And in your case, for that, for example, we would say that that is perfectly reasonable and it wouldn't be a problem.

I think you might be indicating, I'm not sure, but that might be an educational issue we need to do with all the commissioners because a lot of people can just go in on the data. We've worked with this data for years and we know all it ever does, it just points things out. It's not the whole picture. But it could be that people you've dealt with may just take the data as king. So I can't say sure but it could be an explanation for what your experience shows.

Q9: Well, we have just heard from the CQC they're involving specialist dental advisors. They're involving the profession after they've listened to the profession. You will be using lay advisors to read record cards. How will this give confidence to the profession in what you are doing?

SM: Yes, we're going to be using caseworkers at the initial phase but after that, the clinical advisor team, who are qualified dentists, will be looking at their work and will also be

monitoring what's going on. So it's very much clinically-led with the caseworkers just helping to support the clinicians.

The caseworkers will be providing the first pass but every decision will be going through a clinical advisor through a review panel. So there won't be any independent decision-making by administrative workers.

Q10: I just wanted to make a point that, I think has already been made which is you just don't know where to start with this. It is so misguided it's almost unbelievable, to pick an average figure and think that you can then extrapolate. It looks like you're going to be contacting almost 1,000 contracts on that. It just makes absolutely no sense whatsoever and if you want clarity, we've been asking for that time and again and again. Bring out your rulebook. We'll have a look at it.

Q11: You're taking the behaviour change as a positive effect of your intervention on the contract, when in likelihood you're going to have a cohort of practitioners who are actually claiming things legitimately but on the basis of the fact they find themselves as an outlier on the national averages in an area where those national averages may not apply (And then probably, in likelihood, not claiming for things that they should be to try and get themselves down within the percentages that aren't going to flag themselves up as an outlier.)

CR: None of what we're doing here is intending to drive dentists to not claim for what they're entitled to. This is the first time we've publicised this sort of data so I don't think we would have seen that behaviour before now, if that does become an unintended consequence. Looking forward, we are looking to engage with dentists who have low rates, so we will at that point, hopefully, be picking up if there is anything like that happening. But it's certainly not a driver for this piece of work.

Contract Reform Policy update from Helen Miscampbell, (Department of Health) followed by Q&A with a panel consisting of Dr Serbjit Kaur (Acting Chief Dental Officer), Carol Reece (Senior Programme Manager, PCC, NHS England), and David Glover (Department of Health) and Helen Miscampbell

So, I'm starting with a brief description of the timeline from here out. We've selected the prototypes. Training will be over the summer. We will start to go live by this Autumn, from the middle of the Autumn. There will then be at least eighteen months of prototyping. If that has gone well, we'll then move to what we call stress testing, when more site will join and we'll see if it works in harder to reach sites and locations. If that goes well, the start of a possible national rollout will be 2018/19.

Now, I'm just going to very briefly describe what's in the prototypes. The clinical approach is as it was in the pilots. For the prototypes, the preventative pathway is as it is running in the pilots now. We're not making any changes to the clinical approach for next year.

The DQOF, the principle, remains the same and it is still ten per cent of total contract value that could be at risk. There are slight revisions to the data collected and the metrics, but there's no difference to the amount of remuneration at risk. And it's still top sliced, it's not additional money.

Remuneration is the new bit; as I'm sure everybody is aware. And we're going to be testing a blend of activity and capitation. And we're going to be testing two blends with the boundaries set at slightly different points. There's also a slightly less well known bit of the pilot. They are testing registration in a very basic shadow form, as the mirror image to capitation. Contracts actually state that while a patient is under capitation, they have a right of return. That will also continue with the prototypes.

Now, the final thing I want to leave you with, before we go into the discussion, is the very high-level success measures for this programme. We have three high level measures of success. We have to deliver on access, and we have to deliver on improving oral health

and delivering appropriate care because those are the two goals ministers and the government set for contact reform. It is the point of contract reform. And we also, as with any government department and any initiative, we have to deliver value for money. And we have to assume that we've got the existing envelope. There isn't going to be a fairy godmother with extra money.

Questions and comments to the panel - Dr Serbjit Kaur (Acting Chief Dental Officer), Carol Reece (Senior Programme Manager, PCC, NHS England), David Glover (Department of Health) and Helen Miscampbell, Department of Health

Q1: I'm just curious that from the pilots, the one rock solid piece of evidence was that additional care affected access. And I think pretty much all the pilots suffered on access. And it seems to me that you've completely ignored that fact and you're, more or less, trying to force an extra productivity gain onto us in addition to the other elements you've brought on.

SK: I think one of the key elements of the preventative care pathway, is about appropriate care for patients and appropriately using NHS resources. Now, I think that if the pathway is working in the way it should, that means that patients who have less need, are seen less often, and, therefore, they use less NHS resource. And that decrease in the resource that they use is used to take on new patients.

Now, we don't really understand how the pathway really works in practice because the pilots actually didn't have any levers or incentives in place. So there was no efficiency measure, if you like, in terms of how practices were delivering the pathway. We also think, within the prototypes, what we really need to test is whether the pathway is actually value driven all the way through. I think there are parts of the pathway which pilots have been telling us are very resource intensive and may not actually be delivering an improvement in outcomes. I think the prototypes will tell us that as well.

So I think we haven't ignored it... I think the pilots have told us an awful lot. But what they didn't do, was work within a contractual framework with the right levers and incentives in place. And we need now to see how this actually operates in a real system. And it very much depends on, actually, where those levels are set around access; around activity and around capitation.

HM: I would just add that we've just done a recent round of practice visits. Because while the majority of pilots did lose access, we have at least nine who either didn't or have recovered it. And we've just done a series of visits led by a clinical advisor from DS and also with an experienced manager, to look at those pilots and see what made them different. And I can talk a bit about what did. But, our first questions was: have they simply got rid of the pathway? And the answer was: absolutely not. They were performing clinically in the view of the BSA's Dental Adviser.

Q2: Your three success measures seem to be mutually exclusive. You cannot have more treatment provided on the same number of patients for the same amount of money that is being provided now. Something within those three has to give to be able to make it workable. And I... I want to know, what you want to look at changing to make the contract workable.

HM Well, I think that assumes the right level of activity is happening now. And I think part of the learning is seeing whether people do need quite the level of treatment that, arguably, the UDA system promotes.

(Prevention is the side that's getting brought into the contract, and that's not measurable within the UDA system)

That's exactly why we're prototyping a new system, because we know we can't measure prevention; we can't measure outcomes in the UDA system. We want to measure both as we move forward, because that is the way the NHS is moving. Preventative focus and a focus on outcomes, rather than activity. But we need to make sure, within a capitation system, that appropriate activity is being delivered. And that's why we moved to a blended approach to make sure we can actually... to see if we can actually measure that. We don't know if we can yet because that's what the prototypes are testing.

Q3: I have three questions. My practice is a pilot practice. It's really regarding, first of all, the activity targets. Will they be based on the pre-pilot activity targets? The second question is: how much time will I have once I actually receive the details – the final details of the prototype to decide whether to go into the prototype or not? And then if I decide not to go, will I be required to deliver all the UDAs pre-pilot within the first year?

DG: Well, the first bit is: obviously, we're very conscious of what the volume activity levels have been. And, obviously, we have the data on what pilots have been delivering now and what they were delivering when they started taking part in the pilots. Unfortunately, I can't give you a direct answer because the decision has not actually been taken yet. But we are mindful of the situation. We're looking to make a sensible decision on that. I realise that's a very political answer, but that's all I can say at the moment.

HM: On the second… the short answer is: as long as it takes. But, obviously.. there would be a reasonable amount of time; it won't be, we'll write out with the details and expect an answer next week. And as with the pilot start up, the national team and the commissioner will be working through with the practice owner, the implications of the contract. It's probably worth saying that one of the learning points from these nine practices we visited, and also the wider learning from the programme, was that, necessarily, we were all learning together in the pilot. So we didn't give providers the clear steer as to how to make this work. This time, we want to discuss the business element just as much as we discuss the clinical element, because a lot of the feedback has been about the clinical side, and it was much, much later that we had clarity on what we had to deliver contractually.

HM: On point three… We can answer in general terms about exits, but I can't obviously, answer a particular individual. Those who are now exiting, are agreeing recovery with their commissioners. The programme is facilitating that, and so far the feedback is, generally, that those conversations are going okay. ..We are doing everything we can. And commissioners are telling us that they want to be reasonable, because we recognise that people have put a lot into the programme.

Q4: In terms of DQOF, it is listed as 10% of the contract value. ... and my understanding is that we're looking at clinical effectiveness, patient experience and safety. In your prototypes, pilots or financial modelling, are you expecting practices, particularly those in high needs areas to actually be fulfilling all the DQOF and getting their 10%? Or is your financial modelling showing that you are recovering some monies that way?

DG: First of all, I have to say, there seems to be a slight misunderstanding that no monies get recovered from DQOF. Any money where one individual practice doesn't score their full points, that money goes into a pool, which then gets redistributed to the other participants in the scheme. So that's how some people can earn slightly more.

(That is recovery then? In your analysis, have you got experience of how practices in socially deprived areas are performing ?)

DG: We haven't done a full analysis on those levels, but, just looking at the figures yesterday, the vast majority of participants have high scores. So over, say, 900 points. I don't have the proportions off-hand but there are large numbers which are getting at least 900 points. Obviously this is a pilot and prototype stage so we've deliberately tried to set thresholds at an achievable level.

SK: The thresholds are quite realistic. It is about setting the thresholds at the right level. The other thing that we recognise is, that actually, to deliver outcomes on patients who don't engage, is far more difficult. And so that's why the DQOF also has a number a number of process measures in there as well because as a practitioner you can give the advice; you can give the preventative interventions, but you can't actually dictate the outcomes, because it requires a patient to do something as well. So, the DQOF also has a number of process measures. So providing the practice is doing all the things that they should do, then, actually, that takes away some of that, if you like, inequity in terms of the patient base. But actually, the inequity is taken out by setting thresholds at the right level.

And we have to see how that works. As I say, we're being quite ambitious, in many ways, in going straight to outcomes; there is nowhere else in the health service that, actually, outcomes are measured in this way from any clinical intervention. So, we are being quite ambitious and that is what we're trying to test out on the prototypes. …does it actually... is it a disincentive to take on the high need patients? If it is, then clearly, it is not fit for purpose.

Q5: The information that's been given out prior to the prototypes, states that you... you're going to analyse A and B, to see which one is right. ..my question is about the evaluation, and at what stages in the process are you going to re-evaluate that; and at what point might you decide that A or B are not right?

HM: I'll answer that in policy terms. As I said: the prototypes will run for at least eighteen months. So I would expect… in fact, I'm absolutely sure both plans will run for eighteen months, unless there is something catastrophic about one of them. They will test for at least eighteen months. After that, we'll take a view.

Q6: Since you last presented to us, about three months ago, your roll out dates seem to have slipped a year. And, on that basis, I wonder about your commitment of ever getting to where we're trying get to? And if you look at those three high level outcomes, as our colleague in Wales stated, it won't work in a fixed budget. There's a simpler, quicker, easier way of getting to where you want to get to, and that's full capitation.

HM: I'll take the first question first. Unusually, for a civil servant, I can be categoric. Our roll out date hasn't changed in the last three months. It absolutely hasn't.

Q7: Thank you. Mine is a very simple question. The UDA has been discredited by everyone, including the outgoing CDO. So why do we still use the UDA as a measure of activity?

HM: The short answer is: we're using it for the prototypes is because, in the time available, the complexity needed to develop another activity measure would be completely unfeasible. We're talking about starting prototypes in years, not six months. That does not mean the UDA is set in stone. It does not mean the UDA will be the measure of activity in any rolled out contract.

(But it's highly unlikely that when the prototype does become the eventual final contract, that you will have developed a new currency).

That will depend very much on what we learnt from the prototypes. But we do realise that there's some work that needs to be done on the UDA. The UDAs, at the moment, as they stand in the bands of course of treatment don't reflect the complexity, particularly the band two, doesn't reflect the complexity of some of the care that's delivered there. But at the moment, we have a patient charge system which is related to UDA and course of treatment, which we have to keep using, because we can't have a different charge system for prototypes than we have for the existing practices. So we have no option but to continue to use what we have in terms of the patient charge regime at the moment. But we will need to look at that because you're quite right.. the activity measure must reflect .more accurately. .the amount of care patients receive –the amount of care from the practice's end in terms of making that patient healthy. So, it's something that needs to be looked at, but we can't do it in this time frame.

Q8: I have a concern regarding the flexibility between capitation and activity. I understand from today's event, there will be flexibility one way but not the other. And there are many different types of practice and different patient cohorts that have made different demands. I do feel that could cause stress within the prototypes.

HM There is flexibility both ways, it's just a different level of permission needed. To flex from activity into capitation, no permission is needed from the commissioner. It is the provider's discretion. To flex the other way from capitation into activity, because patients need more treatment, is allowed in exceptional circumstances, but has to be pre-agreed with the commissioner.

(How could that be proven,... I don't understand how that would work)

DG: It's contract discussion, in the same way at the moment if you wanted to have a contract discussion for an expansion of your contract or more UDAs, you would have a discussion. I think I should also say there will be some tolerance levels with the contract as well. So, although there'll be what the notional level of activity should be, there will be tolerances either side of that to.. to give a degree of flexibility.

(What degree are you talking about? What percentage?)

So we're still working through the figures based on the delivery variation which happens naturally at the moment. I don't have the figure that I can tell you today.

Q9: A couple of questions, very quickly. Within your patient service, have you ever tried to determine what the patients understand by UDA? The next point is: there is a quantitative factor which everybody understands. Patients understand it. Clinicians understand it. You will understand it. Because we should be paid by the amount of time we spend with the patient. And that way we can measure activity; we can measure prevention, and we'll give you value for money.

SK: We did some surveys in the pilots, asking about the approach to care.. about the information they're receiving and whether that was appropriate but we haven't specifically asked the question as to what they understand by UDAs because that isn't really the focus of what we're doing. We want to get away from an activity-based mind set to a holistic care of a patient mind set...

(If you're trying to get away from an activity measured system, why are you bringing activity into the prototypes? You're already measuring us against access. So, let us get our access targets. We'll look after that number of patients, and it's a capitation based system. Let's... let's make it work).

SK: As a clinician I would love to have a capitation based system. I think everybody in this room would love to have a capitation based system. The pilots did not show us how this was actually going to work and deliver the care that patients needed or, more importantly, the access that was needed so we need a stepped approach. That is still what we want to end up with; that is a capitation based system. But we probably need a step approach to get there, to make sure we're not actually making big mistakes. The Government made a commitment to pilot the new contract. We are trying to pilot the prototypes to see actually what happens. They are not the final contracts. We are actually looking at what works, what doesn't work. But what was clear from the pilots was that we did need an activity measure to be able to understand what's happening to the patients themselves.

Q10: There are two blends being prototyped. GDPC has come out, very openly, and said that blend A, which has a large... relatively large amount of activity... in other words, effectively UDAs, involved; GDPC has said that blend A is not a good thing to go into. There is a lot of advice that practices would not be doing well to go into blend A, and yet, it is still being put forward. The danger is going to be that blend A is going to appeal to practices with a very, very particular business model. That probably relates more to the corporates. The fact that you're bringing this in, and the fact that a lot of other practices are not going to want to go in to blend A, at all, because of the risk associated with it, does this mean that you're actually very happy to see a lot more corporates in the dental arena?

HM We need to test both blends. I mean, this is a prototype stage when we test it. There certainly isn't some covert policy to increase or decrease corporate share. You know, it's really for your own associations to decide what to advise. We can only offer the prototypes to volunteers and see who takes it.

(In that case, are you going to release, with the prototypes, the ratio of independent and corporate practices, both in gross figures and in terms of blend A and blend B? And are you going to try and push equal numbers of independents and corporates into each blend?)

HM We usually try for a balance. One can never have a perfect balance. We tried for a balance in the pilots and we will try again for a balance here.

Q11: I'm a little confused **…** you were talking about the activity within the pilots. And yet Jimmy Steele spoke at BDA conference and suggested that the practice visits that they'd done suggested that the patients that they'd looked at had had the treatment that was appropriate. And hadn't been under prescribed any treatment.

SK: There were a small number of practices that were visited. But if we look at the variation in activity across the pilots as a whole, it was huge. And we couldn't, actually, using that data, determine why there was such a difference in that level of activity. So, that's why we needed to go to a blended system at this point, to understand, .. and what Jimmy Steele said in his report and what we, actually clearly know is: we still don't know what the appropriate level of activity for patients is. And we need to really start thinking about that; and that's what we will try to get to from the prototypes.

(So if we... we don't know the appropriate level of activity; we would expect it to go down possibly? Because if there's been over prescription in the past...?)

SK: Well, I'm not saying there's over-prescription... we don't know there's over-prescription, but what you're looking at now is actually, because you have to make somebody fit, you have to provide all the care that they need within that course of treatment. In a pathway approach, what you're saying to patients is actually: for those resource intensive interventions we need to make sure the patient has a stable oral health environment because you actively deliver them. So, that treatment may be delivered but it would be delivered, maybe, at a later stage when the patient has actually improved their oral health. Improve their motivation so we get better outcomes. So, that's the sort of complex, if you like, measure that we're trying to look at to see, .. can we measure, therefore, what sort of activity we would expect to see. At the moment, the pilots gave us a huge variation which was very difficult to understand.

Q12: Obviously, you're doing research here. You're testing unknown things on the general public. I ask you the question: have you undertaken ethics approval? And how're going to consent members of the public for ethics to do this testing on them. Because without it, you're breaking the law.

SK: We're not testing anything on patients. We're actually testing the implementation of delivering oral health. We're using delivering better oral health as the foundation of the preventative care pathway. It's an evidence-based approach. What we're trying to say is actually how does that work in real life. Which bits of delivering better oral health give the greatest benefits to patients and ought to be delivered by members of the dental team and, in reality, which bits actually might be delivered by somebody else outside the dental practice or in a different way?

Election results

At the conclusion of the day Dr Nick Stolls of Norfolk LDC was installed as Chair for 2016.

Dr Alasdair McKendrick was elected Chair Elect for Conference 2017.

Dr Tony Jacobs was elected as the Representative on the Conference Agenda Committee.

Dr David Cottam and Dr David Cooper were elected as the Representatives to the GDPC (for three year and one year terms respectively).

Other appointments were confirmed as follows:

Honorary Treasurer of Conference	Will Newport
Two Honorary Auditors to the Conference	Brett Sinson and Clive Harris
One Representative to the Board of Managers of the British Dental Guild	Howard Jones