General Dental Practice Committee

Report of the meeting held on 7 October 2016

Elections

1. Barry Kinshuck was elected to the GDPC Executive in place of Brett Sinson who has resigned from the GDPC due to ill health.

Presentation from the General Dental Council

2. Matthew Hill, Director of Strategy at the GDC gave a presentation and then answered questions from the Committee. He covered the following issues:

- Relationships between the GDC and BDA had gone through some difficult times but the invitation to attend the meeting was a positive step.
- Eighty nine per cent of the GDC's financial resources are spent on fitness to practise. That balance is wrong and needed to be shifted towards prevention.
- Very little has been done in the past to get the learning from cases back out to the profession.
- The GDC can't do everything by itself. It needs to be involved in the early part of the professional's career.
- The GDC is looking at how it supports the profession in meeting its standards.
- There is a tendency for all the regulators to use their fitness to practise powers to deal with everything. Perhaps other tools should be used. How can we support local structures
- There needs to be clear signposting to patients to enable their complaints to be dealt with by the correct agency and much better collaboration between the different organisations.
- The aim is to make the dental regulatory system more agile and more proportionate and for this the GDC needs to work with the profession.
- The GDC wants to expand the role of the Dental Complaints Service, average cost of a complaint dealt with by the DCS is £220 while the average costs of an FTP case is £72,000.
- The GDC is working with the larger dental corporates because of their good complaints handling measures.

- Fitness to practise processes should be reserved for those issues that need this level of sanction.
- The GDC should be more focused on public confidence in the profession and patient safety, it was not here to deal with minor disputes between professionals and patients.
- The GDC needed to help the profession to help itself.
- Looking at the future of regulation, the GDC was talking to people now and running policy workshops to develop its thinking. A public consultation would be launched in January 2017.

3. A GDPC member asked when these changes are going to happen when every month we are seeing cases that the GDC shouldn't be dealing with. Matthew Hill's response was that culture takes time to change, it doesn't happen overnight. If things don't look radically different in three years then the GDC will have failed.

4. The DH is considering a possible amalgamation of regulators from nine to between one and three. The GDC isn't in the game of self-preservation but criteria for decision making on regulation needed to centre on what is best for patients.

5. Members drew attention to the fact that NHS England local offices were still tending to refer cases to the GDC inappropriately. There needed to be very clear direction from the centre about what should and should not be referred. The new GDC NHS Concerns handling process was now up and running but it was still early in its development. With the lack of staff within local NHS England offices, GDPC members expressed doubt that cases would be dealt with locally by the NHS. Local performer list panels were also considering cases that had already been dealt with by the GDC.

6. Matthew Hill's comment was that there was a big education piece of work to do and cultural hurdles to get past. The GDC also has some legal constraints on what it does which will take time to deal with.

7. A member asked why Scotland had less complaints proportionally than other countries. The response was that the Chief Dental Officer for Scotland had developed some systems for resolving issues between patients and dentists. A member said that the NHS contract in England was a factor leading to more complaints. Matthew Hill responded that 40 per cent of contacts with the Dental Complaints Service were about NHS treatment. The service was starting a pilot to enable it to look at NHS complaints. The GDC would be asking dentists to promote this initiative by word of mouth.

Dental foundation training

8. Widespread problems with dental foundation training in England were reported. In some areas the number of foundation dentists in each scheme had increased because some schemes had been closed. In some areas work for Training Programme Directors was increasing, there was less support for Foundation Dentists and Educational Supervisors, many Foundation Dentists have joint Educational Supervisors. This was cumulatively leading to low morale.

9. Satisfactory completion had also increased ES workload. The e-portfolio has meant much more work for Educational Supervisors.

GDPC members reporting back to LDCs

10. Members noted the need for members to be attached to an LDC so they could distribute the meeting report and report back in person and then take the views of LDCs back to the GDPC. Many LDCs also funded the representative to attend the GDPC meetings. The list of which GDPC member is attached to which LDC can be found here.

GDPC by-elections

11. Arrangements for three forthcoming GDPC by-elections were discussed. Presently dentists were allowed to stand in any constituency where they worked. This could lead to problems if they were elected in more than one constituency. The Committee agreed that candidates should only be able to stand in one constituency and they would be free to choose which one if they worked in several. They would however be able to vote in all constituencies in which they worked.

12. Given the inaccuracy of the NHS performers list/dental lists, the Committee considered whether dentists should instead be asked to opt into an electoral register for these elections. Nominations and voting could then be done electronically. The need to register would be publicised widely. It was agreed to trial this system in the forthcoming by-elections.

Amalgam

13. The Committee considered a paper describing the current deliberations at EU level with regard to implementing the Minamata Convention in Europe. There are concerns that there is some support, especially amongst Members of the European Parliament, for working towards a phase-out of amalgam, as opposed to a phase-down as advocated in the Minamata Convention. The BDA and the Council of European Dentists are lobbying strongly against this possibility and for a reasonable approach to a phase-down based on available scientific evidence.

Prototype update

14. There were lots of issues with the prototypes particularly around patient numbers. Managing performance was a lot more complicated now that UDAs have been re-introduced. The claw back issue is hanging over practices, and it was agreed that the BDA needed to make clear to the Department that claw back in the first year is not going to be reasonable. There was a danger that the care pathway will be compromised as practices have to meet their patient numbers target and reduce the time it takes to do oral health assessments.

15. The view was expressed that the experience of 21 UDA practices wasn't enough to base a decision on whether the contract is suitable, given the variation in patient need, practice type and demography. There should be some research into patients' views. But we also need to find a system that will work for roll out. The amalgam situation also needed to be factored in.

16. A patient registration period of three years was felt to be too short. The BDA was holding three meetings of prototypes to gain their initial experiences. It was agreed that the BDA needed to collect information from all of the prototypes including how many are considering leaving the Programme. The BDA's shadow evaluation group was being convened again to

look in detail at what is happening and the Chair would make clear to the DH the serious concerns that the GDPC had about the prototypes.

NHS England

Performer list issues

17. There were serious issues with Capita who is now managing entry to the dental performers list. There were very long delays in getting dentists onto the list, getting attached to contracts when associates move and foundation dentists getting onto the list. The BDA was a member of the PCSE stakeholder forum and along with other professional groups had been putting pressure on Capita to resolve all the issues. As a result BDA lobbying, NHS England had relaxed the two month rule for dentists with a performer number who were having difficulty being attached to a contract. Practices in this position should contact the BSA. The BDA is considering mounting a case for compensation.

Other NHS England issues

18. There was a lot happening with NHS England at the moment:

- The GDPC and BOS were discussing with NHS England some new guidance on orthodontic close down arrangements. Initially NHS England had offered a price of 30 per cent of agreement value to finish off cases, which was not acceptable and this had been dropped. Negotiations were ongoing.
- NHS England was looking at tidying up contractual terms in advance of contract reform.
- After an almost two year delay following the GDPC agreement, the DH was proceeding with the introduction of a cap on parental leave and sickness payments. The BDA had responded to the consultation with some technical points and the demand that once introduced, there would be at least a nine month gap before implementation.
- The England Community Dental Services Committee was concerned that patients with special needs were being fined where accompanying carers (through ignorance) claimed exemption on their behalf when they weren't actually exempt. The committee had written to Sara Hurley on this and other issues who had responded asking for evidence.

New models of care

19. The BDA and the CDO's office would be holding a workshop on new models of care, local devolution and STPs. GDPC's position was that it wanted to retain a national contract in any new models that preserved existing NHS benefits. It was vital that LDCs/LDNs attempted to engage with the STPs. LDNs were merging in some areas with no additional funding. There were lots of problems with funding for GDPs on LDNs.

Consultation responses

20. The Committee received the BDA's evidence to the House of Lords Inquiry into the long-term sustainability of the NHS and the DDRB.

NHS England quality workshop

21. In September NHS England held a workshop considering a draft new quality framework for general dental practice. This work arose from the recommendations of the Dental Services Programme Board. The scheme included compulsory clinical audit and peer review. While the

framework was well received by those present, the point was made repeatedly that practitioners needed funding or protected time in order to take part in these activities.

Associates

22. Associate pay was continuing to drop but there appeared to be growing recruitment problems in some areas. This particularly applied to some large corporates. .

Scottish action plan

23. The Scottish government was consulting on a dental action plan that would effectively introduce a new dental contract. The plan contained both welcome and unwelcome proposals including reducing allowances, simplifying the fee scale, introducing a minimum NHS commitment for practice owners, protected learning time and an element of local commissioning.

Cancer incidence among dentists in Northern Ireland

24. Anecdotally it appeared that there were a greater number of cases of cancer in dentists in Northern Ireland. These seemed to be linked to places in the body that might be linked to carcinogenic aerosols. The Chair of the Northern Ireland Dental Practice Committee asked members to let him know of any other cases and the BDA was also seeing if any more information was available.