General Dental Practice Committee

Report of the meeting held on 25 and 26 January 2018

1. The GDPC met on 25 and 26 January 2018 for its inaugural meeting.

Policy update from across the UK

2. BDA staff provided the GDPC with a summary of the policy issues which the GDPC had dealt with over the last three years and which were likely to dominate the agenda of the Committee during its current term.

3. Regulation had been one such issue and a DH consultation on possible changes to professional health regulators, which might lead to a change in the number of regulators. The BDA's response supported maintaining a dental-specific regulator, but stressed the need for reform of the GDC. The response had also questioned whether it was necessary for dental nurses to be registered.

4. Health Education England's (HEE) and the Office of the Chief Dental Officer's (OCDO) review of dental education and training, *Advancing Dental Care*, could lead to significant changes to dentistry. The review is said to respond to the changing oral health need and aims to increase the quality of care within the current budget. One of the proposals would be to introduce common entry to shared dental degree programmes with different entry points for different DCP roles and dentists. It seems that the review is set on encouraging skill mix, reducing the number of dentists and increasing the number of DCPs. The HEE board will consider a report from the review in March. While HEE's remit is only for England, it would be difficult for the proposals to be implemented without consequences for dental schools elsewhere in the UK.

5. There are also a number of workforce challenges. In 2016, nearly half of practices that had tried to recruit associates experienced difficulties in doing so and in 2017 this had increased to two-thirds. As the UK leaves the EU, it is worth bearing in mind that 17 per cent of registrants are from the EU and 20 per cent of NHS work is done by EU dentists. Research had shown that EU dentists were likely to be registered for a shorter period of time. Yet there remains uncertainty as to how Brexit will impact on the supply of dentists.

6. There are also further issues with the UK leaving the European Union about regulation, the supply of goods and services and the mutual recognition of qualifications.

7. Public sector pay restraint across the UK has restricted rises to an average of one per cent for doctors and dentists. For 2018-19, the Scottish Government has indicated it will allow greater flexibility over

pay and there has been some indication of greater freedom for pay review bodies elsewhere in the UK. In Northern Ireland, the delays in implementing pay recommendations is unacceptably long.

8. In Scotland, the Government had recently published an Oral Health Improvement Plan, which set out proposals to expand Childsmile and improve community engagement. The mix of payments to practices would continue, but the balance would shift, and the items of service list would be simplified. As yet there is no detail regarding the proposals and the BDA has a number of reservations about what may result.

9. In Wales, contract reform has taken a different approach to England with two Swansea practices prototyping a 100 per cent capitation contract for a number of years. However, the Welsh CDO had indicated that this model was not going to be pursued and was instead looking at other options to modify the 2006 contract so that UDAs can be used for prevention. In September 2017, a new pilot scheme began with 21 practices taking part in the initial stage. This pilot scheme will work within current regulations, being based on the UDA system, with a small percentage of UDAs given over to preventive work. It might be that a similar modified UDA system would be introduced in England if the current contract reform process fails.

10. In Northern Ireland, one issue had been that prior approval was required for all treatments over £280, a figure set in 2003. In Scotland, the prior approval limit had been increased to £390, and therefore this was a significant obstacle for dentists in Northern Ireland. A change to this limit would require legislation, which is not possible given the political situation in Northern Ireland. Negotiations on a new GDS contract for Northern Ireland had begun in 2006 and some elements of a new contract had been piloted in 2014-16, but an evaluation had not yet been published. The new contract would be capitation-based.

New Models of Care

11. Paul Batchelor gave a presentation to the Committee on the development of new models of care within the NHS in England and the involvement of dentistry. There was a Europe-wide trend towards the integration of health systems, but there are a number of challenges to integrating dentistry into the wider NHS including the separate budgets for dental and medical services, the patient charge for dentistry, the different geographical areas for commissioning dentistry and medicine and the subtle differences in the contractor status of dentists and medics.

12. NHS England's attempts at integration are known as 'new models of care', bringing together different health providers and organisations in new structures and/or arrangements.

13. Accountable Care Systems (ACSs) are alliances of providers to collaborate to meet the needs of a defined population, with fixed resources and the objective of delivering an improvement in health outcomes. The idea comes from the US and Paul Batchelor pointed out that ACSs could present opportunities for large US-style private health providers.

14. Primary Care Homes (PCH) is a new model of care created by the National Association of Primary Care and is based on a bottom-up process, rather than a top-down prescription. The PCH has four key features: an integrated workforce, a combined focus on personalized care and improved health outcomes, aligned clinical and financial drivers within a capitated budget and the provision of care to a defined, registered population of 30,000-50,0000.

15. Paul Batchelor has led work to consider how dentistry could be integrated into the PCH model. There were a number of barriers to doing so, not least the contractual issues that the PCH is based on fully

capitated budgets when dentistry is not. However, there are potential benefits, particularly if an integrated health system is able to collaborate to tackle the common foundations of multiple chronic conditions. There might also be opportunities to ensure that patients access the most appropriate care, such as attending a dentist rather than A&E for toothache, and in doing so improve efficiency.

16. Full integration of dentistry into a PCH might not be possible, but there might be scope for NHS commissioners to use clawback funds and flexibilities in the GDS contract to integrate some aspects of dental care.

Elections

17. On the second day of our meeting, elections took place for the various officers and Sub-committees. I was grateful to have been re-elected as Chair and thank my colleagues for their continued support. **Dave Cottam** was re-elected as Vice-Chair, along with **Shawn Charlwood**. **Leah Farrell**, **Shiv Pabary**, **Nilesh Patel** and **Nick Stolls** were also elected to the Executive Sub-committee. This group will form the team that negotiates with the Department of Health and NHS England.

18. Elections were also held for the GDPC Remuneration and Legislation Sub-Committees and the Associates' Group. For the latter, we agreed a number of changes to help ensure improved representation for 'career associates'; those associates who have never been practice owners.

Contract reform

19. Since the last meeting, the Executive had agreed a negotiating paper, which set out a number of proposals based on the discussion of the GDPC, and had submitted these to the DH. The process has now been ongoing for nearly eight years and so we are pushing for the DH and NHS England to agree to begin detailed negotiations on what form a reformed contract would take.

20. With the prototypes now extended to 2020, there might be a smaller 'wave four' cohort of practices brought into the prototypes later this year. This might be as few as 10 new prototype practices and risks not providing a broad enough data set to take a view on whether this is fit for a national roll-out. The evaluation of the first full year of the existing prototypes will be published shortly. Initial indications are that wave three practices are better able to meet their targets than those from the earlier waves.

21. We restated our opposition to the inclusion of UDAs in the prototype blends and any future reformed contract. If the DH are insistent on measuring activity, they will need to find an alternative to the UDA.

22. The LDC Conference Chair's practice will be withdrawing from the prototypes and such a senior member of the profession is withdrawing from the process was a serious warning about the viability of the prototypes. Even where prototypes are able to meet their targets, this is often done at a cost to the practice. It was also reported that staff morale in prototypes was suffering. There were concerns that the improvement to dentists' working lives sought through contract reform was not materialising. There is no point to introducing a change unless dentists' working lives improve.

Tier two accreditation

23. Three tier two documents had already been agreed, setting out the requirements for endodontics, minor oral surgery and a general document on the accreditation process. These had not been officially published yet, but are already with commissioners. There are a further four documents four

in development on paediatrics, special care, periodontics and orthodontics. Each of these had a working group with representation from the GDPC and/or the England Community Dental Services Committee. The periodontics document has been circulated to the GDPC for comment.

24. We do not support the tier two programme and the participation of GDPC representatives throughout this process has been to get the best possible deal for the profession.

DDRB

25. The BDA submitted its evidence to the DDRB in December and asked for an uplift of RPI plus two per cent as well a number of other measures to tackle increased expenses and recruitment and retention problems such as commitment payments and access to state-backed indemnity cover for NHS general practice.

26. The DH had submitted its evidence late on 25 January. As a result of the delays to the process, the oral evidence session will not be held until April and therefore we expect the uplift will not be implemented on time. Eddie Crouch (Chair of the BDA's Review Body Evidence Committee) has written to the DDRB to state that this delay in the process, due to the DH and the Treasury, was not acceptable.

Orthodontic procurement

27. We discussed the orthodontic procurement process in the South of England and concerns were again expressed about the use of the Dynamic Purchasing System (DPS), but the BDA nor BOS were able to prevent NHS England from using it. The BDA's legal action was currently 'stayed' and further discussions were planned. It is expected that the procurement will go live from 19 February. We have submitted detailed comments on the tendering documentation and raised particular concerns regarding the pricing structure which we believe makes the contracts unsustainable.

28. We remain concerned about the costs to NHS England and to practices for the tendering and procurement process in general. This had been raised with NHS England previously. However, it was bound by EU procurement rules and the Government is committed to competitive tendering regardless of whether EU law continues to apply in the UK.

Henrik Overgaard-Nielsen
Chair, General Dental Practice Committee

Get in touch

If you would like more information on any of the areas on which we are working or if you wish to raise an issue for the GDPC to discuss, please contact Tom King, BDA Policy Adviser - Tom.king@bda.org or 020 7563 4579.