General Dental Practice Committee

Report of the meeting held on 4 May

1. The GDPC met on 4 May 2018.

Contract reform

2. We discussed a set of proposals on contract reform in England that the Executive had developed. There was broad agreement that the paper set out sensible proposals for developing the prototypes to ensure the business model will be financially viable for practices. This paper had been used in discussions with the DHSC and NHS England and would be circulated at LDC Conference.

3. The GDPC continue to be frustrated by the slow rate of progress on contract reform. The prototype evaluation report for 2016-17 was still yet to be published and would now be out-of-date by a full financial year.

4. There was debate about how activity could be measured in a reformed contract, with a consensus that the UDA needed to be removed altogether. Some members felt that a measure somewhere between an item of service and the UDA should be explored. Prevention should also be acknowledged as an activity. It was felt that there should be better remuneration for endodontics, but NHS England would likely ask what dentists should be paid less for if endodontics or other treatments were to be made more rewarding.

5. In Wales, the CDO is piloting a different approach to contract reform where practices have their UDA target reduced by ten per cent to support them to conduct an oral health risk assessment. The Welsh CDO was said to be open to other changes that would focus on prevention and provide incentives to treat high needs patients.

Contract values

6. We also discussed whether practices in a reformed contract should receive the same payment for providing the same treatment to the same patient. This would ensure that inequalities within the current contract were not carried over into the reformed contract. This could only be done on the basis of practices receiving the same contract value who would be given enough time to increase patient numbers if they needed too. This could be done through a minimum practice income guarantee and a long implementation period. The national tariff would also need to be weighted by age, sex and deprivation and could also have a geographic weighting.

7. On the basis of seeking the highest national values and ensuring protections on financial viability, we agreed that a patient being treated under a reformed contract should attract the same payment for the same treatment, regardless of which practice they choose to be treated in.

DDRB

8. Along with representatives from other BDA committees, the Chair gave oral evidence to the DDRB in April. This session would normally take place in November, but instead had taken place more than a week into the current financial year. The session went well and it appeared that the DDRB had been persuaded by the arguments we put forward regarding recruitment, retention and morale issues. We expect the report to be published at the end of May or June and for any uplift to be implemented later in the year and backdated. The BDA has made clear to the DDRB that the delays to the process are unacceptable.

9. In Northern Ireland, BDA staff had identified an error in the calculation of the 2017-18 uplift and as a result it had been increased from 1.13 to 1.5 per cent.

NHS England

10. There are a number of difficult issues currently under discussion with NHS England and a number of reasonable proposals that the Executive had put forward had been rejected.

11. The Executive had proposed that NHS England increase the tolerance for under-delivery by one per cent to recognise the impact that the severe winter weather had had on practices close to the year end. For many practices, the required closure time accounted for more than one per cent of the time they had to do dentistry within the year. However, NHS England had rejected this proposal and would only consider applications for force majeure on a case-by-case basis. The GDPC proposal would have meant that activity would have been delivered in 2018-19, but instead NHS England would now clawback the money and risk losing it from dentistry. It is regrettable that NHS England has adopted this approach as allowing some flexibility would have shown goodwill towards the profession. Some health boards in Wales have allowed an additional one per cent of under-delivery. Practices in England should contact their Area Team if the have had specific problems in relation to weather as ATs have the flexibility to use Force Majeure on a case by case basis.

12. NHS England has now acknowledged the recruitment problems practices are facing in many areas and have agreed to work with the Executive to identify solutions to support practices to recruit.

13. After the Executive had sought clarity from NHS England on the matter, a letter had been circulated to providers setting out the position for charging for referrals to secondary care for an OPG. However, a degree of uncertainty remained about some of the wording in the letter and further clarity was now being sought on these areas.

14. A note for the avoidance of doubt had been circulated by the CDO on phasing treatments for high needs patients, which appeared to adopt a reasonable approach. However, there were issues for those patients who required more courses of treatment than the note permitted. It was suggested that it should state that it should ‘normally’ be no more than three in 12 months. The BDA had not been consulted on the note prior to its publication.

Amalgam

15. The Committee had received a consultation on SDCEP guidance on the phase down of amalgam use in deciduous teeth, children under the age of 15, pregnant women and nursing mothers. It was felt that it would be preferable for dentists to be allowed to exercise their clinical judgement in deciding when amalgam can be used in the specified groups. The CQC and defence unions would require good clinical justification for the use of amalgam and clear patient consent and for this information to be included in the patient records.

16. The BDA had called for the for the communication to the public explaining these restrictions to be led by the four CDOs, not the profession, but there appeared to be a reluctance from the CDOs to do this.

17. The Executive had also raised with NHS England the need to acknowledge the additional costs practices will incur as a result of implementing the phase down and there was ongoing work by the BDA to establish an estimate of the impact.

18. In Scotland the SDR would be amended to allow for composite fillings and the SDPC was negotiating the level of remuneration.

Scottish Oral Health Improvement Plan

19. The Scottish Government's Oral Health Improvement Plan had been published earlier in the year and was focused on prevention, but was felt to be light on detail. The Plan sets out a number of changes to dentistry in Scotland including a potential phase-out of scale and polishing, the practice allowance being reallocated to provide additional funding for practices in deprived areas, and Childsmile would also be extended to cover over six-year olds. There was an intention that in future patients with good oral health would be covered by capitation payments and those with poor oral health would be treated on the item of service. Dentists would also be able to access occupational health. There were also plans to introduce dentists with enhanced skills for oral surgery, IV sedation, complex restoration and domiciliary care. There would be a director of dentistry in each health board and there were some concerns that these posts might not be filled by GDPs. Dentists and their teams would also have protected time for learning.

Patient charges

20. We also considered our view on patient charges and agreed that, ideally, patient charges would not exist as they deter patients from seeking necessary dental care, that as long as patient charges exist, dentists should not be required to collect them and that any increases in patient charges should be no more than inflation.

Tier two

21. 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.

22. Documents concerning tier two paediatric dentistry had been circulated to the Committee for comment ahead of the meeting. It was felt, that unless the criteria were desirable rather than mandatory, there would be few performers and providers that would meet the threshold for tier two accreditation in paediatrics. There were particular concerns about the requirement for recline

wheelchairs and microscopes, and this had been acknowledged by NHS England and these specifications had been removed.

23. In London, procurement of tier two endodontic services had begun and tier two accreditation was being piloted. However, the tier two steering group was not informed of this before it was announced. It was not clear how or if this pilot would be evaluated. There was also a lack of clarity as to where the funding for these services was coming from. Some had been found from existing tier two provision.

24. There are a number of other groups working on tier two frameworks for the other specialties. However, the orthodontic workstream had paused, in part because of objections from the BOS. It is unlikely that NHS England would look to commission tier two orthodontic services soon given the current specialist-led orthodontic procurement. Much of the existing non-specialist orthodontic services were in GDS contracts and therefore would not be re-procured.

GDC

25. We discussed the GDC's consultation on fee setting. The consultation would lead to the policy being set for three years and there would be no further consultation on the level at which the fee was set. There were a number of related issues that the BDA would be responding on such as the GDC's reserves policy and its intention to fund non-statutory, discretionary areas.

26. We felt that the GDC should consider introducing reduced registration fees for those working part-time, as the Annual Retention Fee was leading many part-time dentists to leave practice. There was also support for paying the ARF by instalment and for having a register for retired dentists. Dentists who retire mid-year are not reimbursed pro-rata and we felt that this should be the case. The Students Committee had discussed allowing newly-qualified dentists to defer their first payment until after they had been paid for their first month at work.

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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.