Elections

1. Henrik Overgaard-Nielsen was re-elected Chair and Dave Cottam and Richard Emms were re-elected as Vice-Chairs.

Presentation by the Chief Dental Officer for England

2. Sara Hurley, Chief Dental Officer (CDO) for England, presented to the Committee on current issues for general dental practice and answered questions. Key points from the discussion were:

- The CDO’s role was to provide advice to NHS England, the Department of Health and HEE, rather than to lead on the commissioning of NHS care.
- The CDO’s office’s capacity was being developed and there were bids in for budgets for a number of projects.
- The focus of this oral health work included urgent care and out of hours, diabetes, tackling significant levels of oral disease in some populations and commissioning care for homeless people.
- Dentistry had to recognise the constraints on the NHS budget but the current budget was underspent with 1.5 million UDAs not being commissioned.
- More professional input into commissioning would be an advantage.
- Dental practices need to be seen as being able to have an impact with patients and the profession needs to be mobilised to work outside of its traditional area.
- When asked about falling practice profits, the CDO said that delivering high quality patient outcomes should be the focus of public-facing debate, rather than profit.
- The CDO suggested that practices having to collect patient charges got in the way of the dentist-patient relationship. It was not impossible to envisage alternative systems, such as a payment card solution for NHS care.
- When asked about continuous contracts, the CDO said that a personal view was that rolling contracts with quality indicators may be the way ahead, with those falling to meet KPIs not being rolled on.
- Regarding local devolution and DEVOMANC, the dental community’s was a small voice, but it needed to make every effort to be heard.
- In response to a question about needing to clarify the NHS offer, the CDO said that it would restrict a dentists’ clinical freedom for there to be a list of treatments available on the NHS where dentists should be able to decide what a particular patient needed in the light of their particular clinical circumstances.
Regarding the prototypes, the CDO thought that the programme would deliver further learning and did not see Blend A or B being the final solution. For a small group of patients with high needs, there might be merit in looking at an additional fee per item arrangement. The Commissioning guides implementation was going ahead and work was being done to implement them. As far as referral systems were concerned, these could be centralised allowing economies of scale. The CDO had asked for an audit of breach notices from NHS England to see how many had been issued for what purposes. Throughout the discussion the CDO emphasised the need for the profession to present evidence and solutions to issues that concerned them.

Continuous GDS contracts

3. Following the Government's stated intention to look at whether to retain continuous GDS contracts as part of contract reform, the Committee discussed what could be done to resist any change. Continuous contracts saved expensive tendering processes, were highly beneficial to patient care, increased value for money because those tendering did not have to factor in the fact that the contract was short-term, facilitated practice investment and increased goodwill value.

4. Removing the cap on the amount of NHS care a practice can provide was also considered and it was agreed that there were clear benefits in enabling successful practices to grow. It was unlikely that the DH would agree to this proposal however.

Devolution of health and social care in England

5. The Committee has formed a Working Group with the Greater Manchester Federation of LDCs to deal with Devolution in Manchester. Plans were well advanced for general medical practice to be commissioned by GP Federations in 12 Localities with practices volunteering for their contracts to be novated into one MCP contract. If the same happened for dentistry from 2017/18 with co-commissioning, there was concern about practice goodwill, NHS benefits including pensions and maternity pay may also be at risk. Contracts would be commissioned on the basis of care for populations of 30,000 to 50,000 using capitation and quality payments.

DDRB and efficiencies for 2016/17

6. The DDRB report and recommendations for dentists' pay increases for 2016/17 was expected at the beginning of March. By email, the GDPC had agreed to the informal proposal by the Department of Health that the BDA, NHS England and the DH jointly ask DDRB to stand down this year in return for NHS GDPs receiving a one per cent increase in the pay part of a contract uplift. In the event the Department was not able to go ahead with the idea. The Chair stated that he would want earlier consideration of such issues in future years and did not want the Committee to take such decisions via email discussion again.

7. The Committee considered its position on responding to future proposals of this kind. NHS England and the Department had said that they wanted to begin discussions on the uplift for 2017/18 soon after this year’s award was settled. The Committee discussed its position against the background of:

- public sector pay being capped at 1 per cent of the overall pay budget until 2019/20, with the potential for further instruction for review bodies to target awards within remit groups
• no general recruitment and retention issues for GDPs but acute shortages of GMPs
• practice owners’ expenses to earnings ratios currently averaging nearly 70 per cent
• Falling taxable income for GDPs since 2006
• Non-payment of any uplift in Northern Ireland in 2015/16
• DDRB refusing to recommend awards for contract value uplifts and only recommendations for GDPs’ net pay
• Very low inflation and the Treasury wanting to use CPI rather than RPI in calculating rises in practice expenses.

8. There was agreement to consider any offers made by the DH/NHS England for future pay years but there was also agreement that there should be consideration by the GDPC of a Plan B: encouraging dentists to change the balance of their practices towards private care. The Scottish Dental Practice Committee has a working group looking at support for members in Scotland and Robert Donald, the Committee Chair will be presenting their work to date at the next GDPC meeting.

Breach notices

9. GDPC representatives have discussed breach notices with NHS England and the CDO has asked for an audit of regional teams to understand how many notices are being issued and for what reason. The Committee’s position is that notices are being given for minor contract breaches and that notices should be spent after two years. A response from NHS England is awaited.

COMPASS

10. The new NHS Business Services Authority (BSA) COMPASS system for GDPs in England will be operational shortly and the new system will be able to add patients’ NHS numbers to claims.

FP17s and DMF scores

11. From 1 April 2016 there will be a new requirement for GDPs in England to record patients’ DMF scores into the FP17 return. This was apparently to provide data for a new public health outcomes measure. The Chair wrote to the Deputy Chief Dental Officer following a meeting to record concern about the new requirement that would involve extra time and would not provide reliable data given that dentists would not be given any training. The BDA was not consulted on the introduction and was not informed about it until after the decision had been made and software suppliers instructed to make changes to their systems.

Christmas opening/religious holidays

12. The Christmas opening arrangements negotiated by the GDPC for GDPs in England had worked well and NHS England had agreed to implement similar arrangements for other religious holidays and other holidays for very small practices. They had also agreed to look at closing for practice-wide CPD.

Local Dental Networks

13. LDNs were currently merging following new NHS England local boundaries and it was difficult to get a current coherent national picture. There was a real danger of them covering a too large geographical area which meant that members did not have the local knowledge to advise commissioners properly. Communicating with
local practitioners was challenging for LDNs because of the absence of national coverage for nhsnet accounts and difficulties with passwords. Users have to log on regularly in order to maintain access to their accounts.

NHS commissioning guides

14. The BDA had submitted comments on the draft paediatric and restorative commissioning guides. NHS England was pressing ahead with implementation.

28-day re-attendance

15. The Committee received correspondence between the Chair and the BSA regarding concerns held by the BDA on the current BSA initiative for GDPs in England. GDPC members had met relevant BSA personnel to discuss the issues in more detail. The Committee’s belief continued to be that under-claiming was the real issue rather than over-claiming.

Contract reform in England

16. So far not all pilots and non-pilots have signed prototype contracts but the non-pilots were still being given their figures. The DH was hoping that there would be at least 80 prototypes but there was concern from practices about inaccuracies in patient number targets, the inclusion of UDAs and difficulties with paying associates. The BDA had nearly finalised its model associate agreement but there had been issues with performer level data that had delayed its production.

GDPC policy on 100% capitation

17. During discussion of the minutes of the previous meeting, current policy towards 100% capitation was considered. Previously there had been clear support for a capitation based remuneration system for any reformed contract and that the capitation element should be as large as possible. However there had been no actual vote. Although it appeared unlikely that the DH or NHS England would ever agree to 100% capitation it had been felt best not to be tied by a vote.

18. Following discussion it was agreed that the Committee would re-visit the issue at the next meeting and have an informed debate about whether a vote on the issue should be held.

Indemnity cover: premiums and continuity of cover

19. The Chair had met with Dental Protection in the last of the meetings with the defence organisations regarding the perceived increased premiums and withdrawal of cover for dentists. As with the other organisations, DPL stressed that they did not leave practitioners without help. All of the organisations had stressed their reasonable behaviour but for some individuals higher fees were needed because of the claims risk they presented. It was also clear that for the small number of practitioners that had to go to alternative providers for cover they needed to check the terms of their policies carefully to ensure they had run-on cover for future claims as well as continuous cover when switching providers.

Scotland

20. As mentioned above, the Scottish Dental Practice Committee had formed a working group to develop ways to support practices in Scotland in shifting the balance of their practices away from the NHS. The Committee was continuing to survey dentists in Scotland to canvass opinions on important issues. The Scottish
Government was intending to allow unannounced inspections of dental practices and this was being resisted.

**Northern Ireland**

21. It appeared that there would be no fee uplift for dentists in 2015/16. Northern Ireland dentists' incomes had dropped substantially in the last few years and their morale was the lowest in the UK.

**Wales**

22. Two practices in South-West Wales had agreed to take part in a pilot/prototype on a new primary dental care contract. This would be capitation-based around a deprivation index and with no activity component. There were numerous issues with Health Inspectorate Wales.