General Dental Practice Committee meeting report
29 January 2020

1. The GDPC met via videoconference on Friday 29 January to discuss the latest COVID-19 developments. This report provides a contemporary record of that meeting, but as this is a fast-moving situation, its content is likely to become rapidly out of date.

2. The BDA is providing live updates at www.bda.org/coronavirus

3. The BDA has been having regular meetings with NHS England/Improvement (NHSE/I) and the OCDO throughout this period in order to address the issues the profession is facing and to ensure that adequate support and resources are in place.

4. Our discussions focused largely on issues in England, as the devolved dental practice committees have been leading the response in Northern Ireland, Scotland and Wales.

Elections

5. The GDPC elected Shawn Charlwood as Chair. He thanked the Committee for electing him and paid tribute to Dave Cottam for his work on behalf of the profession. His initial priorities would be to continue to oppose the 45 per cent target, to ensure that appropriate mitigation was in place for those unable to reach the lower threshold, to negotiate arrangements for 2021-22, to move away from UDAs, to support mixed and private practices and to work closely with devolved general dental practice committees. Flexible commissioning had a role in the short term, but was not the comprehensive change that was needed. The GDPC would shortly be putting proposals to NHS England on this. He was also very aware of the risks associated with the integrated care agenda. He hoped to bring a listening, engaging, energetic and proactive leadership to the GDPC.

6. Vijay Sudra and Shiv Pabary were elected as Vice Chairs. This created a vacancy on the GDPC Executive Sub-committee and Joe Hendron was elected to this position.

Contractual updates - England

7. We continue to raise objections to the 45 per cent target and use of UDAs to measure this in meetings with NHS England. These targets incentivise the wrong behaviour and practices should be supported to focus on urgent treatment need.

8. We thanked the BDA's Communications and Parliamentary Affairs team for their work in securing the recent House of Commons debate on dentistry and the current targets. Eighty per cent of MPs in England had been contacted ahead of that debate and many MPs that had not previously engaged on dentistry were now interested. We are extremely frustrated with the contribution to the debate from Sir Paul Beresford MP, the only dentist in the Commons. The Minister had been

clearly under pressure as a result of cross-party criticism, but does not appear willing to change position.

9. The activity figures for December were not reassuring that practices would be able to achieve the 45 per cent target, but NHS England was placing its hope that the January ones would be better. NHS England has not shared the full modelling on which its view that 45 per cent was achievable was based.

10. There continued to be negotiations with NHS England on whether the payments in relation to the 55 per cent of activity that practices were not undertaken should be abated. This was being contested vociferously, as delivering 45 per cent of activity did not reduce practice costs by 55 per cent.

11. It is vital that practices keep records of any issues they are facing in delivering the targets, such as staff absence and patient cancellations. We continue to seek a national approach to mitigation in these instances. YouGov polling and a BDA survey both showed that patients were now less likely to attend for routine dental care and that practices were seeing a greater number of late cancellations and failures to attend.

12. Ninety-seven per cent of practices had met the previous 20 per cent target; 215 UDA GDS practices and 53 orthodontic practices.

13. The OCDO was continuing to advocate for its 'Transition to a Better Future' proposals. The GDPC's representatives had been asked for thoughts on a future contractual framework. While it was necessary to continue to push against the 45 per cent target for quarter four, it was also important not to lose sight of quarter one of 2021-22. There will be a need for practices to have plenty of notice of any changes to the contractual arrangements for April 2021.

Updates from across the UK

14. NHS dentists in Northern Ireland are now subject to a 15 per cent target. Practices are required to source PPE at their own expense and therefore this created a hard financial limit to what work could be done. There were also Brexit issues of PPE supply across the Irish sea, as well as the impact of the global glove shortage. The Department had accepted the DDRB recommendation and, using RPI for expenses, had reached an uplift for GDPs of 2.58 per cent.

15. In Scotland, the CDO announced on 5 January that the pre-existing arrangements would be maintained and that the implementation of a target for activity would be delayed by three months. Free PPE has been extended to the end of June. Private practices are only allowed to provide similar treatment to those available on the NHS, so are not able to provide cosmetic treatment. The SDPC has formed a new funding model working group to consider a future NHS contract.

16. In Wales, there had been work to ensure that the requirements on practices were clear and fair. There would be no target on the number of AGPs practices would be expected to provide. The requirements on seeing new patients had been defined as a new patient being an adult that has not attended in the last 24 months and a child that has not attended in the last 12 months, and practices are expected to see two new patients per week per £165,000 of annual contract value. The WGPDC was seeking to ensure that those who were unable to deliver this would be treated reasonably. It was expected that contract reform would restart in 2021-22, but details had not yet been provided about how this would work. The WGDPC wanted any arrangements tested first.

Associate pay and contracts

17. James Goldman, Associate Director for Advisory Services, presented on the BDA's approach to associate pay for quarter four. The BDA had initially issued a side agreement for practices to use with associates on the basis that most practices were likely to be able to meet the lower 36 per cent threshold within the current framework. This was developed prior to the resurgence of the virus and with the new national restrictions from January it now looks far more likely that practices will issues with falling below this threshold. Therefore, it was necessary to rethink the approach. This sought to share risk within practices so as to ensure that the practice worked as a team and supported one another. As a result, the new version of the side agreement would be on the basis that if the practice received the 2.2 UDA multiplier for achieving more than 36 per cent, then everyone in the practice receives this, and where the practice did not hit this threshold then no one in the practice would receive a multiplier. It also set out that practices should pay on the basis of UDAs now and then add the multiplier later once this is confirmed. The BDA would continue to make the first version available, but, as well as this exposing associates to a lot of risk individually, it also left practices in a situation where they could be required to pay out a 2.2 multiplier to some associates, when the practices had not received this from NHS England.

18. We also discussed the more than 1,000 associates, who had not been treated properly in quarters one, two and three. Those practice owners who had acted poorly then were likely to continue to behave poorly now, and there was little scope for redress. It was regrettable that in quarter four there was no obligation to pay associates and staff from NHS England and so the issues with practice owners abusing the arrangements were likely to only become worse.

19. Associates were reportedly coming under pressure to perform far more work than they were originally contracted for. The pressure to do more NHS work meant that they had less time for private work and therefore had lower incomes.

Integrated care

20. We discussed the recent NHS England consultation on integrated care and the BDA's response to it. This response had raised issues about local variation, loss of national efficiencies and the potential for the proposals to benefit bigger organisations over small businesses.

21. Some committee members expressed deep concerns about the impact integrated care and the legislation expected to introduce it on dentistry. This was focused on the idea that it could lead to funding being pooled in primary care and the loss of non-time-limited contracts. NHS England had stated that this was not it's intention.

SNOMED

22. Practices are required to implement SNOMED CT, an international clinical coding system, within practice management systems from 1 April 2021. We have been working since 2016 to ensure that roll-out of this would be smooth for practices. However, there still remained a number of outstanding issues. The matching of the current codes in each practice management system to their SNOMED equivalent would require clinical input and could be time consuming. There were also concerns about the impact on the time taken to make contemporaneous notes. The Dental Software Suppliers Association felt that the impact was likely to be significant, whereas the OCDO had said it would be minimal. The GDPC's representatives have been seeking to understand which view was correct. SNOMED has not been tested in a GDS practice and this was a source of particular concern in establishing the practical impact of implementation.

23. The BSA could not currently receive data coded in SNOMED, but it was possible that it would be in future. The long-term aim was to achieve interoperability in patient records. This would bring potential benefits in terms of patient safety and public health data.

24. We will continue to work on this issue and would look to request a postponement to implementation if the issues had not been resolved.

Shawn Charlwood
Chair, GDPC
February 2020