General Dental Practice Committee meeting report
2 October 2020

1. The GDPC met via videoconference on Friday 2 October 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a contemporary record of that meeting, but as this is a fast-moving situation, its content is likely to become rapidly out of date.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 DHSC 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.

Contractual updates

5. Negotiations with NHSE/I continued on the contractual framework to be used for quarters three and four. NHSE/I was seeking an increase in activity, but the GDPC's representatives were arguing strongly against this. The GDPC's approach was to prioritise patient safety, to ensure the framework remained simple and for remote triaging to continue to be counted. The Office of the Chief Dental Officer was also arguing for a reasonable contractual framework.

6. The BSA had reported that contracts were delivering activity equivalent to 37 per cent of UDAs for the equivalent period last year. During the meeting, we conducted a survey of members to establish some indications on time spent on remote consultation, time spent on each band of treatment and the maximum number of patients that could be seen each day.

7. The contractual framework must take account of the fact that the virus is now spreading more rapidly across the country and that many areas are subject to local restrictions. It was said that in some areas where local lockdowns had been in place over the summer it had been difficult to restore activity beyond providing urgent care. Increasing activity, and therefore social contact, was at odds with the wider government public health guidance. We heard reports that patient cancellations and Did Not Attend/Was Not Brought rates were increasing. There were also workforce capacity issues, with an increasing number being required to self-isolate. Increases in AGPs would also reduce the overall capacity to see patients.

8. It is crucial that the clinical judgement of what can be safely and realistically delivered is the main criteria for decision-making, rather than the financial concerns of NHSE/I.

9. We were concerned that a very small number of practices were said to not be behaving within the spirit of the current contractual framework and would urge all contractors to do the right thing.

We must also be very clear that the overwhelming majority of practices are providing as much care as is possible within the infection prevention and control guidance and that patients and the public must not be given the impression that dentists are not providing care and treatment.

10. With regard to long-term contract reform, progress had stalled during the pandemic, although it was hoped that discussions would be revived soon.

Orthodontics

11. The BDA continued to meet with NHSE/I, the British Orthodontic Society (BOS), the Association of Dental Groups (ADG) and the BSA to discuss orthodontic contractual issues. Again, there had been no agreement on the arrangements for quarters three and four.

12. Agreement had been given to provide free treatment to those 18 year olds that had been referred when under 18 but are still waiting to be assessed and NHSE/I had been asked to extend this to those who would have been referred by their GDP before they turned 18 under normal circumstances.

Devolved updates

13. In Northern Ireland, practices would continue with the current contractual payments until the end of the financial year, with the expectation that 20 per cent of previous activity (not including remote triage) is delivered. There was also an expectation that the number of AGPs conducted would be increased, but this would also increase the costs to practices. There was concern that the traditional link between increasing work and increasing incomes had been broken by the current circumstances. There were also concerns about the implementation of air changes per hour and the costs and practicalities that would prohibit it for many practices. The Department was stating that no support would be provided because HTM0103 had required practices to have 10 air changes per hour since 2007.

14. In Scotland, despite the campaigning that had taken place, there was still no prospect of support for private practice. It was said that patients who are not registered were struggling to access treatment, as practices were mostly focusing on seeing their own patients. There had been controversy around the issuing of out-of-date face masks. The Scottish Government were providing free PPE for NHS patients. After the pandemic, the SDPC was keen not to return to the SDR as the basis for the contractual framework and so had established a working group to look at different funding models. Some health boards were using dentists to administer flu vaccinations.

15. In Wales, practices whose PPE orders did not match with their patient numbers were being subject to scrutiny. The same financial arrangements were continuing. The widespread pandemic restrictions across Wales were not impacting on dentistry. Health Education and Improvement Wales had become the lead employer for FDs and as a result a new contract with Educational Supervisors was necessary. The WGDPC had some concerns about what had been proposed and was seeking reassurances.

Fallow time

16. The SDCEP review on APGs and fallow time had now been published. Ian Mills, Dean of the FGDP and who had been a member of the SDCEP working group, said that the SDCEP review had involved a wide range of evidence and expert review, and would be reviewed going forward. It was not guidance, but provided information for dentists, and the FGDP would be updating its guidance in light of it.

17. There was discussion as to how practices were to measure air changes per hour and how there would be validation of this and the mitigation measures used. There were concerns about those surgeries that would find it difficult to put in place either natural or mechanical ventilation to achieve the required number of air changes per hour.

Flu vaccinations

18. It was appalling that dentists and their teams in England were not being provided with free flu vaccinations. The GDPC would continue to call for these to be provided in recognition of the frontline role of dental teams and of the impact the flu season could have on pandemic management.

CQC

19. John Milne presented on the CQC's approach to regulating dentistry until May 2021. It was intended that there would be fewer face-to-face inspections, which would only be used where specific concerns had been raised. Instead, there would be more frequent contact but for shorter periods, using one-hour phone calls instead of day-long visits. It was hoped that this would deliver smarter regulation. The CQC would be consulting on its 2021-26 strategy. John was not able to comment on whether there would be a reduction in fees.

20. A mythbuster on washing machines in practices was due to be published soon that would set out that practices must comply with the water regulations for clinical premises.

21. The CQC's view was that 'remote' orthodontics was regulated activity and that those bodies providing it needed to be registered with the CQC.

Select Committee responses

22. Over the summer, the BDA had submitted a number of responses to House of Commons Select Committee inquiries. This included providing written and oral evidence into the Health and Social Care Select Committee (HSCSC) inquiry into 'Delivering core NHS and care services during the pandemic and beyond'. The report from this recommends that the CDO sets out a plan for restoring patient services, while ensuring financial sustainability.

23. The BDA had also submitted evidence to the HSCSC inquiry on 'Workforce burnout and resilience in the NHS and social care'; highlighting the mental health impact of the pandemic, the financial stress and uncertainty. This had called for resourcing of the Practitioner Health Programme to deal with the long-term effects, for contract reform to design-in wellbeing to the system and for action now to alleviate financial stresses. Evidence had also been submitted to the Housing, Communities and Local Government Select Committee inquiry on 'Supporting our high streets after COVID-19' calling for business rates relief to be extended to dental practices.

Private practice

24. The GDPC's Private Practice Group had met on 4 September and discussed the financial pressures facing practices. The next pressure point would be corporation tax payments due this autumn.

25. Deputy CDO Jason Wong had attended that meeting to discuss his report on the risk of insolvency for mixed practices. His view had been that the risk of widespread insolvency was low, but the Group was not convinced of this and even a relatively small number of practice insolvencies would have a very significant impact on the provision on patient care. It was also noted that personal insolvency was a risk and this would impact on practices.

Contract uplifts

26. The BDA had responded to the DHSC consultation on the uplift to contracts in England and had criticised the use of CPI as the typically lower measure of inflation. It had also challenged the continued freeze to FD service costs, which had now been in place for a number of years and had therefore significantly eroded the support Educational Supervisors receive over time.

Dave Cottam
Chair, GDPC
October 2020