Overview of GDPC policy since its inception in 2003

1. This document brings together the key themes, policy decisions taken and the rationale for them since 2003. GDPC was newly formed in 2003. The previous committee had been the General Dental Services Committee (GDSC).

2. The GDPC is asked to consider drafting a new GDPC policy for approval by the Principal Executive Committee in 2018.

2003 - GDPC inaugural year (Triennium 2003 – 2005)

3. In October 2003, the GDPC set out a policy statement on its aims and hopes for general dental practice. The main issues facing the GDPC in 2003 were:

- The three year NHS pay deal
- Office of Fair Trading's report into private dental practice
- Options for change field sites
- DDRB submission
- Response to LDC Conference motions

4. **GDPC Draft Policy Statement on Dentistry in General Dental Practice**

i. *GDPC will work to help GDPs to:*

a. *Provide high quality dental care to their patients*

b. *Promote oral health through effective preventive measures*

c. *Achieve their practising ambitions within a profitable and sustainable business.*

ii. *GDPC believes that, unless changes to the current GDS system go hand in hand with substantial extra funding, dentists and patients will increasingly choose the private sector.*

iii. *GDPC recognises the need for patients and dentists to have choices in the provision of dental care, and sees a significant role in actively supporting practitioners who wish to develop alternative funding streams for their practices in the Private sector.*

iv. *GDPC will nevertheless work towards an improved system of NHS dentistry, and believes that practitioners working within the NHS deserve first class terms and conditions of service.*

v. *GDPC believes that the current independent contractual status of General Dental Practitioners should be maintained.*

5. By the end of October 2003 the Committee reported that there was currently no resolution on the following issues:

- Funding arrangements
- Gross earnings detail
- Treatments available on the NHS
- The currency of the new contracts for example time related or patient contacts
- How the contracts would be monitored
- Superannuation issues
- Patient charges
- How the GDS contract would differ from the current contract and who the dentist would have an obligation to
- PCTs would have money for providing assistance and support but it was not clear how it would be administered
- The BDA had requested that the out of hours services not be a part of the base contract. No response to this request had been received.

2004 – New GDS contract proposals

6. The main issues facing the GDPC in 2004 were:

a. New GDS base contract
b. BDA response to Department of Health *'Framework proposals for primary dental services from 2005'*
c. NICE review of dental recall intervals
d. Dental Reference Officer visits pilots
e. Section 60 order amending the Dentists Act
f. DDRB submission
g. Responses to LDC Conference motions

7. In early 2004 the profession was considering the consultation by the Department of Health on a new GDS base contract. At this time for the implementation of a new contract the (BDA determined) policy was that there should be no 'big bang' implementation. The negotiation team raised concerns with the Department of Health and by October 2004 concerns remained about a practitioner's right to charge for missed appointments, financial reimbursement for attending professionally NHS related meetings for example PCT negotiating meetings.

8. Concern was expressed that the currency of the proposed contract would effectively lead to an alternative version of the treadmill. In summary, the Chair of GDPC stated that:

- The base contract does guarantee 3 years income for an agreed NHS commitment
- BDA would fight to retain the ability to mix
- Any income earned would remain in the contract value, including laboratory expenses

- Seniority would be paid out automatically. In 2 years' time a new experience related pay scheme would be in place
- The 2% lower tolerance limit on NHS commitment remained, any upper limit had been removed.
- Thus far courses of treatment would be the only method of measuring NHS commitment. A dentist would be required to carry out 95% of the weighted courses of treatment carried out since April 2004 until Mar 2005
- There had been no announcement on a new patient charges system but any patient charge shortfall would come from a separate central fund.

2005 – Not a core service

9. The main issues facing the GDPC in 2005 were:

a. Implementation of PDS
b. That stalled talks with DH should resume on a base contract
c. BDA policy on primary care
d. Position on dental specialities
e. DDRB submission
f. Responses to LDC Conference motions

10. There was wide, but not unanimous, agreement that the BDA policy should support *the principle* of comprehensive NHS primary care dentistry available to all rather than a 'core' NHS service, in terms of patients treated and/or treatment available. However, the GDPC noted that this was an aspiration and, with current Government policy and levels of funding, was unrealistic. Therefore BDA policy should explicitly recognise that this is dependent on adequate resources and note the repercussions of a lack of resources – that is the Government would need to ration the services it is providing and should not pretend that current resources were sufficient to deliver a comprehensive service for all patients.

11. The GDPC felt that it was not for the profession to detail how an under-funded service might be rationed; this was a decision for elected politicians to take and debate with the public. For the profession to act otherwise would open the Association to accusations of self-interest. BDA policy should make it clear that if this were the decision taken by Government any 'core' system would also need adequate funding.

12. The BDA should acknowledge to the Government – either in the policy statement or elsewhere – that currently overworked dentists were being made to deliver a 'core' service every day, when they turn patients away. GDPC noted that BDA policy should cover the whole of the UK

13. In May 2005 the GDPC recognised the value of the review of dentally-based specialities but felt the potential danger to the role of the generalist.

14. By September 2005 the GDPC responded to the draft dental charges regulations and stated its policy;

a. GDPC is opposed to patient charges
b. That patient charges are a government tax
c. That charge levels are a matter for government but are inequitable.

15. The GDPC also discussed the draft GDS/PDS regulations and expressed a range of concerns. There was some discussion as to whether the contract should be rejected outright and the GDPC should disengage from talks with the Government. It was agreed that GDPC and BDA should send out a strong message to the profession and the media that it hated the new contract. However, a message must also be sent to the many dentists who will be forced to accept the new GDS contract who must be reassured that the BDA will provide them with continuing support.

2006 – New contract introduced (New triennium 2006 – 2008)

16. The main issues facing the GDPC in 2006 were:

a. The new contract
b. Occupational Health resources
c. DDRB submission
d. Responses to LDC Conference motions

17. In early February 2006 the GDPC passed a motion on a new BDA policy for primary dental care:

> *The General Dental Practice Committee unreservedly supports the new British Dental Association policy which states "The British Dental Association believes that the Government's aims of securing patient access, improving oral health and raising the quality of patient care will not be achieved by the imposition of this target driven NHS contract". Accordingly, we demand suspension of this inequitable UDA target and monitoring system pending meaningful consultation with the profession.*

18. The GDPC was also concerned about the availability of occupational health services. Following on from a particular LDC Conference motion, GDPC members were asked to ensure their LDCs pressurised PCTs to ensure these services were available.

19. Another policy area considered was NHS failure to attend (FTA) charges. The committee understood that FTA charges were not permitted under the new contract, but the GDPC would remain committed to retain its policy of charging for FTA.

2007 –Implications of the new contract

20. The main issues facing the GDPC in 2007 were:

a. Local commissioning
b. New contract
c. DDRB submission
d. Responses to LDC Conference motions

21. In 2007 the GDPC agreed that it would lobby the Department of Health to remove the UDA target from Dental Vocational Trainees because it was a blunt output target, particularly if only notional.

22. By 2007 the GDPC were concerned about performers' superannuation. With the new contract, the GDPC felt that it was not acceptable for providers to be able to affect performers' superannuation and that they would send out that message.

2008 – Updated 2005 GDPC policy statement

23. The main issues facing the GDPC in 2008 were:

a. New contract - effect on non-practice owners
b. Decontamination guidance HTM 0105
c. Changes to pension dynamisation from gross to net
d. DDRB submission
e. Responses to LDC Conference motions

24. The GDPC discussed in 2008 the impact of the new contract on non-practice owners. It was noted that this group had not done well form the contract and GDPC determined to ensure their interests were pursued.

25. For 2008 the dynamisation was expected to be based on 2% net rather than gross and the GDPC unanimously supported the policy of strong opposition to this change.

26. The main policy making document for GDPC in 2008 was the updated 2005 Policy and values statement that went to the BDA's Representative Body for ratification.

2008 Values Statement on Dental Practice

1. *The principal role of dentists is to promote the health and well-being of their patients.*
2. *The BDA supports the principle of comprehensive dental services available to all.*
3. *The BDA will work to create an environment where the patient-practitioner relationship is central to service planning and delivery and is properly supported.*
4. *The BDA believes that the following principles and standards should apply:*

    - *A high standard of patient-focused care and a high quality patient experience.*
    - *An open and communicative attitude towards patients and colleagues.*
    - *A preventive approach to oral health.*
    - *A positive approach to continuing education and professional development.*
    - *A service free from adverse financial pressures and with reasonable workload.*
    - *Proper engagement with the dental team.*
    - *Appropriate engagement with other members of the health and social care workforce.*
    - *An appropriate environment supporting the above.*

2008 Policy Statement on Dental Practice

i) The BDA believes that, in the UK, dentists should be able to practise dentistry to a high standard employing a preventive approach in the provision of high quality dental care and treatment to patients.

ii) The BDA supports its members in achieving improved working lives, promoting the availability of contracting options consistent with individuals' life choices and career goals.

iii) In choosing their preferred contracting options, practitioners should evaluate whether an appropriate quality of care can be achieved.

iv) Quality underpins patient-focused care and comprises treatment from appropriately trained professionals, working in a safe and clean environment with well-maintained equipment, properly trained support staff, with

sufficient time to carry out the procedure properly, and materials that are appropriate to address the individual needs of the patient.

v) The BDA welcomes the contribution made by the entire dental team under the clinical leadership of dentists.

2009 – New triennium (2009 – 2011)

27. The main issues facing the GDPC in 2009 were:

a. Steele Review of NHS dentistry
b. Dental access agreements/PDS Plus
c. DDRB submission
d. Responses to LDC Conference motions

27. In 2009 Professor Steele published his *Independent review on NHS Dentistry*. The GDPC responded to the review and made clear the following points of GDPC policy.

- There needs to be clear definition of what patients have access to on the NHS and the quality of care that will be provided.
- NHS care must be centred on patients.
- Any major changes to the current contractual arrangements must be properly piloted.
- The UDA is an extremely poor measure for achieving good oral health, particularly if used as the sole currency of the contract.
- Patients with high oral health needs should have access to high quality NHS care and the contract needs to provide incentives for this.
- Dental commissioning must focus on the long-term health of the population.
- PCTs must engage constructively with LDCs to be good commissioners and engage positively with clinicians.
- Dental practices need a stable environment in which to operate.
- PCTs need to map oral health needs within their populations.
- Dental care must be based on prevention.
- Clinically appropriate regular attendance by patients is the basis of good oral health.
- Payments made to PCTs should reflect the full cost of contracting for dental care and the requirement on PCTs to collect patient charge revenue has been a source of instability in care provision
- Those commissioning education and training must recognise and cater for the changing aims and aspirations of those starting out on a dental career whilst also encouraging and motivating those in the middle or end of their careers.

28. To take the work of the Steele Review forward, the GDPC carried a motion that *"The Committee endorsed full GDPC participation in the proposed Steele implementation work streams."*

29. Over the summer the Executive was involved in discussions over the proposed dental access agreements brought in because of the dental practices that had left the NHS following implementation of the 2006 dental contract. The view of the Committee was that these agreements (developed within a PDS framework) were wholly unsuitable. The Committee endorsed a strong and public stance by the GDPC opposing the PDS Plus agreements should it prove necessary once discussions with the Department were concluded. The endorsement was given unanimously.

2010 Steele Review of NHS dentistry

28. The main issues facing the GDPC in 2010 were:

a. Steele review of NHS dentistry
b. CQC registration
c. DDRB submission

d. Responses to LDC Conference motions

29. Given that the 2006 contract was based on contracting with providers and not associates, the GDPC explored the issue of associate self-employed status. The discussion did not reach any firm conclusions, but the changing relationship between practice owner and associate was recognised to be an important emerging problem for the profession that should be kept under review.

30. On time limited GDS contracts, the committee hoped to finalise its position. The Chair confirmed that the position was that these contracts were outside the regulations except in the exceptional circumstances defined in the regulations.

31. Regarding the piloting of a new contract the committee reiterated a preference for a contract based on capitation with a small amount relating to quality, where quality was predominantly measured by clinical activity and not by access indicators or patient experience. It was agreed that it was essential to continue to participate in the implementation programme, albeit with extreme vigilance. The following principles were approved:

- Continue to engage, but be more proactive.
- Press for 50+ pilots, including the whole range of quality incentives.
- Formalise the BDA's position on the use of time-limited GDS contracts in the evaluation process.
- Quality measures should better reflect clinical quality.
- Press for a timings exercise on the OHA to protect against loss of income.
- Ensure that dentists' clinical judgment remained the most important factor in care, not the care pathway.
- Protect the profession against potential de-skilling.

32. By the end of 2010, the negotiations on contract reform with the Department of Health were on the horizon so GDPC agreed to ratify its policy positions in advance of those negotiations. The final agreed principles were:

- Capitation, weighted according to deprivation and age.
- Simple national contract with current benefits/additional payments preserved.
- No time limit on contracts. Contracts transferable.
- Good transitional arrangements to safeguard practice finances.
- Government funding for IT if this is a requirement for monitoring.
- Registration should be capped at a reasonable capacity to treat – determined by the profession on clinical measures.
- Registration for no more than three years.
- UDAs to be scrapped and a better activity model developed.
- Any payment linked to "quality" must be based on incentives, not punitive measures.
- Legal position and funding of LDCs to be safeguarded.
- Contractual income to be paid monthly, with any reconciliation made at the end of the year.

- Evaluation must be independent, academic and collective.
- Clarity in what is covered in the NHS offer and what level of advanced care it will include. Some advanced work should be included, but not all unless the capitation payment is sufficiently high.
- Existing out of hours care arrangements to be maintained, not increased as there is no evidence that it is necessary or desired.
- Patient outcomes not to be linked to payment where they rely on patient activity.
- Patient charges for failure to attend to be re-introduced.
- There should be a cap on the number of patients a dentist can register on the NHS determined by the clinical need of the patient demographic.

33. For 2011 and 2012 it was understood that the DDRB would not be asked to report for England. Instead the Department of Health would negotiate directly with the profession on any uplift to contracts (2011/12) to take account of expenses. The GDPC objected very strongly to the loss of the DDRB for that period.

2011 - NHS reforms

34. The main issues facing the GDPC in 2011 were:

a. Health and Social Care Bill and its passage through Parliament
b. Contract reform
c. Seniority pay
d. Responses to LDC Conference motions

35. The Committee kept a close eye on developments on the Health and Social Care Bill and the setting up of Local Dental Networks, how Deanery and local education functions would work and how dentistry would be commissioned.

36. The GDPC continued to monitor the contract reform process and contract pilots and continued to press the Department of Health on the retention of seniority pay.

2012 – Approach to contract reform pilots (New triennium 2012-2014)

37. The main issues facing the GDPC in 2012 were:

a. Dental contract pilots
b. LDCs and Local Professional Networks
c. Seniority pay
d. Dental Foundation Training
e. Responses to LDC Conference motions

38. In 2012 the GDPC was concerned about the ongoing contract pilots and highlighted their core concerns. The top concern for a new contract to address was the transferability of contracts and the removal of time limited contracts. The risks identified were:

- Patient charge revenue in a capitation based contract, particularly as in pilot sites PCR was dropping.

- Continued argument should be made for the removal of the dental budget cap.
- Concerns about the robustness of the pilot evaluation process by the Department. The GDPC agreed to set up a Shadow Evaluation Group.
- Restrictions placed on treatment by the advanced care pathways.
- IT costs of implementation and the GDPC agreed to push for financial assistance for this.

39. Going forward the GDPC agreed their most important issues:

i. No time limit on contracts. Contracts transferable.
ii. Sound transitional arrangements for at least (3) years, to safeguard practice viability.
iii. Simple national contract with current benefits/additional payments preserved.
iv. Government funding for additional IT costs that may be required.
v. NHS pensions to be available to all NHS dentists.
vi. Pilots should be fully evaluated before full implementation of a new contract.
vii. Clarity in what is covered in the "NHS offer" and what level of advanced care it will include.
viii. Patient outcomes not to be linked to payment where they rely on patient behaviour.
ix. Any payment linked to "quality" must be based on rewards, not punitive measures.
x. No minimum contract size and single-handed practice to continue.
xi. Legal position and funding of LDCs to be safeguarded.
xii. UDAs to be scrapped.
xiii. Contractual income to be paid monthly, with any reconciliation made at the end of the year.
xiv. Patient charges for failure to attend.
xv. Existing child-only contracts to continue.

40. However the contract was to be implemented it was agreed that there should be an opportunity for the profession to vote. It remained the position of the Committee that the profession should be given the option to accept or reject a new contract.

41. Another important policy area was seniority pay, which was an issue that GDPC felt should be retained by practitioners. Although legal action could not be taken (on advice from counsel) this remained GDPC policy and evidence about loss of seniority pay and lack of alternative options and compensation for this would be included in the DDRB evidence for 2013.

42. The GDPC policy on efficiency savings was that while efficiencies would be sought by DH, the GDPC position would remain that efficiencies could not be made by GDPs and that any failure to meet the rise in practice expenses would result in a pay cut.

43. For Dental Foundation training the Committee was in favour of the BDA pressing for a standard approach to the allocation of trainees to practices, and that this should involve the trainer.

44. The importance of Local Dental Committees was reiterated. In order to strengthen the local role and ability for flexibility where appropriate, it was considered important that the GDPC supports the establishment of LPNs and the engagement of LDCs with them. The Committee strongly approved of the appropriate use of funding and of consultants in dental public health supporting clinicians.

2013 – Ongoing monitoring of contract reform

45. The main issues facing the GDPC in 2013 were:

a. Dental contract pilots
b. CPD
c. NHS reforms
d. Direct access
e. DDRB submission
f. Responses to LDC Conference motions

46. An Associate strategy was received and approved by the Committee. A level of "fair pay" for associates was considered important and work would have to be undertaken to determine what would constitute "fair".

47. GDPC policy on Foundation Training was that:

- There should be trainer input to the allocation of graduates.
- Deaneries should provide indemnity insurance to practices if they did not have input into that allocation.
- There is insufficient funding of DFT places.
- The DFT salary should not be cut.

48. Regarding the GDC decision to permit direct access to DCPs, the following motion was proposed, seconded and passed unanimously:

> *"GDPC condemns the decision making process and subsequent decision the GDC took in relation to direct access on the basis that it does not protect the patient."*

49. The current position regarding the classification of dental care into three complexity levels was considered. The Committee felt that it undermined professionalism and limited scope for development if the ability to perform certain dental treatments was to be restricted. The BDA had made it clear that it did not consider such strict demarcation of skills to be appropriate but did recognise that not all dentists had the skills or confidence to attempt all treatments. The relationship with patients was thought to be threatened by these proposals, and the potential for patient dissatisfaction were a practitioner to suddenly stop providing a treatment that they had provided for years because of a lack of a qualification.

50. On contract reform, the Committee felt there was no incentive to improve, only the fear of underachieving against the contractual target. The GDPC supported the proposal that patient experience elements in the DQOF could remain as money to be lost, while patient improvement elements could be funded through additional money to act as an incentive (seniority pay allocation). The incentive model was in keeping with the Steele Review and that there was evidence that QOF had improved outcomes and patient experience.

- The principles of DQOF was accepted in theory.
- Concerns remained, however, that it would be used to reduce contract values.
- Supervised neglect continued to be an area of concern for the Committee and they reiterated their commitment to the use of Dental Reference Officers.

51. The Committee considered a paper on *Heads of Terms for a reformed contract*. The paper outlined the positions that GDPC had taken in previous meetings on a range of topics. The Committee was asked to consider if it still supported the same positions.

- The Committee considered, as a result, three years was a sufficient registration period, though an extended period during transition may be required.
- The number of patients that could be registered was still open to debate.
- The GDPC would continue to argue for non-time-limited contracts, but a minimum time limit would have to be considered.
- The GDPC was hopeful Ministers could be persuaded to remove the capped budget, so that access could be increased.
- The Committee agreed that transferring contracts must be permitted.

2014 – Ongoing monitoring of contract reform

52. The main issues facing the GDPC in 2014 were:

a. Dental contract reforms
b. GDC Annual Retention Fee
c. Dentists with enhanced skills
d. DFT (salary)
e. DDRB submission
f. Responses to LDC Conference motions

53. The GDPC looked to update its constituency boundaries. The merits of changed constituency boundaries to mirror NHS Area Teams were discussed. A vote was taken and the decision to accept the boundary changes was passed.

54. The GDPC considered the proposed changes to proposed amendments to the provisions for NHS maternity, paternity and sick pay in England which the BDA would oppose.

55. On contract reform, the committee considered the progress and unresolved issues. Although little progress had been made, after group workshops the committee felt that there was general agreement that reform of the contract was important and worthwhile. The Committee supported the GDPC Executive to maintain and increase the pressure on the Department of Health and the Government to continue the reform process.

56. With regards to NHS efficiencies, the BDA remained willing to participate in discussions regarding efficiency savings but only on the basis of mitigating damage rather than agreeing any cuts.

57. The committee received an update on the current situation regarding GDC proposals to increase the Annual Retention Fee. Committee members felt that GDPC should send a strong message to the GDC. It needed to be stressed that problems with the GDC as a regulator went far beyond the increase in the ARF. The BDA should consider clearly indicating that the GDC is not an effective regulator. The following motion was passed unanimously and would be considered by the BDA's Principal Executive Committee:

> *"In view of the recent findings of the Professional Standards Authority, the GDPC believes that the General Dental Council is a body no longer fit for purpose to regulate the dental team and protect patients."*

58. The committee considered a proposal on 'alternative contract reform' proposed by members of some LDCs in the North of England. There are many interesting aspects included in the proposals and the GDPC would pay particular attention to proposals in relation to increasing patient charge revenue. The present scope of discussion regarding contact reform will remain limited until further details of the contract prototypes are published.

2015 – New triennium 2015-2017

59. The main issues facing the GDPC in 2015 were:

a. Dental contract reform
b. CQC
c. Contractor loss/dental activity review
d. Clinical commissioning guides (incorporating dentists with enhanced skills)
e. Devomanc
f. DDRB submission
g. Responses to LDC Conference motions

60. The Chair asked how GDPC wished to deal with future pay negotiations. Members considered the following issues and for new negotiations, those attending should set out the principles of negotiation. The following points were raised (but no firm conclusions reached) in order to make the process smoother next time:

- GDPC should not always need to refer to constituents but use their collective judgement to seek the best option.
- The GDPC Remuneration and Legislation sub-committees had not been used enough.
- In opposition, the Executive was elected to negotiate and GDPC should be able to rely on them.
- In similar situations the best the GDPC can do is to seek the best outcome within the framework available.

61. It was suggested that for the next negotiation, the BDA/GDPC should stipulate some ground rules (threats of imposition/minimum consultation periods) at the outset.

62. On contract reform, in order to ascertain the new committee's view members split into groups to discuss contract reform and the groups fed back the following points:

- 100 per cent capitation was the preferred option.
- Associates should have their own list with weighted patients and payment as a percentage of a standard rate.
- Preventive advice is activity and GDPC should make sure DH is aware of this fact.
- There was concern that in the new system, the type of activity undertaken will eventually lead to a dumbing down and deskilling of the profession.
- In the prototypes there seems to be no mechanism for growth or change.
- There was concern that the presentation alluded to a move away from weighted capitation – it was clarified that to simplify the prototypes, weighted capitation was not to be used although it would remain in the background.
- Associates could be paid using an in-house salary system.
- Capitation should be the only way of payment with KPIs for activity negotiated locally with the area team.
- There looks to be increased demands on DQOF.
- Associates are heading for a fork in the road.
- Within a practice based DQOF it would be difficult to pick out the poorly performing associate.
- There should be a minimum guaranteed practice income of 80 per cent beyond which there should not be any claw-back.

- Associates could be paid a sessional payment with bonuses.
- Within a patient care pathway, blend A & B create perverse incentives as the care pathway would be undermined by having to achieve certain levels of activity.
- Private practice may increase.
- A pilot practice owner commented that his bottom line had improved because of the use of skill-mix.
- It was too early to tell what the effect on patient care will be.

63. Other points raised were that well paid associates are encouraged to stay long term in the practice which was ultimately good for patient care.

64. The Chair discussed with the committee the NICE recall guidelines and asked whether the GDPC should request a formal review of these guidelines from the National Institute for Health and Care Excellence (NICE). The Chair summarised GDPC's concerns over asking NICE to look at recall guidelines and felt different avenues of research should be explored to ensure any changes are evidence based and not just a cost saving exercise.

65. It was felt by the GDPC that the DDRB was not an independent body, at least since 2002.

66. The issue of commissioning guides was discussed and the GDPC remained concerned about the medico-legal issues for practitioners carrying out level 2 procedures within normal GDS contracts/PDS agreements. Referral management centres were not the default way to handle referrals. Patients and dentists need a choice about to whom referrals are made and adding an extra layer of administration to the process was wasteful of NHS resources.

67. The GDPC had reviewed NHS England's co-commissioning agenda and found that NHS England's commissioning of dentistry was not as good as it could be. The Chair had already written to Simon Stevens, NHS England CEO to request a meeting to discuss the NHS Five Year Forward View and a potential sugar tax.

68. The GDPC was concerned about the dental activity review initiative and wondered why BSA was looking at claiming patterns where there were grey areas, rather than outright fraud regarding ghost patients or claiming for treatment that had not been provided. The dental activity review could lead to practitioners not making claims, even when the claims were legitimate.

69. For the NHS contractual uplift, the GDPC agreed on the following recommendation:

> *'"The Doctors and Dentists Review Body this year recommended an increase in net pay of 1% for independent contractor general dental practitioners in all countries of the United Kingdom. The award has been implemented by the Department of Health in England and by the Welsh Assembly Government, although they have both abated the amount allowed for staff costs, resulting in a gross uplift of 1.34%. In Scotland, the recommended gross award of 1.61% was implemented. No decision on implementing the uplift has yet been made in Northern Ireland. Whilst the DDRB recommendation does not relate directly to the pay of associate dentists, associates might reasonably look to the award for an indication of an expected uplift in their own income. The GDPC recognises that practice income has been under enormous pressure for a number of years and therefore any decision on pay increases for associates will inevitably reflect local business circumstances, and will be a matter for direct negotiation between the parties. However, the GDPC would expect practices to recognise that associate income has also declined significantly in real terms, and to reflect the DDRB award in associate pay wherever possible. Associates are encouraged to engage with practice owners to discuss their contractual arrangements in light of the DDRB uplift." BDA Advice on Associates Pay."*

70. The GDPC endorsed the BDA's stance against the taking of radiographs for non-clinical reasons such as determining the age of child migrants.

71. The GDPC considered an update on the use of LDC statutory levy. The BDA's position was that FDs should not pay the levy and it was generally agreed that GDPC members could be reimbursed for loss of earnings from the statutory levy given that they were an important channel of communication between the centre and the LDCs. The NHS Act specified that levies could be spent on "administration" including reimbursement of members' travel expenses.

2016 – Contract reform

72. The main issues facing the GDPC in 2016 were:

a. Dental contract reform
b. Fixed term contracts
c. Minamata Treaty
d. Commissioning guides
e. Compass
f. Devolution and new models of care
g. DDRB submission
h. Responses to LDC Conference motions

73. The GDPC policy was that the NHS England clinical commissioning guides were not fit for purpose.

74. From 1 April 2016 there would be a new requirement for GDPs in England to record patients' DMF scores into the FP17 return. Concerns were raised by the Committee regarding data management, lack of training for GDPs carrying out data collection and remuneration for performing this extra work.

75. The GDPC had agreed via email to the informal proposal by the DH that the BDA, NHS England and DH jointly asked 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 DH 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.

76. The Committee discussed its position on future proposals and agreed to consider any offers made by the DH/NHS England for future pay years. 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.

77. The Westminster Government had stated its 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 in line with previous GDPC policy.

78. The GDPC was asked to consider a position on lichen planus referral. The overall consensus from the committee was that dentists should use their clinical judgement and, when appropriate, refer patients on to secondary care for a biopsy to confirm the diagnosis of lichen planus, without any cost to the dentist.

79. The GDPC discussed its position on 100 per cent capitation. Following the discussion it was agreed by the GDPC that a reformed contract should be funded to the greatest extent possible by capitation and that a DRO system should be included. The reformed contract needed to be capitation centred to support the focus on prevention and to safeguard NHS dentistry in the long-term where treatment need would continue to decline for most of the population.

80. For future GDPC elections the Chair clarified that where a practitioner worked across different constituencies they would be able to choose which constituency they stand in, but would only be able to stand in one seat. Practitioners working across constituencies would be free to stand in different constituencies at different triennium elections and at by-elections. The Committee agreed to the proposal unanimously.

81. The Chair outlined the proposal to trial a reformed electronic process for elections to the GDPC at a number of upcoming by-elections. The Committee passed the proposal with one abstention.

2017 – Contract reform

82. The main issues facing the GDPC in 2017 were:

a. Dental contract reform
b. NHS offer
c. PCSE – Capita problems with entrance to the national performers list
d. Responses to LDC Conference motions

83. Because of practices being subject to both NHS England inspections and CQC inspections within a short period the committee's existing policy that the profession was over-inspected and over-regulated was reiterated.

84. There was concern around the 28 day recall process and business rates exercise. The GDPC felt that this review was about encouraging dentists into not claiming what they are entitled to out of fear of a more comprehensive audit in line with 2015 GDPC policy (para 68). Where practices undertake their own audits and the outcome was more favourable than the BSA figures, the BSA has made it clear that they would investigate and have threatened reporting to the GDC. This was felt to be entirely unreasonable. The committee discussed the BSA comments on the recording of clinical examinations and noted that not recording an examination did not mean that it had not taken place. It was felt that this needed to be raised with the BSA again.

85. The Committee discussed how GDPC policy decisions were recorded and the Chair stated that the Committee's minutes serve as an official record of discussions and decisions. Going forward, a new record of all GDPC policy from 2003 to present would be compiled.

86. The GDPC had called for a list of NHS treatment when previous contract reform discussions began in 2003 and had stated that if limitations on NHS care were to be in place then it was for the DH to define this. It was felt that clarification of the NHS offer should be a higher priority for the GDPC, however, it was noted that there was little incentive for the DH to provide a defined NHS offer and some committee members felt that a list of treatments defined by the DH might not be beneficial to GDPs. Work on this matter would be undertaken by the GDPC Legislation Sub-committee.

87. The Committee discussed a proposal to use an electronic and online voting system for the next triennial elections, based on the trial which had taken place for a set of by-elections earlier in 2017. The Committee agreed to the proposal.

88. The Committee agreed to the advice to providers to consider passing on the pay uplift to associates as proposed by the Associates Group using wording that had also been approved and used in 2016.

89. The Committee felt that the professions affected by the PCSE failure to process applications to the National Dental Performers List should receive the funds from the penalty charge Capita had paid NHS England. While NHS England had stated that this is the case, it had insisted that the details of the penalty charge were commercially confidential and therefore it was not possible to verify this claim.

90. The Committee discussed DFT by equivalence and noted that it was now known as 'Performer List Validation by Equivalence' (PLVE). Concerns were expressed that the operation of PLVE varied significantly across different areas. The Committee felt that in some instances trainees were being exploited by practices and the BDA was looking to produce advice for both practices and dentists about PLVE.

91. The Committee remained concerned about the business model of prototype practices in contract reform and whether it would prove to be sustainable for practices when rolled out. The GDPC continued to push the DH to mitigate the financial impact for these practices.

92. It was felt that the GDPC needed to develop a set of proposals or principles to put to the DH as an alternative to the current prototypes.

- A contract based predominately on capitation with dental reference officers (DROs) and no activity targets. It was felt that the DH would be unlikely to reintroduce DROs or to remove activity targets and therefore the GDPC should seek the maximum proportion of capitation possible.
- Move to lifelong registration.
- As prototype practices were experiencing difficulties maintaining patient numbers, the definition of access should refer to the accessibility of services, rather than regular attendance
- That Blend A was not a viable option and that the GDPC should advocate for it being withdrawn.
- Need to consider greater weighting on capitation payments for high needs patients.

93. The Committee discussed whether, given the problems with the prototypes, it should continue to support and engage with the contract reform process. The Chair noted that the DH has made clear that if contract reform is rejected by the profession, the 2006 contract will continue and there is a risk the DH will impose the OHA within the UDA system. It was agreed that the GDPC should continue to engage and support contract reform, while advocating robustly for the need to make significant changes to the prototypes before they could be rolled out. The GDPC would continue to seek a capitation- and prevention-centred contract.

94. The Committee discussed a motion passed by the LDC Conference about engagement with the DDRB process. It was noted that the motion having passed was an indication of the frustration felt by the profession about the prolonged period of pay restraint and of the decline in dentists' incomes over the last decade. The Government's public sector pay policy had been changed and therefore it was felt to be of greater importance to submit evidence to attempt to ensure the best pay uplift possible. It was possible for the DDRB to target uplifts and this could mean that dentists receive a pay uplift below one per cent. Therefore the GDPC voted overwhelmingly in favour of continuing to submit evidence to the DDRB for GDPs in England, with two members abstaining.