Morgannwg
Local Dental Committee
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Morgannwg LDC response to enquiry by Cross Party Health, Social Care and Sport Committee on Dentistry in Wales

Morgannwg Local Dental Committee is the Statutory Committee
that represents the interests of GDS / PDS Providers and Performers
to the Abertawe Bro Morgannwg University Health Board,
in line with Welsh Statutory Instrument 2010 No. 2846 (W.234)

1. Scrutinise the Welsh Government's Contract Reform

a. The dental profession both generally and locally felt that the last General Dental Services (GDS) contract reform introduced in 2006 was not a success, both for certain groups of patients and for dentists. The general idea of the current contract reform was welcomed and supported.
GDS dentists had, since the inception of the NHS general dental services, been accustomed to being paid on a fee per item of service basis, where each item of service was paid for on an agreed scale of fees, reviewed annually, with non-exempt patients paying an agreed proportion of gross fees up to a maximum contribution which was centrally set. Various exemptions from payment were in place in general based on ability to pay and age. There were indeed problems with this; for the government there could be no limit on the amount spent on NHS General Dental Services, for the patient in many cases the patient payments were difficult to understand. As far as dentists were concerned many fees were too low, there was no fee for any preventive work, the system rewarded intervention but the contract was workable and generally successful. Superannuation was easy to track and centrally administered for each individual dentist. Payment was made monthly based on claims submitted and if claims were mistakenly made improperly then they were returned to the dentist for correction with an explanation why. Gross fees paid (including patents' charges) paid for all practice expenses and dentist income.

b. The 2006 contract (the current contract) is a fixed price contract, where regular payments of 1/12 annual contract value are made every month to cover income and expenses, and performance targets are expected to be met to avoid clawback. Patients charges based on claims submitted are retained by the practice and subtracted from the monthly payment of gross fees. The contract was introduced in April 2006, in a hurry, without piloting, without training of NHS staff and without training of dentists and their staff in aspects of administration of the contract. This lack of training resulted in much confusion relating to submission of claims, and consequent interventions from NHS staff, some necessary and some unnecessary. As mentioned previously the contract was for a fixed annual gross income for which a fixed amount of activity was expected in order to avoid clawback. Banded courses of treatment were introduced, each carrying a set number of Units of Dental Activity (UDAs). Patient charges were based on the band of treatment delivered. From a dentist point of view, there was a general feeling that certain items were going to be difficult to provide without considerable financial loss e.g. complex

treatments involving crowns, bridges, certain types of dentures, high needs patients which sometimes demanded a considerable number of visits to complete a course of treatment, other complex treatment such as surgical removal of teeth, complex molar endodontics and advanced periodontal therapy treatment. The contract incentivises simple treatments (e.g. extractions) over the provision of more complex treatments (e.g. molar endodontics) which require more time and visits for the same fee. Furthermore, the same fee was payable for the provision of one crown and for three crowns, yet the laboratory bill for the three crowns was three times that for one crown: also, the surgery time is considerably more. In addition to this, increasing costs of practice management because of continually increasing regulation were not factored into a fixed price contract at its inception and had to be absorbed by the dental practice. As with the previous contract there was little reward for prevention and again the contract rewarded intervention. The regulations also removed practices' ability to charge for frequent missed appointments by patients, thereby increasing the likelihood of not being able to hit contract targets and thus increasing the risk to the practice of clawback which is unable to be compensated for.

c. The method of calculating contract value and number of UDAs required to meet the target was unclear at the outset and the method used to calculate all this and ultimately the UDA value left different UDA values for each practice, varying from less than £20 to almost £40. This meant that some practices would be paid £20 for a Band 1 treatment whilst others were paid £40 with other practices any amount in between, Band 2 treatments varied between £60 and £120 and Band 3 treatments between £240 and £480. This caused considerable discontent in and amongst the practices as can be imagined. It also affected ability to pay associate dentists, the higher paid practices having a distinct advantage over their lower paid colleagues

d. The idea of reform of this contract was welcomed by the profession provided it was to be piloted over a suitable period of time and be properly evaluated. Welsh Government has been developing a new dental contract since 2010 following a report of a Task and Finish Group. In 2011 eight practices in Wales took part in the initial pilots, and then in early 2016 2 practices in ABMU moved to trial a more advanced prototype. There was a shift in emphasis from treatment to prevention, using the whole practice skill mix in delivering care and giving patients more responsibility for improving and maintaining their oral health. One of the worries of LHBs with implementing these reforms was the potential loss of patient charge revenue (PCR), and although initially there were reductions in theoretical UDA claims, on which patient charges are based, latterly one of the practices reports that it is now up to 70% of the theoretical measurable outcomes. The other is similar although the prototype is more child based and therefore much less PCR is expected.

e. The Chief Dental Officer (CDO) has subsequently introduced a piloted reform programme in line with one of the three priorities contained in the framework of priorities published by WG in March 2017, Taking Oral Health Improvement and Dental Services forward in Wales. In this, practices experience a 10% reduction in their contracted UDAs for the same contract value in order that they submit clinical profiles on all patients assessed and treated. If the percentage is gradually increased then there would be more scope for practices to treat the patients and items mentioned previously that practices find difficult to provide because of financial restrictions, high needs patients, more expensive (time consuming) treatments such as molar endodontics and minor oral surgery.

f. Morgannwg LDC fully supports the further development of this project, and the development of a preventive based rather than intervention-based model of dental care in general dental practice. It is clear that some part of contracts will remain UDA based and consideration needs to be given for further Bands of treatment to be introduced which will encourage colleagues to see the high needs patients, difficult minor oral surgery, molar endodontics and multiple provisions of laboratory products. It will require some thinking outside the box in terms of contract monitoring but this must be achievable with close collaboration between the profession and the Health

Boards and WG. Colleagues would also find it useful if an agreed document on 'claiming regulations' could be introduced as long as UDAs are retained, this would help to eliminate the many 'grey areas' of the claiming regulations.

2. How 'Clawback Money' from the Health Boards is being used.

a. Morgannwg LDC is only able to speak with any authority on clawback money in ABMUHB.

b. Since 2016/2017 ABMUHB has fully collaborated with Morgannwg LDC on the use of ring fenced dental funds and developed a three-year plan ending in the investment of the whole of the dental allocation being invested in oral health care by 2020/21.

c. Prior to this it was agreed that all commissioning of dental activity should be made through a formal procurement process with LDC involvement. This involvement is in line with the document WSI 2010 No. 2846 (W.234) previously mentioned.

d. In September 2017 a plan was agreed which included a range of service and financial initiatives to achieve a series of formal strategic objectives:

- Improve the Oral Health of vulnerable groups, e.g. children, adults in care homes,
- Improve equity of access to general dentistry
- Reduce variation in dental pathways
- Improve access to special care dentistry
- Reduce Referral to Treatment times in restorative dentistry
- Improve governance and leadership
- Improve compliance with key legislation

e. Through a mixture of schemes, the service made significant progress to make a range of improvements against objectives that had been prioritised for years 1 and 2:

- Increased UDA value to £25 for those practices (43) who agreed to a range of quality initiatives, including taking on new patients, including direct referrals from Health Visitors and Designed to Smile, participation in contract reform programme, computerization.
- Commissioned additional GDS activity in 7 practices in high need areas (30,000 UDAs) including re-opened, expanded practice in Afan Valley and new practice in Port Talbot in 2018/19
- Halved children-only contracts, rewarding practitioners who 'converted' to full range of patients with a higher UDA rate
- Introduced Referral Management Centre [RMC] and new paediatric pathway to support referrals for treatment under a General Anaesthetic [GA]; savings from GA contract being reinvested in building alternative pathway, including RMC administrative and clinical staff in Community Dental Service
- Transferred resources to the Community Dental Service recognizing its contribution to providing domiciliary dental services in Bridgend county (only) and to support the new paediatric pathway
- Enhanced Clinical leadership and management at Port Talbot Resource Centre, investing in additional Dental Practitioner sessions, Clinical Leadership roles in Community and Restorative Dentistry and primary care management support.
- Supported practices to comply with the Equality Act through award of improvement grants to introduce hearing loops, disabled access, commissioned bariatric waiting and toilet facilities to support Dental Training Unit and CDS patients in Port Talbot Resource Centre.

f. The LDC is happy that it is now being fully consulted on use of GDS ring fenced funds, including the use of clawback monies. It will of course, continually monitor the situation.

3. Issues with the training, recruitment and retention of dentists in Wales

a. One of the reasons that the Dental School in Cardiff was set up was to increase the Welsh dental workforce, which it appeared to have done successfully in the initial graduate years from 1967 onwards. The 2012 workforce survey says that *'Welsh trained dentists account for 41% of the dentists currently working in Wales'*. Surely it is not beyond the realms of possibility for some preference to be given to Welsh domiciled students because of the likelihood that they will stay in Wales to work following graduation, but it is a politician's call.

b. In the 2012 workforce review it stated that '*On average during the period 2007-2010, 58% of Welsh-trained dental graduates entered the Welsh workforce after completing DF1.* ***Undertaking DF1 training in Wales is a significant factor in the decision to continue working in Wales****. Of these, 90% undertook DF1 training in Wales and 10% undertook it elsewhere before returning to work in Wales'.*

c. The Welsh Government funds DF training in Wales on a matched basis, but Wales is now part of a national (England and Wales) recruitment programme. It is difficult to obtain figures for the recent proportion of Cardiff trained graduates doing DFT in Wales. Anecdotal evidence suggests that English trained undergraduates come to Wales to do their DFT and then return to England to further their careers.

d. The Dental Training Unit at Port Talbot Resource Centre has trained 35 dentists since 2010. Only 9 (28%) are still working in the ABMU area, 2 of these in the CDS.

e. There are 13 other training practices in ABMU. Many of these would want to keep on trainees as associates but the contract does not allow this, additional UDAs being needed to employ an associate. There is also the surgery cost and extra staff costs. We are trying to establish figures for these issues at the moment and will continue to do so. Not all practices have the facilities to retain a DFT as an associate, without giving up their status as a training practice.

f. Morgannwg LDC believes that consideration should be given to giving priority for Welsh domiciled potential dental undergraduates (including Welsh speakers) to train in Wales, and once qualified to pursue their DFT in Wales. We do not suggest solutions to this at this stage, nor how this should be achieved, but will be willing to contribute to any discussions relating to this. Perhaps discussions of a new dental school in North Wales might be appropriate,

4. The provision of Orthodontic Services

a. ABMU commissions 7 PDS primary care orthodontic contracts from specialists on the GDC specialist register, 3 primary care GDS orthodontic contracts (with an orthodontic element attached for a Dentist with Enhanced Skills (DES)). It also provides secondary care consultant services from Morriston Hospital. The DESs work from treatment plans provided from the consultant service at Morriston Hospital.

b. The Local Orthodontic Committee (LOC) represents orthodontic providers on the LDC and has a representative, together with the LDC on the Orthodontic Managed Clinical Network (OMNC) which advises the HB on orthodontic services in both ABMU and Hywel Dda and helps to develop policies to improve the quality of orthodontic care by:
   - Identifying patterns of referrals which are considered inappropriate (further discussed later).
   - Plan and deliver suitable targeted interventions.
   - Improve waiting times.
   - Identify robust waiting times monitoring arrangements.

c. The LDC dislikes the term 'inappropriate' referrals. The GDC guidance on Standards for the Dental Team and WG Prudent Healthcare guidance speak of patients being treated by the most appropriate clinician, and if a primary care dentist feels that an opinion of, or treatment by a specialist is required then there is a duty to refer. We are aware that in the past colleagues have referred earlier and earlier, and often to multiple providers in the hope that a patient will be seen at the correct time, and we agree and are aware that this has the effect of increasing waiting times. E-referrals will benefit this and should help identify outliers, although the reasons for outlying the norm must be taken into consideration, e.g. high proportions of child patients. We believe GDPs should have specific training in IOTN funded by and organised by LHBs or centrally.

d. There have been orthodontic waiting list initiatives in the past and these have proved unsuccessful in reducing waiting lists in the long term. The proportion of child dental health spend on orthodontics is 40% and the LDC feels that resources for waiting list initiatives should come from central funds not from ring fenced dental budgets and that any such initiatives should have clearly defined aims and outcomes established.

e. The LDC believes that there should however be a review of all orthodontic provision in terms of efficiency and value for money. PDS and GDS services are scrutinised closely, but the same cannot be said for the HDS and CDS. Prof Stephen Richmond appears to make this point in his Review of Orthodontic Services in Wales 2015-16 where one of his recommendations is that a comprehensive review of the Community and Hospital Services should be undertaken incorporating numbers and types of orthodontic treatment provided per year and the contribution of the services to overall orthodontic care in Wales. The LDC believes that a comparison of the cost per case and cost per patient visit of hospital care, CDS care and GDS/PDS care might be useful but it needs to be borne in mind that HDS treats severe, multidisciplinary cases that are unable to be treated in primary care.

5. The effectiveness of local and national oral health improvement programmes for children and young people.

a. Morgannwg LDC fully supports the CDS run Designed to Smile (D2S) programme and has a representative on its local forum.

b. The scheme has enjoyed successes such as a tooth decay prevalence falling by 12% among five-year olds. D2S has had a recent refocus to include children 0 to 3 years old, as it is extremely important to include this age group. However, this refocus of D2S now excludes children just as their permanent teeth are erupting. Therefore, it is a gamble to remove 5-6-year olds from the remit of D2S as it could greatly impact their future oral health.

c. The success of the D2S programme is well documented and we will not comment on the statistics further, just confirm Morgannwg LDC commitment to supporting the programme.

Morgannwg LDC offers this submission to the Committee's enquiry. In the interests of readability and brevity, it has deliberately not included statistics which are widely available, but refers to them when necessary. Any evidence that it is unable to source in the literature it offers and defines as anecdotal evidence.