Morgannwg
Local Dental Committee
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Contract Reform – The April 2022 Variation

Unintended Consequences

The unfavourable effects on numerous dental practice team members have been significant:

Practice Managers/Receptionists

- Running Appointment Books – Extra time taken with New Patients
- Increase in Monitoring
- Increase in Administrative Time
    - QAS, Quality Assurance
    - Monitoring
    - Greener Wales
    - Audits
    - Registering New Patients

It has been reported by one practice that receptionists are spending a great deal of time having repetitive conversations with our irate existing "longstanding" patients about why their wait for an appointment is so long, and yet we are accepting new patients. It really is grinding them down, day after day. Morale is rock bottom. Also having to tell patients in pain to ring back tomorrow as all the days slots have gone. We simply are not funded commensurate with demand and therefore do not have capacity to deal with the huge need in the population.

Dental Nurses

- Increase in demand to do enhanced skills
- Increase in Indemnity costs if doing enhanced skills
- Need an increase in salary if extra duties
- Costs of CPD
- CPD – need time to do this which
- Increased decontamination time
- Increased time for documentation eg. regular checklists

} reduces time at chairside and doing general duties

Therapists / Hygienists

- Increased Contract demand for skill mix
- NHS fees are far lower than private fees
- No NHS pension rights to balance lower fees
- Costs of CPD
- Working without DN support in many situations
- Increased indemnity costs if Direct Access.

Associate Dentists

- Uncertainty of payment methods going forward
- Unable to access Eden to monitor progress
- Threat of Clawback
- No incentive to do Band 3 treatments with UDA targets so low, and laboratory fees so high, plus the number of visits often required to complete Band 3 Treatment plans.
- High number of visits needed for Band 2 new patients, who often fail appointments.
- No metric credit for failed appointments
- No metric credit for seeing a patient someone else on the contract has seen – affects teamwork among colleagues
- If target hit, wanting to get time off – not getting paid mentality.
- Many on daily rates which can lead to not achieving metrics.
- Effect of daily rates on employment status.
- Increased and increasing time on administrative tasks – e.g. ACORNS 30 tick boxes, increasing time spent on record keeping etc., all affecting patient contact time

Practice Owners

- Increased Running Costs with no recompense within an NHS contract
    - Increased Utility Bills
    - Increased Laboratory Costs
    - Increased Equipment and Materials Costs
- Practice Owners carry all the financial risks
- Lack of clarity on Associate payments
- Difficulty managing colleagues because of issues outlined under Associate dentists above.
- Workforce Issues
    - Difficulty recruiting Dentists
    - Difficulty recruiting Dental Nurses
    - Difficulty recruiting Reception Staff
    - Difficulty recruiting therapists and Hygienists for NHS work
    - Staff leaving for less stressful, better paid positions outside the profession.
- Because of recruitment difficulties, staff demanding higher and higher incomes; there is no scope for owners within the current contract to increase staff remuneration unless it is subsidised by private income

Foundation Dentists

- Lack of competence when entering FD positions, leading to increasing time needing to be spent by Trainers, reducing the contact time with their patients and the subsequent consequences.
- When they complete training, often not suited to a target driven system early on.

The Reality

Health Board / WG	Practitioners
Honesty - Trust	*Reality*

Wanting to work and collaborate in a high trust environment	• Clawback – HBs not consistent across Principality in how they deal with clawback – appears to be related to difficulty recruiting dentists.
	• Workforce problems
	  ○ Dentists retiring
	  ○ Staff sickness
	  ○ Staff leaving for various reasons
	  ○ Difficulty replacing staff, both professional and DCPs
	• Targets being hit early – no need to continue working
	• New patients require considerable time – increased risks
	• 4.5% Uplift – Reality 6% Cut

	? Unworkable Contract?

The Big Questions

- What other contractor profession in the NHS has clawback if targets are not met?
- Factors beyond practice owners' control affect the outcomes and the achievement of metrics. These include:
  - Missed appointments
  - HB not fulfilling agreed numbers of new patients
- Practice owners face pay cuts this year, BMJ modelling shows profits will fall by 16% this year. The big question is not about these profits, but whether banks will continue to support practices that need support because of falling real gross income and increasing costs.
- The Private sector can pass on costs to their patients.
- BDJ modelling predicts
  - Laboratory Fees up 15%
  - Utility bills up 35%
  - General Expenses up 12%
- In the last decade associate dentists' income has been reduced by 47% - Governments have the responsibility to ensure appropriate funding for contractor health services so that it can be delivered on a financially sustainable basis.
- Dental teams are being asked to do more and more for less and less. DDRB pay awards are constantly delayed and have not kept pace with "dental inflation" for more than a decade. Also, clinical standards have changed immeasurably over the decades (note keeping, less scope for cost effective treatments like amalgam). The more time practice staff spend away from patient facing duties, the less likely targets will be attainable.

Summary and Some Suggested Solutions

Problem 1: Welsh Government is intent on making NHS Dentistry accessible to the whole public with no additional resources. The efficiency of NHS GDS services was reduced when the UDA Contract was introduced in 2006, and it is further reduced with the current contract. The advantage to the government of both the 2006 and 2022 contracts is the money spend on GDS is under control, limited and predictable.

Solution 1: The most efficient use of services is when contractors are remunerated on equal terms for each item of treatment or prevention that they deliver, or a fee per item of service. If a current metric is application of FV then a fee could be introduced for that item. In addition to this the benefits of a weighted capitation scheme should be

considered and is well argued in a BDA blog at https://www.bda.org/news-centre/blog/Pages/Dental-contract-reform-our-asks-for-2019-02.aspx). This was written in 2019 prior to the pandemic interfering with the process of reforming the contract, but it has much to recommend since it is fair to both the public and the profession and a monitoring system could easily be designed to support it which would be easier for Health Boards to operate and for contractors to understand. Alternatively, an enhanced banding system could be implemented which takes into account more complex, time-consuming treatments and treatments that attract laboratory fees, with equal unit values throughout the Principality so that different interpretations by different Health Boards are neutralised.

Problem 2: The new metrics do not provide dentists with the opportunity or incentive to spend more time on prevention. By counting unique historic and new patient attendance per year, dentists are not incentivised to provide recall appointments, which are essential to a preventive approach, and we not incentivised to see high needs patients who will need multiple appointments. Similarly, there is no incentive to see patients who have already been seen in the current year.

Solution 2: Dentists should be rewarded for seeing red or amber risk patients more regularly. A fee per item system would provide this but we think a weighted capitation system would too. Perhaps a combination of the two would be ideal.

Problem 3: The funding in the GDS is insufficient to provide a comprehensive dental service to the population. Effective preventive programmes might in the future help to stretch the resources, but this will take years to develop effectively. At present, those practices that have private income are subsidising the NHS with this income. This is unsustainable.

Solution 3: A return to a fee per item of service system would partially address this but for it to be successful limitations to treatment, which there currently are, would be addressed by limiting the treatment freely available through the NHS. We realise that a core service, or a service where items are rationed is a difficult political decision currently, but there could be many variations to this and if argued correctly and with conviction this might well be achievable.

Problem 4: The new metrics were introduced at short notice and without having been trialled this despite Prototypes being operated from ten years or so ago. This did not give practices time to satisfactorily prepare for the changes. Similarly, there was little time for the Health Boards to prepare and this resulted in considerable uncertainty and stress among both Practice and Health Board staff.

Solution 4: Any changes need to be properly trialled and introduced following effective consultation with the profession. In addition, any bodies making decisions relating to the operation of the contract should have a large proportion of currently active GDS clinicians to advise on potential problems and solutions.

Further problems Related to Underfunding

- NHS Digital says that the average NHS net income in the GDS in 2005/6, the year before the UDA contract was introduced was around £76,500 (this would be worth £106,000 in 2019 using Bank of England Inflation Calculator) and in 2019/20 was £68,700. This despite ever increasing expenses, and the value of the income has decreased enormously. This is 64% lower than it should be allowing for inflation.

- As mentioned previously some metrics introduced in April 2022 have had a deleterious effect on practice moral, and non-practice owners are wondering why they should see patients who have been seen previously under the same contract in a financial year when they get no credit for it.

- Welsh Government are suggesting that Health Boards should not claw back money in this trial year, but the Health Boards are autonomous and can do so if they so wish. This means that there is a postcode lottery on clawback and contractors on similar contracts are potentially being treated differently.

- Practices are losing staff to better paid, less stressful jobs, yet the current funding system is not allowing increases in staff wages, particularly when they are being expected to undertake extra responsibilities, explained previously.

- The ever-increasing amount of administrative work results in dentists and staff having to work longer hours to complete obligatory tasks, longer hours being essential to maintain the same number of clinical hours to attempt to meet the targets.

- There are serious workforce issues. We have recently conducted a survey of workforce in Practices in the Swansea Bay University Health Board area. The report is not yet complete and will be presented to the SBUHB Workforce Planning Group in January 2023. All practices in the area with NHS dental contracts were asked to complete a questionnaire. 47 of 57 GDS Practices responded (82%). Some relevant figures to date can be seen in the following table:

Dentists Working in General Practice	
Number in 47 GDS Practices	***156***
Number of NHS Sessions worked	***634***
WTE doing NHS Work	***63.4***
WTE doing Private Work	***34***
WTE doing General Dentistry	***97.4***
Sessions Available for Further NHS Work across 47 Practices	***144.5***

- In summary, of 156 performers in the Practices that responded in the area, the whole-time equivalent doing NHS Dentistry is 63.4, less than half, demonstrating the inaccuracy of using raw figures when considering workforce issues.

- Recruitment of dentists is difficult outside of the major population centres nearer the Capital, and there are serious shortages of DCPs, with Dental Nurses leaving their stressful jobs to work under better paid, less stressful conditions. Foundation Dentists appear to be less well prepared for their professional work than previously, resulting in trainers having to spend more and more time with them, and it appears from our survey that a high proportion (46%) do not remain in the Principality for long after their Foundation Training.