Firstly, I would like to thank you for your presentation at our LDC meeting and your interest to get feedback of GDPs regarding ideas for this transitional period. Practitioners like myself appreciate your time and your keenness to listen.

In your presentation you referred to the document **‘A Fresh Start - Inquiry into Dentistry in Wales’**.  Most GDPs wish and hope for this "fresh start" to happen ASAP and are keen to modify the current broken and unfair system of UDA metrics where all metrics are measured against dentist performance alone and not practice performance, for example investing in workforce wages, skill mix, upskilling dental nurses to have extended duties, technology updates within practices, decontamination, and ever-increasing waste collection contracts to name but a few.

I have enclosed some suggestions for your attention and feedback to Welsh Government for further consultation.

**"Don't wait to be told ..... you have permission to act "  ( NHS Clinical Framework 2021 )**

At the LDC evening you highlighted 3 key areas of working to reform the dental contract

1. **Patient views**
2. **Professional views**
3. **Policy set by government**

However, any reform must start with baseline evidence of 3 key areas.

1. **What is the current workforce?**
2. **What is the budget?**
3. **What is the risk need?**

Each of these need to be considered prior to providing metrics otherwise every practice is doomed to fail!!!

A more tailored model is needed.

HEIW has provided an excellent workforce toolkit; might I suggest each practice starts with this immediately?

All the data collected through ACORN so far on locality needs should be applied to practices in that locality.

Further investment is needed to ensure the contract is a workable and successful contract.

Based on the 3 key areas of working you mentioned, I would recommend the following:

1. **Patient Views**: -Welsh assembly government needs to engage more with the public and communicate better with regards to the new reform process.  Patients want access and service local to themselves. Let practices be proactive, not reactive, and health boards have more freedom and flexibility on how they commission services in their locality. By allowing this flexibility in the contract you'd be facilitating government policy of community-based approach.
2. **Professional View**: - GDPs and practice owners need more flexibility in how they work and deliver their services. The current transitional reform package does not take into consideration a number of fundamental factors; patient's needs within that practice or practice locality i.e., rural practices who have difficulty in recruiting.
3. **Policy set by Government**: -**A Healthier Wales: Our Plan for Health and Social Care**
4. Prevention is key and therefore I recommend the continuation of Fluoride monitoring in adults and children.
5. 'Person Centre Approach' - access fundamental and therefore maintain this metric for practices but to revise numbers of new patients regularly.
6. 'Community based approach'- you mentioned at the meeting your vision for an innovated primary care post, promoting and encouraging existing dental skills and reducing barriers to specialisations.

I fully support this breath of fresh air; however, health boards need to recognise and collect information with regards to existing workforce, skills and specialist interests, and invest in these practices with extra funding, or different metric system.

DCPs have yet again been overlooked not only in the old UDA system for the last 16 years but also in the new transitional reform package. It is essential to maintain and grow our workforce; investment is needed to encourage staff in our teams to stay and to facilitate them to take on extra duties.

We held a further discussion at an LDC members’ meeting on 5th July and the meeting wanted to bring further issues to your attention and suggest possible solutions. Some attendees at the meeting had attended the WGDPC open meeting on the evening of 4th July and some of the points raised at that meeting were discussed at length. Based on the discussions at the LDC meeting we felt that you should be updated of our concerns.

1. **Contract Reform and Clawback**

Practices are doing their best to return to ‘normal’ working but there are certain factors that are causing considerable stress and are making the working environment a difficult place now. These include:

1. Uncertainty about the interpretation of the HB in relation to clawback.
2. The ‘all or nothing’ metrics of FV applications and Recall Intervals.
3. The shortcomings of eDen which are well documented and the difficulties in interpreting data to satisfactorily assess the performance of individual dentists in a practice.
4. COVID-19 related sicknesses in the workforce and other sicknesses, many related to stress. We appreciate that this is a problem across the services in the HBs, but other services are not working under the threat of repaying money at the end of the year.
5. In relation to patient counts, only first CoTs in a year are recorded as contacts, which means there is no incentive to bring patients back within the same year if it is clinically necessary.
6. Dentists are spending increasing amounts of time on writing contemporaneous notes, and this alone reduces the time available to treat patients, which in turn can reduce the ability to achieve metrics.
7. The absence of a definite metric relating to failed appointments, which has an impact on the ability to meet current metrics.
8. The increase in COVID-19 in the community. This might well result in more time having to be spent on appointments, and less likelihood of metrics being met.
9. It appears that many dentists are investing increasing amounts in their practices, with no return other than an increased ability to meet metrics in CR practices, or to meet UDA targets in UDA practices.

It has always been stressed that this is an experimental year, and that metrics may be changed during the year. It would be much more reassuring, ease stress on practice teams and would ensure equality of contract management across Wales if the threat of clawback were lifted by WG for the year 2022/2023. It would also be appropriate if the CR model for 2023/2024 was released in a time which allowed practices to assess the possible impact on themselves and in time for ample consultation and negotiation with representatives of GDPs. We also would recommend that more active GDP representation should be included in the committees that are advising yourself and the WG, particularly on the All-Wales Dental Leads Group, which has no active practising GDPs in its membership. Similarly, the WDC does not reflect proportionately the number of active GDPs in the Principality.

1. **Workforce Issues**

It is well known that there are workforce issues in Wales, practices finding difficulty in recruiting both professional staff and DCPs.

Clinical experience of dentists graduating and entering DFT is a problem which is well documented.

Colleagues completing DFT are reluctant to work in Wales, perhaps the salaries offered for further training might be a factor, illustrated in the table below, which shows considerable differences between the salaries in England and Wales

|  |  |  |  |
| --- | --- | --- | --- |
|  | **England** | **Wales** | **Difference in Pay between England and Wales** |
| **Foundation Dentist** | £33,720 | £33.372 | £348 |
| **Dental Core Trainee 1** | £39,467 | £33,948 | £5,519 |
| **Dental Core Trainee 2** | £39,467 | £36,031 | £3,436 |
| **Dental Core Trainee 3** | £50,017 | £38,115 | £11,902 |
| **Speciality Trainee 1** | £50,017 | £35,955 | £14,062 |
| **Speciality Trainee 2** | £50,017 | £38851 | £11,166 |

Furthermore, it also appears that on completion of DFT dentists are choosing to work outside the NHS, which some might say is not appropriate given their levels of experience.

Following sharing the above with LDC members we had the following responses which we feel are relevant.

The only thing I would ask to add is consideration that practices struggling to hit historic patient target can supplement with over-delivery of new patient target. There seems no logical reason why not. We cannot force previous patients to attend, and it is unfair to clawback when there are factors outside of our control on this point.

I have recently had an associate resign as he could not find a training course in Wales suitable for him as Cardiff were only accepting overseas students on their postgraduate courses and he didn’t want to travel. He would have stayed if there was the option of a hands-on part-time masters course in the country so it’s not just the pay but also the availability.

We have also just had an email from HEIW to tell us the west Wales MES event has been postponed as they haven’t recruited enough DFs for it to go ahead. The other schemes are going ahead as planned.

I think that the lack of investment in NHS dentistry needs to be mentioned. Dentistry money has been ringfenced for many years - but population has expanded and no new monies (that I can recall) up until very recently - and that was a drop in the ocean.

Patient charges have not gone up in line with inflation or with England - this would put more money into the system if it came back to dentistry.

The old UDA system was unfair - differing UDA values. The new system is also unfair - practices who had a higher UDA rate (and all SBUHB practices can be counted in this metric as all are on or above £25 per UDA) are expected to see more patients per dentist. Dentists can only safely look after a certain number of patients - less if they have a high needs cohort. I don’t have the answers, but the ACORN data and RAG rating must be involved in any new contract in my opinion.

If the CDO really wants to engage, then I think we can do a lot more collectively to advise on a future contract.  Therefore, I think it should be made clear that we need to concentrate on some of the current issues first. WG needs to listen before GDP's leave the NHS in droves. Once the current situation is addressed, we can work collaboratively to shape a future of NHS dentistry that works as best it can within the budget constraints.

The only thing I would add is that many of the "new patients" I have seen recently are already registered in other Swansea practices and a lot of them have been seen by another practice in the last year. They are new to our contract so will count towards our new patient metric, but they already had access to NHS care, they just faced long waiting times as new patient metric is harder to hit and therefore prioritised over historic patient metric. Maybe it's not relevant to this letter but I think the new patient quota is not achieving greater access, it is just encouraging patients to move from practice to practice depending on where they can be seen first. This is frustrating to patients and practices and wrecks continuity of care. I'd like NHS BSA to release figures on what proportion of "new patients" seen under contract variation are genuine new patients to NHS care and how many are just existing NHS patients moving between practices. That information is essential to know if contract variation is improving access to NHS care.

We have submitted these issues and suggestions as constructive comments which we feel WG needs to consider. We look forward to hearing from you.