Morgannwg
Local Dental Committee

Morgannwg LDC Open Zoom Meeting Thursday 1st May 2025 19.00.

In Attendance

Andrew Dickenson, Chief Dental Officer, Welsh Government

Andrew Pryse, Head of Dental Policy, Welsh Government

SBUHB GDPs and DCPs

Welcome and Introductions by LDC Chair, Dr Imtiaz Khan

The LDC had provided a document prior to the meeting which included eight composite questions based on the responses received from local colleagues. These were based around the issues described in the consultation document. Any general questions not covered in the meeting were to be welcomed at the end of the meeting to keep structure for the evening.

The Chief Dental Officer thanked the LDC for invitation to the meeting and felt this was a worthwhile opportunity to meet with the profession to understand views and answer any questions due to the short timescale of the consultation. It was understood there was never going to be a perfect contract but there was the option of a workable contract.

There had been tripartite negotiation with WG, BDA and NHS around what a new contract would look like and how it would serve both the profession and the public. All three were aligned on some of the issues which allowed more time to discuss more complex issues, this was over a period of thirteen months.

To keep a control over discussions this was kept confidential, a lot of evidence was included to get a true picture of what a new contract needed to include. This was to be a Wales only contract with no cross-border input for other parts of The U.K.

A lot more granular detail will be included post consultation once the general census of opinion from both the profession and public had been analysed. This was to be carried out by an independent data analysist company.

WG want as many different groups of people as possible to respond to the consultation to get a comprehensive view. Community, Secondary care, specialist services have all been asked to take part and respond to consultation. If this was not felt to be a feasible option, then thought will have to be given on how to proceed further.

Question 1. Patient Registration, Continuity of Care and Responsibilities.

The starting point with the BDA and NHS was what can be provided for patients? They were all in agreement with The Steel Report which is now sixteen years old, and nobody had had the ability to take anything forward from it in this timescale. Patients were to get the treatment they require based on risk

and need, there were a lot of patients who are self-caring and therefore needed less intervention and frequency of visits. Although patient registration had existed in the past it now no longer exists in the true sense since 2006.

Looking at The Steel pyramid prevention element, how to get it done at the level of the patient looking at their local area population and ensuring their oral disease is managed in an effective way.

Capacity has to be built based around data available i.e. workforce. If the whole population of Wales was to receive a dental examination there would be no possibility of treating any dental disease purely due to workforce constraints.

Although it was recognised the proposal would remove a patient's attachment to a dental practice, in effect this attachment doesn't really exist and hasn't for nearly twenty years.

GDS spend is currently in the region of £170 million, 10% of contract value is available for new patient assessment which currently equates to 347,000 patients per year. This gives the ability to have a flow of patients around the system. Patients who need a continuity of care will be in a care package and therefore will receive continuity of care from their dental practice. Only patients capable of self-care will be involved in the Dental Access Portal (DAP) flow. WG feels this a positive for GDPs as it makes clear to the public once their treatment is complete and they are stable that the practice is no longer responsible for their care.

Clarification was asked for regarding what patients are GDPs responsible for going forward in terms of both urgent and regular care.

The evidence from conversations with the public suggest they require immediate access for urgent care; this was to be for one definitive treatment and GDP responsibilities therefore end there. The question is what happens to them then, this was the purpose of the DAP, and the responsibility was then transferred to HB. GDPs would have the ability to ask the HB if they can keep these patients and enter them into a care package going forward if further treatment was necessary. WG appreciates there will be a number of patients who will never leave the maintenance phase and will therefore become a regular patient of their dental practice. NP, NUP and patients receiving a care package i.e. anyone who is not under an eighteen-to-twenty-four-month recall will only become the responsibility of the HB once they are transferred back to the DAP. Although if that patient has an issue within two years whilst on the DAP you will be responsible for seeing them however there will be a fee of £75 payable for any urgent care carried out. There will be regular reviews of this aspect of the contract to gauge how it is working and what, if any the issues are.

GDPs felt that registration is helpful as it generates goodwill and trust between clinicians and patients which in effect is the basis for good dental care. There is concern this proposal will destroy continuity of care going forward.

The question was asked which patients practices will be responsible for under this contract. WG confirmed as of 01/04/2026 GDPs will no longer be responsible for the last four financial years' worth of patients. From that date on they will only be responsible for patients who are currently under an open course of treatment and these patients will be counted in the care package segment.

GDPs need clarification how-to manage appointment books going forward as recalls are sometimes booked months in advance. It is unclear how to manage patients going forward, practices have patients

who they would never be happy to put on eighteen month recalls. Concern was raised this will end up as a COVID situation with a greater number of neglected mouths due to recall period being too long.

WG confirm the proposed model is segmented for GDPs to work to their practice profile, if a GDP can complete their entire contract by only providing care packages, then this is acceptable. Although the main concern of practices in reform was the lack of historic patients needed to meet their contract targets. The proposal is about building a flexible model that allows HB to tailor a commissioning package for every practice.

GDPs are not happy with promise of flexibility as historically this has not been the case. Further clarification of HB flexibility Is needed.

GDPS require clarification around urgent care, the consultation states permanent definite treatment is required under urgent care. Is there a definition of what this treatment entails?

More detail is needed as to what materials are deemed permanent, due to the phasing out of dental amalgam, placing a large composite filling is unrealistic during a NUP appointment. Would glass ionomer be deemed sufficient?

If a patient attended with an acute pulpitis the definitive treatment would be a root canal, this was felt to be an unrealistic expectation of WG. Getting the patient out of pain was the purpose of an Urgent appointment and WG agreed what happens next was the level of detail they needed to work on and will take GDPs views onboard.

How has WG engaged the public in Consultation as GDPs report their patients being completely unaware of proposals?

WG report having distributed information widely through all of its various networks, specialty organisations and anyone they have a link with. It was now five weeks into consultation process and there had been a very high response, within 33 days there had already been a greater response from the public than there had been to Optometry service during their entire consultation period. HB are making use of their social media platforms to inform patients.

GDPs report that the public are generally completely unaware of the consultation and its proposals, and it was down to them to keep patients informed as this proposal will completely change their continuing care going forward.

GDPs feel the lack of detail in consultation document is unacceptable, and it was unfair to expect them to respond to a document that was so lacking in detail. The fact the BDA negotiations were cut short in effect makes this a non-negotiated proposal to a large extent.

WG asked the question If this is so bad should we go back to UDAs? As the whole purpose is to listen to the profession's views and opinions through responses to consultation document.

The LDC asked if WG will accept a response from them to consultation document in the form of a report that includes the views of local professionals based on research and questionnaires completed.

WG will only accept responses to consultation included in questions at end of document. There are free text boxes with no character limitations, which enable personal views. This allows WG to analyse answers

to relevant questions, the responses will be independently analysed and therefore only the online responses will be accepted.

The ability to copy and paste responses into free text boxes is available.

Question 2. Funding, Workforce and Capacity.

WG are currently actively trying to recruit to increase workforce demands in Wales, there are various conversations taking place with potential groups to attract more dentists into Wales.

Cardiff University is unable to expand the number of training places due to complex reasons, but they are able to increase training places for Dental Hygienists and Therapists as have Bangor University.

PLVE doesn't work well in Wales with only attracting three candidates in a year.

The four nations are currently working on increasing dental workforce numbers and this is to include changing current GDC regulations.

There is no quick fix to this issue and providing home grown dentists is not viable as to would take several years to come through universities. Therefore, WG must look elsewhere and make Wales an attractive option to the workforce.

GDPs feel retaining the workforce currently in Wales should be a priority instead of trying to look elsewhere. This would be greatly helped by proposing a workable contract that is fully negotiated and detailed in its content.

The response was WG negotiated with BDA and NHS, this proposed contract is what they helped to craft, WG are now asking for anything that isn't included which the profession wish to include, opinions on what is workable and what isn't.

GDPs disagree that this is a fully negotiated contract due to WG pulling out of negotiations and there hasn't been an adequate chance for the profession to mould the contract. The consequence of which may be a further reduction in the current workforce with dentists returning their NHS contracts.

WG had stated negotiations needed to end in September 2024 for a new contract to be in place for April 2026. It took thirteen months to shape a document that went out for a twelve-week consultation in March 2025.

Negotiations had to end in September 2024, or this would have resulted in a fifth year of variation which WG could no longer carry the financial risk of and may have resulted in a return to UDA contract.

WG view was talks did not break down it in fact timed out. WG need to know if the proposal is more attractive to the profession than reform or UDA contracts, since if it is not the case then they need to go back to the drawing board.

GDPs asked why this contract has not been piloted as unintended consequences cannot be seen often until you are working under the contract. This was felt to be the case in 2006 with the UDA contract which was also unpiloted.

WG stated piloting something of this magnitude of change would involve the BSA rewriting their entire programme for something that may last no time at all. Pilots work when they are carried out within an

existing framework that can be tinkered around the edges. To have definitive change we have to start from scratch and there is no option to do that within the existing regulatory framework. WG lawyers have made this point very clear.

WG confirmed the BDA will have input and be involved in sorting through the final detail of the contract which is currently embargoed until further discussions have taken place. Although all statistics and data being used is currently in the public domain if GDPs wish to look for it.

Question 3. Remuneration Model, Prevention and Clinical Autonomy.

The limit set on Crown and Bridge restorative treatment in the consultation currently 10% of contract, is to ensure a control on all funding not being spent on the top end of The Steel Pyramid. It is not uncommon in health care to set a limit on how many complex procedures can be carried out in a year. Lab costs have been removed from the GDP responsibility and now given to the patient as a choice they can make themselves.

This model is based on time whereas the old UDA model did not take time into consideration especially within the old Band 2 category.

Prevention is set at 5% and this is felt to give more clinical freedom to implement effectively. Care for children is incentivised more than previously.

Amalgam alternative is a grey area for posterior restorations, with composite being the only suitable alternative which takes vastly more resources and time. It was felt the term amalgam alternative implies it shouldn't be used. Clarification is needed around this statement.

WG agreed to clarify this, the main producers of mercury are closing and mining is reducing across the world. Therefore, the worldwide availability of mercury is in rapid decline. There is a lot of research currently taking place around amalgam alternatives. We will still have amalgam available until 2030 based on current data.

The question to WG is the proposed remuneration to use amalgam alternatives sufficient, this needs to be added to response to consultation as this is currently just a proposal.

Amalgam is currently still an acceptable restorative material, and its use is down to an individual's clinical decision until it becomes unavailable.

High need referrals needing ten or more interventions to include endodontics, an hour was agreed to stabilise the patient and ensure not in any pain until they are seen on the high need pathway. There had to be a cut off and this is what was agreed. Stabilisation time of one hour was felt to be a good benchmark.

GDPs felt the removal of endodontic requirement as part of the referral criteria would be a more amenable approach.

WG agreed to consider.

Question 4. Contract Segmentation, Monitoring and Administrative Burden.

Segmentation will work in the same way it currently does in variation with service lines on Compass. As you deliver treatment i.e. Patient assessment £49 get added to that service line and care packages the same. The target for the year will be visible and will normally be updated month on month (as this will not

be live data the practice will be able to see where it is against target only on a monthly basis). If they able to incorporate FP17 produced on opening courses of treatment, then there will be the ability to see costs of treatment in the system awaiting completion making the practice aware of all OCTs in the system. This is currently not the case and was felt to be a great improvement on the current system which will ultimately remove complex end of year reconciliation issues.

WG looking at integrating current software providers with the new version of Compass. It was hopeful this would decrease the current administrative burdens on dental practices.

Question 5. Repair, Replacement and End of Year Reconciliation.

The risk associated with repair and replacement is currently carried by the NHS, this change is about rebalancing risk across all parties. WG are looking for opinions as to whether the time scale for guarantee is felt to be about right or does it need looking at further.

This was an area WG wanted to refer the risk back to dental practice as it is a quality indicator, multiple appointments for urgent care that has failed is a high red flag area for WG. This is part of WG ask that patients are seen once and treated definitively. Although the guaranteed timescale has increase to two years WG also stated the fee payable has also doubled.

GDPs feel patient choice is an issue where dentist are being asked to guarantee work the patient has requested which in fact is sometimes not always the best clinical outcome. For example, pulp extirpation when the patient has no intention of returning for permanent endodontic treatment. If patients request treatment a dentist felt inappropriate due to failure would there be a clause to protect the GDP? Along with patients who are not prepared to take responsibility for their own care.

Tooth wear cases can fail fairly frequently when trying to build up teeth with composite, it was felt a two-year repair guarantee could end up unfair on the GDP who is trying to do some good. Tooth wear is becoming a greater issue due to the vast majority of the public keeping their teeth for longer, it was felt this is not addressed anywhere in the proposal.

WG noted these concerns for further discussion and consideration.

Question 6. Patient Charges, Associate Payments and Communication.

WG were asked to reduce the financial risk of non-payer/bad debt for GDPs and to stop the dental practice from acting as a tax collector for the government. WG have listened and have now transferred the risk back to themselves, the patient charge with be levied going forward by WG.

The only payment collected by the practice going forward will be laboratory fees which the patient will pay in full to the practice. It was thought best to charge the patient prior to sending to laboratory to ensure the practice is not left with a financial burden.

Exempt patients will also be able to choose a higher grade of laboratory work although if they make this choice, they will be liable to pay the lab bill in full. There will be no ability to top up the fee, they would have to pay the lab fee in full. Lab fees will be entered onto FP17 and will be monitored; this would not be possible if an exempt patient paid a top up fee as this fee would not match the entirety of the lab bill.

The public will be made aware they now have to pay the government their patients charge fee and what the implications of non-payment will be. Similar to Council tax and road tax payments they will be mandatory for non-exempt patients.

HMRA registered practices can produce their own lab bill if they use CadCam technology, Cerec although there must be no profiteering from lab bills.

WG agree this needs further clarification going forward.

Payment of associates is entirely between the practice owner and themselves. WG will not be involved in this process.

Question 7. Piloting and CDS.

Part of the whole review of dentistry in Wales is looking at the CDS and HDS system. They provide a valuable resource for patients who find it difficult for whatever reason to access care within the High Street structure with high needs patients falling within this group. The CDS has a salaried workforce who even though challenged seem to have managed to maintain their workforce.

The CDS does have the capacity for these patients and are the ideal place to address not only their high need dentistry but also their psychosocial issues. The intention is high need patients go through this system, complete treatment, receive all the preventative advice and are then returned to the GDS.

CDS are currently looking at returning a number of their suitable stable patients back to GDS to free up capacity for high needs patients going forward.

In 2022/23 data there were 3000 patients seen within GDS who required more than ten interventions, it was felt this was now nearer 4000. To treat this number of patients there needs to be investment. HBs still have the ability to commission this service through PDS contracts.

An option discussed was to use under graduates to treat these patients and increase their skill set, as many are coming into the FD system that have completed less than ten restorations. It was felt this group of patients would provide valuable experience for these dentists. WG agreed to discuss with HEIW.

In SBUHB at the moment the current wait time for some specialist CDS services is currently running at eighteen to twenty-four months with a lot of clinics understaffed and experiencing recruitment issues. GDPs doubted they were in fact ready to accept this volume of high needs patients.

WG feel the higher waiting lists are for GA, sedation services and not basic high needs patients; they are confident it can be absorbed by CDS.

Question 8, Seniority Payments and Foundation Dentists.

Seniority payments had been a subject of much debate during this process with them being removed in England some years ago. WG question whether it is fair going forward to use the dental budget to fund these payments. Part of the consultation process was to get the opinion from GDS whether or not this should continue.

Foundation Dentists sit with HEIW, they must meet their curricular requirements FRCP to be signed off. There will be no change to how FT will be administered as it is a UK wide programme.

Foundation training funding comes through WG and there are no proposals to change, depending on legal advice it may be removed from SFE but this will have no effect on payments. Wales are now significantly ahead of England for payments of FDs and hopefully this will make Wales more attractive to FDs.

HEIW are currently working on a breadth of competencies for FD to complete, this will not include targets of care packages. Any over performance of FDs will no longer post April 2026 be counted towards the provider's contract; this may make the FD scheme less attractive to practices.

Questions from the floor

WG confirmed there will be no prior approval required for any care packages.

Currently there is no way of sharing patient notes between practices, Wales does not have the IT infrastructure to support this. The only solution to this issue would be a single dental software across Wales. WG seeks the profession's opinion on this and all are advised to add to consultation responses.

WG stated it would be impractical to read all the comment boxes on response documents if they are presented as bullet point questions. The best response should be crystalised answers for the responses to be analysed into a published report by an independent advisor. GDPs feel the questions are too leading to provide a balanced document.

Andrew Dickenson and Andrew Pryse thanked everyone for attending this evening which was felt to be very constructive. All the feedback points which will be taken forward for further consideration and discussion.

Any Other Business

There was none.

Date and Time of Next Meeting.

To be confirmed.