Feedback for the Health, Social Care and Sports Committee on the impact of the General Dental "Prototype" Contract on Belgrave Dental Centre, Swansea

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Introduction

We have been involved in General Dental Service (GDS) contract reform at Belgrave Dental Centre since 2011. As a Dental Provider we are in an unique position within Wales in that we have two GDS contracts at two different sites, one of which is the GDS Prototype (Belgrave) and the other is the standard GDS "Unit of Dental Activity (UDA)" based contract (Pontardawe).

The background of the contract reform process has been covered in a separate document supplied by ABMU Health Board. It is a comprehensive and accurate account so I shall not duplicate its information here. I would like to thank ABMU Health Boards continued support of the Prototype Contract.

I would like to quickly outline the important issues that relate to the last two NHS Dental Services Contracts, the pre 2006 "fee per item" contract and the 2006 UDA contract.

Pre 2006 "Fee per item" Contract

Previously, under the pre-2006 "fee per item" contract NHS Dentists were paid depending on the complexity of the treatment delivered and time spent delivering those treatments to patients. There was an extensive, complicated and very prescriptive "menu" of different fees for different items of dental treatment. Long and complicated treatment plans where attributed proportionally higher fees compared to shorter, simpler treatments. There was patient registration and practices also received a separate monthly capitation payment depending on how many patients it had registered on its list. There was little in the way of payment for preventive care but there was some provision for prevention in the contract.

The Fee per item contract was far from ideal. The treatment list was vastly complex and difficult for patients to understand. High value complicated courses of treatment were sometimes delivered to patients who had a high risk of dental caries resulting in many repeated courses of treatment that was ultimately a waste of NHS funds.

Many years of under-inflationary increases to the fees meant that dentists had to work harder and harder, see more and more patients per day as the years passed, to generate the fees that would cover their ever-increasing practice running costs. Whilst the open-ended nature of the contract allowed practices to expand when they wanted to (there was no fixed contract value for each practice) most dentists complained that they felt like they were on a treadmill, having to run faster and faster just to keep still.

2006 UDA Contract

Whilst initially the "New Contract" appeared to simplify things for both Dentists and patients it soon became apparent that the UDA contract had dramatic unintended consequences.

As dentists got paid the same for carrying out one filling as they did for twenty, most practices stopped accepting new patients as they didn't want to take the risk that the newly accepted patients needed time consuming, long treatment plans i.e. the same payment no matter how many patient visits needed to complete a course of treatment. Whilst this would be feasible if the fee was set to cover the cost of five to ten fillings, it was in reality set for roughly one and a half!

Contracts were now limited with set annual contract values for a set number of UDAs delivered. There was a dramatic variation in the UDA rate across Wales, with some Practices receiving double the UDA rate of others! Patients were no longer registered with the practice and responsibility of out of hours care was removed from practices and transferred to LHBs.

Practices would plan their expenditure for the year with regard to the total Contract Value, however failure to deliver the UDAs resulted in "claw-back" equal to the value of the undelivered UDAs. One quick and easy way to have to give a large percentage of your contract back to the Health Board is to accept new high-need patients. Many dentists feel that this is perverse, as it prevents those that need NHS dentistry the most accessing it.

The top value BAND3 course of treatment, that was meant to cover the cost of the most complex dental treatment, involving laboratory fees e.g. crowns and bridgework or CoCr dentures, was set too low to carry out all but the most simple of acrylic dentures or single crowns. This has resulted in complex or high need patients being referred to secondary care and has also de-skilled Primary Care dentists. Younger GDPs that have qualified since the UDA contract started have not had the clinical experience of many treatments that were previously regarded as pretty routine for GDS Dentists under the fee per item contract.

The impact of the Prototype Contract on Belgrave

Clinical Freedom

The working environment of the Practice was instantly transformed once the clinicians were "freed" from the constraints of the UDA. Whilst the UDA system drives clinicians to try and finish courses of treatment in the least amount of time possible the Prototype allows Dentists and their teams to exercise clinical freedom and stage treatment appropriately.

Patients that are experiencing urgent problems (e.g. dental pain) get their problems managed appropriately as a matter of urgency. With the patients consent we then build them a tailored "**Care-Pathway**" based on the patients **Risk** and **Need**, which is assessed via the ACORN template.

Patients move through the care-pathway with the aim of progressing through treatment complexity. The prototype allows proper foundations to support the patient's journey.

The principles of Prudent Health-Care underpin the planning of treatment. No longer are complicated, expensive treatments delivered to patients who can't maintain them. High cost treatments are delivered on patients who have lower risk of developing dental decay so that NHS funds are spent more appropriately and have the least risk of premature failure with an emphasis on quality.

Prevention

Prevention is the core to the Prototype way of working. The practice team fosters relationships with patients based on Co-production in which we motivate and support them to help maintain their oral health and progress along a **RED-AMBER-GREEN** traffic light system.

Skill Mix

The Prototype really does give the practice the freedom to utilize Dental Care Professionals (DCPs) within the practice. Dental Nurses, who have been trained to be Oral Health Educators, deliver preventive advice to patients. They also have enhanced skills that enable them to apply topical fluoride as a caries preventive measure.

Clinicians are able to delegate appropriate treatments to Dental Therapists and Dental Hygienists. All clinicians working at the top of their competency increases efficiency and enables increased capacity to see more patients.

Flexibility of services

We have the flexibility to respond to requests from the LHB to deliver targeted services within the prototype contract such as dedicated appointment slots to deliver much needed dental care to those seeking Asylum in the UK. We also deliver in-hours access sessions and offer those access patients a risk based care plan.

A Transformative effect

The Prototype really has transformed both the working environment for the staff within the practice and also the experience of patients receiving care. We would all hate to revert back to the UDA way of working. It would be devastating for the whole practice and for patients.

Since the Prototype it is not uncommon to hear the following comments from patients: -

" For the first time in 30 years I really understand how to look after my mouth"

"Having had one child with dental pain and decay, I now feel confident that I know how to look after my children's dental health as well as my own!"

"I'm happy for you to refer me for help" (smoking cessation)

But what about the Pontardawe Practice ?

Our second practice has unfortunately been left behind with:

- UDAs
- High needs population
- Frustration attempting to treat patients based on a target, not the clinical need/risk/coproduction and prudent healthcare principles
- Staff retention issues – high turnover of Dentist performers who become disillusioned with the UDA system.
- Annual Clawback – funds being sucked out of the practice and local practice population from missing targets due to trying to treat a high needs population under UDA GDS contract and low UDA rate. Funding that would otherwise be used for capital investment/improving facilities.

However …

Pontardawe has begun its Contract reform journey by being accepted in the WAG 2017 Contract Reform process. At present **PHASE 1** involves only a 10% reduction in the annual UDA target. I can assure you from personal experience

that this has minimal effect of the day-to-day experience of staff and patients but it is a starting point. We have implement as much of what we have learned at Belgrave as we can at Pontardawe, even though we still have to hit our UDA target. We are told that further UDA% reduction is planned for **PHASE 2** of the process but as yet no date is planned for its implementation. I can't wait until the fantastic patients and hard working staff at our Pontardawe practice sees the real benefits of a UDA free GDS contract.