Frequently questioned answers

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16 March 2023

Government ministers and officials continue to use recycled answers about contract reform. Here we give our questions and responses in return.

1) ***Government: Access for new patients can be driven by standardized 12-month recall of stable patients.***

BDA: Welsh government has historically quoted extending low needs and risk (green) patients to yearly recall to open up access for new patients. Recently this directive has been extended to put **all adults on yearly recall**. In the minister's latest statement this week she said, "Members will be interested to know that the NICE guidelines published in 2004—18 years ago—recommended that people with healthy mouths could safely go as long as **24 months between check-ups**."

BDA's Points to note:

I. NICE guidance recommends risk assessment and varied recall 3-24 months. Applying nice recall principles means the new patients which are usually high needs and risk (red) patients will be seen more frequently for more complex treatment which will off-set any potential gains from extending recall intervals.
   a. Note that while lower need and risk (green) patients, by definition, only require a check up – high risk patients on 3 month-recall by definition require treatment and more chair time.
II. NICE recalls were introduced in 2004 and have been gradually introduced by practices up to the 24-month recommendation limit and was specifically part of phase II contract reform. Large numbers of the applicable patients have already been put on extended on recall intervals.
III. NICE recommendations apply to risk assessments and CANNOT be applied to all adult patients. This would directly contradict the NICE recommendations.
IV. NICE guidance gives patients the option to disagree with the risk based recall
V. 12-months recall, BY DEFINITION, applies to patients who need an examination only.
   a. A new patient assessment often takes twice as long as a recall examination. 2:1 ratio
   b. Introducing high needs patients with treatment needs will then require follow up visits. Exact effects are not quantifiable as levels of need in new patients is not fully know but could be estimated at 10:1 ratio

2) ***Government: Use skills mix to improved access***

Mark Drakeford*: "My priority is the diversification of the dental profession. And the good news is that in September of this year we will have double the numbers of dental therapists emerging from Cardiff university; and that in Bangor we will have a wholly new course again providing dental therapists for the future. What we don't need to see are the most highly trained and the most expensive part of the work force carrying out activity that does not require that level of skill or experience to carry it out clinically appropriately and satisfactorily. We need dentistry to follow what has already happened in primary care and to have a more diverse profession, so that the dentist we have can be concentrated on providing treatment to those patients who really need that level of care and complexity".*

BDA: Direct access has existed in dentistry for patients to see Hygienists and Therapists (H/T) since 2009, but legislation has prohibited the use of direct access in NHS practices and has still not been amended. Practices staffed with therapists have been frustrated for 14 years by not being allowed to fully utilise them.

BDA Points to note:

I. H/T restricted from opening course of treatment/completing an examination
   a) H/T specifically restricted from completing an ACORN
   b) Therapist wage in practice is around £35 with a year's experience (self-employed) compared to equivalent of around £45 for a dentist with a year's experience. However, the fixed costs remain the same at around £120 per hour making a 6% saving.

II. Fluoride application by nurses - work for lower costs and a lower wage. These present an invaluable workforce for dental public health measures.
   a) However, patients indicated for 3/12 Fluoride application should also be having a 3/12 assessment (possibly with a therapist). There is **zero cost/time saving** for Fluoride application with a nurse when a patient is having an assessment. This represents an additional cost to practice.

III. Neither resource will assist in more access within the existing budget:
   a) Hypothetically, replacing 15 dentists would allow 16 therapists. Without additional funding this would leave 15 dentists looking for private employment
   b) Design to Smile (D2S) style community visits would benefit from Fluoride application using skills mix but their risk/benefit effect in business terms for practices is likely net negative.

3) Government: Only a small number of dissatisfied dentists

Eluned Morgan *"The fact is only 20 contracts have been handed back out of 413 contracts in Wales. So, as I said, there is a lot of noise, but in reality, most people – the vast majority of dentists – have moved over to this new contract"*

BDA Points to note

I. BDA and LDC surveys show levels of dissatisfaction with WG and lack of confidence in WG contract reforms to be over 90%
II. Over half of dentists are considering reducing or handing back their contract because of the pressure the NHS reforms have generated
III. Less than 40% of practices intend to continue with contract reform
IV. 20 contracts in a financial year represents around 5 times as many contracts as have been handed back in the preceding 5 years combined. We predict the final number could double to 40 contracts handed back at the end of 2022-23 or in the first six months of 2023-24.

BDA view: Contracts being re-based

Most contracts handed back to date have been rebased/re-awarded. Small contracts have struggled to be re-awarded. In reality these appear to be **rural** contracts indicating that the challenges of contract reform are likely o further accentuate the disparity between rural and urban access to dental care.

I. Rebased contracts have been awarded with lower activity
II. Rebased contracts often start with soft targets (ie will underachieve activity)
III. Re-tendering and setting up may take 6-12 months with no activity in the interim

All factors that result in a huge fall in NHS activity despite retendering – and before consideration is given to recruitment when NHS vacancies often go unfilled- particularly outside urban locations

4) The Community Dental Service will be able to pick up shortfall from the GDS.

Repeatedly expounded by the DCDO, included in a Welsh Health Circular and in the DDRB evidence.

BDA points to note:

I. CDS does not have the facilities or workforce in many areas to be able to pick up significant amounts of GDS activity
II. GDS activity provision would detract from CDS core role by occupying surgeries and pulling staff. Is a cuckoo in the nest
III. This infiltration will disadvantage the most vulnerable groups in our society
IV. This has been demonstrated to happen in 2 HBs already – although this has been formally denied
V. GDS efficiency is driven by the efficiency that the contracting/self employed model generates. An employed model GDS provided by the CDS will not provide the same level of activity
VI. Where dentists have moved to private practice in a area – new recruitment will be needed to extend service at a time or recruitment crisis.