GENERAL DENTAL SERVICES REFORM PROGRAMME

Myths, Facts and Frequently Asked Questions (FAQ)

We have had the Units of Dental Activity (UDA) based system since 2006. Major limitations of the UDA based contractual model are well known to the dental profession, public, health boards and others.

The GDS Reform Programme was paused during the pandemic. The programme restarts on 1st of April 2022 with an offer to practices to join the reform programme and test alternative measures and move further away from the UDA system.

Myth: Practices have been asked to sign a new NHS dental contract.

Fact: The offer to join the GDS Reform Programme by signing a contract variation for 2022/23 is not same as signing for a new NHS dental contract. Existing GDS contract and underpinning dental regulations are still extant.

For 2022/23, it is all about restarting the programme using the learning so far which means practices joining the reform programme can focus on providing preventive dental care for a set number of patients for their Annual Contract Value (ACV) instead of focussing on achieving their UDA target.

Learning from the GDS Reform Programme will inform the new dental contractual models.

Myth: Practices do not have a choice but to join the GDS Reform Programme

Fact: Practices have a choice of either staying within the UDA based contractual model or joining the reform programme.

Myth: In 2022/23, a practice joining the GDS Reform Programme will have to see all the patients they have seen in the last 4 years

No, minimum number of patients (from the 'practice list') and new patients a practices is expected to see in 2022/23 will be based on the metrics for 2022/23. Many practices may have already calculated the annual number of patients they are expected to see.

Practices seeing and providing dental care to high need patients can be monitored and Health Boards will use the information from E-Den and other local intelligence to ensure practices providing dental care based on risks and need are not penalised.

Myth: My practice's Annual Contract Value (ACV) will be reduced if I join the GDS Reform Programme by signing the contract variation agreement. I won't be paid until I deliver the metrics outlined on the contract variation.

Fact: No, practices' ACV remains the same whether they join the GDS Reform Programme or not. All practices will be paid their ACV in twelve instalments.

Myth: My practice will need to carry out ACORN on every patient that we see in 2022/23.

Facts: No, risk and needs assessment (ACORN) is done well once a year (not a financial year). Hence, ACORN is only carried out for patients receiving a Banded Course of Treatment in 2022/23 if they have not had ACORN within the 12 months. ACORN does not need to be carried out for patients who is only seen for urgent dental care.

Myth: If my practice joins the GDS Reform programme, I will also agreeing that my UDA value is £25/UDA.

Fact: No. Your current UDA rate remains. In the letter sent recently by the Welsh Government, metrics for 2022/23 were presented with an example of £25/UDA.

It is true that a practice's UDA rate is not important if the practice joins the GDS Reform Programme because the nominal UDA target mentioned on the 2022/23 metrics can achieved by the practice if they provide assessment and dental care to annual number of patients the practice is expected to see in 2022/23 .

Myth: Practices have to prioritise their existing patient list over new patients

Fact: No, we want all practices to prioritise seeing those patients who need dental care first (whether new patient or from the practice list) over patients who have healthy mouth.

Practices can work very closely with their health boards for supply of new patients and can also agree to see additional new patients with lowered minimum number of patient numbers from the practice list.

This can be done at any time during the contract/financial year or at the end of the year contract review.

Myth: All new patients have high treatment need requiring multiple Band II and Band III items of treatment.

Fact: Not all new patients will have high treatment need patients. GDS Reform Programme prior to pandemic showed that new patient population had higher treatment need compared patients seen regularly by practices but a significant

proportion also had healthy mouth. A patient new to a practice may have accessed dental care elsewhere within the NHS or privately.

With the impact of pandemic, it is likely that a higher percentage of new patients may require dental care and it is also likely that these patients will need more dental treatment than newer patients seen before the pandemic. Hence, close monitoring of treatment need of new patients will be required through the data analyses which will be made available via e-Den.

Myth: Practices participating in the reform programme will continued to be asked to see more and more new patients every year.

Fact: No. GDS Reform Programme takes an Action Learning Approach and learning from 2022/23 will inform metrics for 2023/24.

Myth: ACORN toolkit and data does not seem to matter anymore except for recall interval and fluoride varnish

Fact: Not true. Risks and needs assessment (ACORN) and individualised preventive dental care planning and recall based on need remains at the heart of the GDS Reform Programme.

The primary aim of the ACORN toolkit is not data collection but to embed good practice of comprehensive risk and needs assessment and annual preventive dental care planning in dental practices in Wales.

The toolkit also facilitates patient's active participation in Shared Decision Making in prevention and treatment. It also allows dental teams to review how risks and needs of a patient changes over time especially those patients are categorised as 'Red' for caries and periodontal health. A practice can also adopt a practice of continuous quality improvement to study the outcomes achieved for regularly attending cohort of patient population and make any improvements required to achieve better outcomes.

Myth: Practices training the foundation dentists cannot be part of the GDS Reform Programme.

Fact: Like other practices training dental practices have the same option of either joining the GDS Reform Programme or going back to the UDA contractual model. We very much hope all practices training foundation dentist will join the GDS Reform Programme. This will also ensure new cohort of dentists are trained in new ways of delivering dental care including carrying out ACORN, annual preventive dental care planning etc.

If a training practice has any concern, how training of Foundation dentists will be quality assured when they join the reform programme, please contact Health Education and Improvement Wales (HEIW). We are confident that HEIW and Health

Boards can make the GDS Reform Programme work for both training practices and foundation dentists.

Foundation dentists will be assigned a standard baseline for new patients as a marker only. Over performance of this new patient marker will count towards a training practice new patient target if they have signed to be part of contract reform. Health boards should NOT add the nominal 1,820 UDA foundation dentist nominal target to the practice ACV to work out the contract reform metrics.

Myth: New non-UDA dental contract can be designed without testing new metrics and there is a perfect timing and solution to solve all complex challenges.

Fact: Reform of any contractual model, amendments of associated dental regulations underpinning the current GDS/PDS contracts and tackling other complex challenges in the system (e.g. workforce, impact of pandemic, funding model etc) requires multiple years of testing and learning cycles.

A big shift i.e. change from how we have always done things is not easy for any stakeholders including patients and service providers.

Considering complex challenges cannot be solved by any formulae or using the same methodology of introducing the new NHS dental contracts in the past, the Action Learning Approach with built in local flexibility has been adopted.

In terms of use of new metrics, there is no such thing as a perfect measure. All types of metrics have limitations. Limitations of metrics will need to be understood and taken account of by practices and Health Boards. Ultimately all stakeholders want successful NHS practices meeting the dental prevention and care need of local population.

Workforce and funding challenges to meet the dental care need of higher proportion of the population who want to access NHS dental care will require ongoing engagements, discussions between stakeholders and medium to longer term plan informed by the ongoing learning from the GDS Reform Programme.

Frequently Asked Questions

What is a new patient?

A new patient for a practice is someone the practice has not provided any Band I, II or III course of treatment in previous four financial/contract years. However, if the practice had only provided an urgent course of treatment to a patient in previous financial years and provides a Band I or II or III course of treatment during 2022/23, they will count as a new patient. Some new patients will need urgent dental care first followed by ACORN and preventive dental care.

Why has four year timeframe used for new patient instead of two years?

This is to reflect availability of services during the pandemic and also to prioritise patients who have not accessed NHS dental care for longer time and are seeking dental care. This timeframe will be reviewed as a part of the Action Learning Approach of the GDS Reform Programme.

Our practice has a large historic patient list compared to another practice with the same ACV. With requirement to see new patients, do you realise that our practice will not be able to see many of our historic patients during 2022/23?

Yes. It is reasonable for a practice to prioritise dental care towards those who need it rather than simply recall and see patients just because a patient is on a practice's list.

We understand that this means some patients with no treatment need and low risks from a practice list may not be seen during 2022/23 unless they require urgent dental care**.**

Is there a ratio of children to adults required for the new patient target or patients to be seen from the 'practice list'?

No, there is not such ratio. Patients to be prioritised, seen and provided preventive dental care based on need and risks.

Seeing patients with healthy mouth from existing practice list less often (i.e. increasing recall interval) and prioritising based on treatment need will initially create capacity for new patients. But eventually practices may reach a point during the reform programme where seeing the same number of new patients cannot be sustained. What are the plans?

This will be part of the Action Learning Approach which requires monitoring and evaluation including what proportion of patients (especially 'Red' on ACORN) whose need and risk reduces following receiving preventive dental care from a practice.

The metrics outlined in the Welsh Government letter including new patient definition, expected minimum number of patients to be seen and proportion of new patients that remain within a practice/contract will be monitored and learning will inform metrics for 2023/23.

How can practices joining the GDS Reform Programme increase the use of skill-mix?

Each practice situation will be different. Practices joining the GDS Reform Programme are not chasing the UDA target but carrying out ACORN and co-

producing an annual dental care plan with their patients and then providing preventive dental care. A dentist can delegate prevention and dental treatment and any reviews required within the year to appropriate Dental Care Professional (DCP) member.

Although FP17Ws still need to be submitted under a performer number, reporting the use of DCPs, stabilisation etc are part of the FP17Ws dataset.

We understand that there are further barriers of using skill-mix including workforce challenges.

How will the minimum historic patient numbers to be seen by each contract be calculated and will Health Board communicate this to all practices that join the GDS Reform Programme?

Yes, Health Boards will communicate the minimal historic patient target to practices joining the GDS Reform Programme. Practices can calculate the number themselves as well by using 1280 patients per 170k ACV.

Practices joining the reform programme will have some patients who will start treatment in March (i.e. this financial year) but only complete their full course of treatment in the next financial year. Will these patient count in the metric for 2022/23?

Yes, if treatment plan has not been completed and patient comes back in 2022/23 financial/contract year to complete the course of treatment, they will count towards the metrics for 2022/23

If the dental care plan has been completed within the financial year 2021/22, they will not count towards the metrics in 2022/23.

If our practice participated in the GDS Reform Programme, can we still agree with our Health Board to provide additional access sessions for urgent dental care?

Yes, practices joining the GDS Reform Programme can sign a separate PDS agreement for delivery of urgent dental care sessions in addition to delivering expectations outlined in the GDS reform contract variation.

If a contract holder signs a GDS reform contract variation for 2022/23, do they have option of reverting back to the UDA based contract in 2023/24?

Yes

How will additional innovation funding provided to some practices affected?

Innovation funding to be added to the Annual Contract Value (ACV) if that has not been already done so that contract variation metrics apply to the new ACV.

Are children who are categorised as Green for caries, periodontal health (if relevant) and other dental conditions also included on the 20% recall threshold mentioned on the metrics for 2022/23?

No, recall interval metric only applies to adults with healthy mouth i.e. 'Green' for caries, periodontal health and other dental conditions on the ACORN.

Where are we with the Principles of Care for dental caries and periodontal disease which will be helpful especially in management of high need and risk patients?

The Principles of Care for periodontal disease and dental caries were initially developed by local dental teams in the North and South respectively. Using a co-design approach these were then sent out for initial feedback and testing using Health Education and Improvement Wales's Quality Improvement network. In addition, we had an informal consultation process to understand the views of the broader profession. The results from these two processes were collated and the two pathways were further refined by representatives of Work Stream 2 to ensure the clarity of the layout. The two Principles of Care have subsequently been sent out for further testing by dental practice teams with NHS contracts across Wales and we will be collating their feedback in Spring 2022, in readiness to distribute to the profession in Summer/Autumn 2022.
The latest draft being tested can be obtained by contacting our senior project manager Sarah Fisher at Sarah.Fisher4@wales.nhs.uk

Is the RAG rating (for caries, periodontal health and other dental conditions) of practice patient population still useful and how will Health Boards use them?

Yes. Metrics for 2022/23 includes practices seeing a minimum of patients per year without going into the complexity of what kind of RAG status for three conditions on the ACORN toolkit and/or the numbers of treatment bands expected for those patients**.** Annual number of patients to be seen for a given contract value is a 'high trust' volume metric. It is hoped this allows dental teams to focus on prevention and dental care required for patients in front them rather than complex targets.

The NHSBSA will continue to analyse a practice's ACORN profile and other data submitted via FP17Ws and then compare it to their Health Board's average and the Welsh average. Both practice and Health Boards can monitor this on eDen. This information will be considered by Health Boards at 6 monthly and End of Year review to ensure practices seeing high proportion of high treatment need patients requiring many items of treatment are not penalised.

Will the practices joining the reform programme have to sign the contract variation agreement with their Health Board before 1st of April?

We accept that the offer to join the GDS Reform Programme and key measurements for 2022/23 came later than expected. There are multiple reasons for this delay. With this in mind, Health Boards have agreed that practices can initially let their Health Board know that they want to join the GDS Reform Programme. Formal signing on the contract variation can be done on mutually agreed date between the practice and their Health Board.

What happens to the non-recurrent funding my practice receives from the Health Boards and other additional dental contracts I have with the health board?

The contracts with non-recurrent funding arrangements or additional PDS or other types of agreements for urgent dental care or conscious sedation or domiciliary dental care or endodontics etc and PDS agreement for specialist services like orthodontics are outside the scope of contract variation in offer for 2022/23.

Practices receiving non-recurrent funding in 2021/22 financial year should contact their health board to discuss these funding arrangements and service provision in the area.

Will a practices joining the GDS Reform Programme be offered to sign the PDS Agreement or does the practice have a protection of having an open ended contract provided by the GDS Regs?

Practices joining the GDS Reform Programme will be offered to sign a variation agreement only for 2022/23 and open ended GDS contracts still sit in the background which means practices have protection of reverting back to their GDS contract. GDS Reform Programme offer for 2023/24 will be based on learning from the 2022/23.

Risk of claw back seems to be higher under the GDS reform contract variation offer compared to the UDA system. Is this true?

Risk of claw back is much lower if a practice joins the GDS Reform programme because we believe practices are more likely to deliver the metrics under the reform programme compared to the UDA system. Each metric also has a tolerance level built in.

In addition, if a practice is seeing and providing treatment to high need patients compared to other practices, there is local flexibility for health board and the practice to work together adjust minimum numbers of annual patients (from the practice list or

new patients). This will require close monitoring of ACORN and other data submitted on the FP17Ws during 2022/23 which will be analysed and provided on the e-Den.

Will there be public communication to manage unprecedented demand for dental access?

Yes. NHS dental services will not be able to meet the all the demand for dental access with a significant proportion of such demand being routine ‘check-up’ by patients with healthy mouth. Hence, NHS dental access and care will have to be prioritised based on need and risks rather than demand. This may mean patients with healthy mouth and low risks waiting for their ‘check-up’ much longer than they have been advised for many years.

The reform programme will work closely with the Communication Team within the Welsh Government and Health Boards for communication with the public. Some Health Boards have centralised waiting list and all of them planning to improve their communication about availability of dental access in their area.

What is being done with regards to the workforce challenges?

HEIW continues to concentrate on ensuring that they work with stakeholders to have a focus on both recruitment and retention of the dental workforce. This is not an issue for just Wales. Workforce strategy and planning is one of the functions of HEIW. Current challenges include the health and wellbeing of the workforce and the lack of contemporary workforce data which will help in both planning for recruitment and retention. The WNWRS is to be introduced for the GDS dental profession later in 2022 and information from this will enable HEIW to continue to work in partnership with all agencies to develop solutions to current and future workforce challenges in Wales.