Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Deintyddiaeth

This response was submitted to the Health and Social Care Committee consultation on Dentistry

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Ymateb gan: | Response from: Eirlys Dental Practice

To whom it may concern

Please find my name and contact details below. This evidence is submitted as an individual, and on behalf of Coal and Diamond ltd. trading as Eirlys Dental practice. I would prefer my name is not published alongside my evidence unless I am notified and invited to accept the publication after reading it, as I would not like to be taken out of context in any form, or snippets that may not offer the full picture of my experience. If I were invited to elaborate further, or to consent on publication of my name after review, I would be more than happy to do so openly and, in any forum, provided it is working towards achieving a sustainable NHS dentistry in Wales as this is my ultimate and only goal.

I appreciate the initiative you have taken to better gauge the state of dentistry and its recovery I hope this interest extends into the future and helps the transformation of NHS dentistry into a sustainable model that our patients, dental teams and communities deserve.

I will attempt to be a succinct as possible while offering practical solutions to the problems we are facing. I speak on this topic internationally mainly to dental corporate groups and individuals who are interested in expanding into North Wales, so I could speak around this for hours, I would also be happy to meet to discuss this further if this is of help.

I moved to North Wales with my small family four years ago after working in St Albans for years in a desirable position as the clinical director of a dental group in the home counties. Since we moved here in 2018, we have established ourselves as one of the largest independent NHS dental providers in North Wales and adopted contract reform in 2019 (Pre pandemic). The history to this was taking over handed back contracts from Dental practices that had failed under the previous contract for reasons that have finally become very clear to all, including recruitment and the failed contract itself. My intention and the purpose of writing this letter is to ensure I have done my part to offer solutions and facilitate a sustainable NHS dental service in Wales that our communities deserve and desperately need.

We are extremely proud of the recruitment work we have done over the past four years. At a time where health boards and areas as Swansea and Cardiff were reporting up to 22% loss of NHS dentists (BBC) our health-board commended us for the work we did to help increase our recruitment of NHS dentists by 1% , which was “bucking the trend” in comparison to most of the UK according to some media outlets we were mentioned in. The media also took an interest in this and attended the practice for interviews. We consider ourselves very much a success story. Unfortunately, despite being recruited to the highest level ever for these practices, we are still far off reaching the unrealistic patient numbers announced for 22/23 by the deputy CDO. This is extremely demoralizing to staff and dental teams and leads to further “abandoning of NHS dentistry”. One would expect that good effort and achievement would be met with good outcomes, instead we find ourselves

amongst many other practices with the threat of sanction looming over us. Despite the health board's commendable and admirable engagement and reassurance of their discretion I am sure you can appreciate that businesses run on discretion tend not to thrive in times of uncertainty.

The system we had before (UDAs) was unfit for purpose and lead to multiple practice closures, we have been in contract reform since 2019 and thoroughly enjoyed the prospects, and shared the hope of a sustainable NHS dentistry model, there has been phenomenal engagement between practices, our health board, HEIW, and HB executive initiatives; with the NWDA and MCNs and multiple projects that have really been a breath of fresh air and made us all feel that we were moving in the right direction. We were involved in direct discussion with the previous CDO who commended our innovation and work on skill mix, which we have introduced successfully and have trained employees with no dental experience to becoming registered dental nurses, who are now pursuing further education to become hygienists, within a framework set out to encourage retention and recruitment in North Wales. These things do however take significant time and investment which is not recognised by the new form of contract 22/23, neither is QI.

Despite this level of collaboration and being involved in pathways of care as pilot practices, we have nonetheless seen contracts returned and not even sold, due to the very poor prospects of NHS dentistry in Wales, this is echoed by practice sales agencies. This affects the dental market which in turn affects the long term stability and planning for dentistry in Wales, as without good future investment in NHS dental expansion, the service will - as it is now- become hugely overwhelmed with demand leading to a decision on whether or not continuing in NHS dental services is right for practices and their teams, not to mention a shrinking service due to handbacks.

Please be mindful of the fact that converting a practice to private from NHS is not a lucrative or savvy business move, but rather a move that keeps the business alive and relieves stress from staff which allows them to continue in their roles for years to come, offering sustainability, and wellbeing which is a trade-off most providers and dental teams are willing to accept.

Our biggest resource is our highly skilled staff that aren't after any form of excessive financial reward but rightfully expect to be remunerated and acknowledged fairly for the work they do, not only some of it that fits into the new metrics (I will provide detailed examples of this and elaborated further below)

I take great pride in being enthusiastic , positive and a solution based individual and as a company we believe in making things work. As you may see from our track record in turning failing NHS dental services in even the most remote areas of North Wales, into successes, and providing care when around 25,000 people were deprived of it due to contract hand backs.

I would like to outline the main practical problems faced by patients and dental teams with an emphasis on what matters to patients **(Them and their families being seen promptly when they need it most, and not needing to resort to harmful self-treatment)** and dental teams (being acknowledged for the level of complexity and quantity of the hard work they do). I will then put forward some solutions that would radically change the biggest problem we have (ACCESS). Not only do I believe that seeing all these patients is possible, but within the correct framework I am confident we could even surpass the number of overall patients seen in a year to record braking figures.

A very simple example I would like to begin with; unfortunately, we are only remunerated for access relating to patient who have a <u>full examination and completion of all dental treatment necessary</u>, anything less than that is not remunerated under this version of contract reform. It is an admirable

goal to get all North Wales 100% dentally fit, but it's simply unreasonable and unachievable and will lead to more burn out and more negative consequences. More importantly, it is not what patients want (above all else they want to be seen when they most need to be, as you or I would want when we are in need or in pain, or any of our family and friends are, in fact we would expect it, and rightfully so) If we were to adopt some of these suggestions which as clinicians, practice owners on the ground understand will work -and we understand this as we have been collaborating over the past few years in contract reform- I believe this would not only improve access almost immediately, but relieve the work load on 111 operators , out of hours, hospitals, health-board phone lines , allowing us to reallocate these resources back into clinical care , reduce the number of complaints to practices, health-boards and members of Senedd and will ultimately lead to improved patient outcomes and reduced attempts of harmful self-care out of desperation, and negative media coverage. Again, within the correct framework of what matters to patients most, not only can we achieve this but also see more patients than currently excepted and break access records in the process, which means more oral cancer screenings, and doing the most vital part of our role in saving lives by detecting these conditions and their oral manifestations earlier.

Allow me to outline some problems along with some suggestions and solutions:

- **Urgent patients are currently not remunerated** or acknowledged in the metrics

This absurdly disincentives practices to see any new urgent patient to the practice, it also causes disruptions within teams when a dentist is on leave or leaves the practice and other clinicians must take over their patients' care as only 1 acorn is acknowledged and remunerated per patient per year. The solution to this is acknowledging urgent patients (new and historic) and accepting that these should be remunerated. I really believe this to be a very basic observation and a vital part to solving the access problems, this would allow any patient in need, who in many instances hasn't slept for nights, to attend almost any practice they choose not for a full examination, but simply for a quick resolution of the urgent problem in a 30 minute appointment slot, this should be a basic right on the NHS for all the population (EDS sessions have been trialled and are proving to be a great success in relieving the burden as mentioned above) This could be implemented almost immediately and would see and overnight access boost. Dental teams would be able to see more of these patients, pushing the number of patients seen by a dentist within a year to record highs and solving the biggest problem patients face along the way, with all these patients receiving an oral cancer screening. In a nutshell more emphasis on what is needed from a patient's point of view, with a lesser portion of the contract allocated to routine care which can be handled with good skill mix.

- **Only patient who receive an ACORN (NHS risk assessment) are remunerated**

and only once a year, this is effectively capitation, which comes with a large array of problems in health care and previous models of this have failed across the UK in their pilot stages. This also creates new models of work that can be extremely counterproductive, and in future will be interpreted as "gaming" as it was with the failed UDA contract, rather than accepting the contract is flawed. Again, patients who have gum disease and require multiple treatments and appointments are not rewarded or differentiated under this framework which could lead to practices having to compromise on care to reach targets, putting us back in the same position we started off in in 2006. (The solution is in point 3)

- **Patient who requires multiple procedures over multiple visits a year and take hours of clinical time are remunerated the same as patient who attend for 10 and in some instances a 5-minute examination**.

This will clearly incentivise practices to see low risk / low need patients as they are rewarded more for this and are able to meet the unrealistic targets set, to ensure the survival of the practice. This again is an example of going against what is clearly needed. The solution to this could be a weighting system whether through clinical procedures (as most hospitals have) or time , appointments, the complexity of certain procedures etc. This is not a complex mechanism to create, as there are already successful examples of this. With the information collected from ACORN, that is half the work already done by dividing into risk categories of green, amber, and red, this must be taken into account, but the work should continue towards more detailed understanding of deeper needs within risk categories i.e.. Those requiring multiple appoints and complex treatments. So not simply RED, but more detail of this and more weighting, as not all red patients require the same levels of time, resources, and skill to treat.

- **Some aspects of the metrics are entirely unachievable in their current format, mainly patient numbers, particularly for practices that have high need patients.**

In addition, some practise including ours have been asked to see more Historic patients than were ever seen in a year before and in some instances more than the total number of patients on their books. When a practice is fully staffed to the level expected and unable to reach these targets, it leads to decreased morale, trust and burn out and eventually practices will resort to sustainability and private provision in order to maintain their most valuable assets (their staff) who would otherwise individually move to private practice leaving behind shells of dental practices and what have become known in the media as “dental deserts”. The solution is a revision of these patient number, in depth weighting and analysis of patient needs and remunerating accordingly, <u>even if this is within the same funding package</u>.

- **Recruitment processes for overseas dentists must be facilitated**, we have been able to use many innovative ideas for our recruitment strategy and have helped other practices with advice also. There is no longer competition between NHS practices, we are working together to solve a much bigger problem for our patients, and also to see if NHS dentistry is sustainable in any new form, and we are very keen to make it work, but are also not under any illusions when faced by the very real threat of sanctions on businesses not achieving these metrics

- **Direct access for therapists working within a skill mix must be urgently put into place**

This causes a significant slowdown in what could otherwise be a very efficient service. Changes in legislation or emergency measures are required, simply to allow therapists and hygienists to work at the same scope of a private dental therapist! With facilitated patient group directives. This would bring the skill mix efforts to fruition and allow dentists to do what only they can do, focusing on more complex treatments and increasing access furthermore.

- **Dental teams must be paid for the level of work they are providing to individual patients**, a root canal treatment is an extremely time consuming, not to mention litigious procedure that demands additional time, skill and equipment to provide good evidence-based outcomes. Equating this to an examination or a simple filling is absurd and drives away ambitious dentists who have undergone further qualifications in order to improve and perfect their art that stems from passion, when passion and talent are rewarded, they usually move on to a more appreciative environment. It really needn’t be this way.

- **Time must be given for all the necessary adjustments** to be met by other field players , this includes NHS BSA , EDEN and software providers, when practices cannot yet fully measure their own performance accurately and in real time then provide transparent information on this to their associates as we were able to do previously, it becomes very difficult to remunerate dentists and measure performance accurately which is extremely frustrating for all those involved and demands hours of additional management time and resources particularly with coding and rolling out new ways of working. This again can be done from the same funding package.

- **Staff pay and associate remuneration** , simply put, If I were to figure a mechanism of pay and pass on these targets to our dental teams who are already working at full capacity and doing a phenomenal job at a fully staffed practice, I would inevitably be asking them to do the impossible, and I would not be surprised if this adds to the lists of staff leaving the NHS and practice closures , as effectively at a time where inflation is up by 10% I would be offering them a 30% pay cut for producing the same amount of work they have been over decades. Applying these new metrics rigidly as self-employed dentists would undoubtedly mean the end of our NHS contributions and the serious need to consider other more sustainable models of dentistry. I mentioned earlier and would like to emphasize this is always a final resort for practices and is not done out of greed, rather out of an instinct to survive. I come from a family of doctors who have all contributed decades of their lives to the NHS, and I wish to continue this above all else and serve our patients as I have promised to do. The solution: reasonable metrics in patient numbers as per previous suggestions and collaboration of practices with the BDA, as current contracts mention 'claw back' which means thousands of dentists are currently under performing and at risk of claw back from practices, if claw back occurs from Health boards. If this takes place it could lead to a chain reaction seeing many more NHS practices hand back their contracts in the coming 2-5 years.

Some of the excellent work that has been done and need to be continued upon

- Addition of preventative metrics in contract reform

- Health-board communication in North Wales and engagement with practices has allowed them to see the problems on the ground and how practices are different and unique, and each patient is different in the time required to treat them based on the complexity of their needs. This engagement and trust are the main factors practices are still open in our health board but again I'm not sure how sustainable this is in the long term for any business.

- HEIW engagement and education

- The collaboration between independent practise and willingness to share experiences and systems

- Reliance on evidence-based recall intervals also as a metric

- Introduction of pathways of care and stabilization for periodontal disease and dental decay, this is very useful, however it is still vague and has been delayed multiple times with very poor feedback on its progress, and roll out, dentists do not wish to engage in this if it puts them at medico-legal risk (happy to explain further if required)

7- ACORNs (NHS risk assessments) these outline broadly -not to the level of depth required- the differences between groups of patients and their requirements based on their risk category it still doesn't identify the difference between individuals within a risk category as mentioned earlier. These need to be used as a building block to acknowledge the work dental teams and dental practices and teams proportionally with the work required, i.e., a high-risk patient attending several appointments must be multiples higher in remuneration than a low risk patient attending 1 appointment. As it stands, we are only being remunerated for every patient once a year.

To summarize a lot of hard work has gone in by WG, HB, HEIW, LDCs, Practices, Dental teams and many more field players the collaboration has been refreshing and the trust is excellent, however, we must be realistic and businesses that rely on discretion and trust to avoid bankruptcy very soon become a hugely unattractive venture. To solve access and relieve pressure on our secondary care services we must take a fresh look at the problem from a patient's perspective and consider providing more of what is needed, not more of what we admirably yet unrealistically aspire to.

I apologise for the typos, I haven't proof read this as I was only made aware of this opportunity today and after a long day's clinical work the deadline is in 10 minutes. I am always available to discuss this further and I hope you have found this of some use. We will continue with our hard work and commitment to our teams, our patients, our communities, and our values. We are the NHS, and we will continue to do everything we can to ensure there is a place for sustainable NHS dentistry in Wales now and into the future for our children and coming generations.

Yours sincerely,

Mostafa Hassaan

CEO & Clinical Director – Eirlys Dental Practice