The introduction of the new dental contract in England – a baseline qualitative assessment

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IN BRIEF

- The paper captures opinions held by those embarking on the new dental contract.
- The study allows any future changes in views about the new contract to be compared with baseline data.
- The study reported the views of professionals and managers about the new NHS dental contract.
- The study identified misgivings about the introduction of the new NHS dental contract.

PRACTICE

VERIFIABLE CPD PAPER

Objective To record immediately prior to its inception the views of key stakeholders about the new dental contract introduced in April 2006. **Method** Nineteen participants (11 dental practice principals and eight primary care trust dental leads) were interviewed using a semi structured approach to find out their views and opinions about dental practice, the reasons for introducing the new dental contract, its implementation and content of the new dental contract. An analysis based upon the constant comparative method was used to identify the common themes about these topics. **Results** Practice principals expressed satisfaction with working under pilot Personal Dental Services schemes but there was a concern among dental leads about a fall in dental activity among some dentists. All participants believed the new contract was introduced for political, financial and management reasons. All participants believed that it was introduced to limit and control the dental budget. Participants felt that implementation of the contract was rushed and there was insufficient negotiation. There were also concerns that the contract had not been tested. Dental practitioners were concerned about the calculation and future administration of the unit of dental activity system, the fixing of the budget and the fairness of the new dental charge scheme. Dental leads were concerned about patient access and retention and recruitment of dentists under the new contract. **Conclusions** The study found a number of reasons for unease about the new dental contract; it was not perceived as being necessary, it was implemented at speed with insufficient negotiation and it was seen as being untested. Numerous and varied problems were foreseen, the most important being the retention of dentists within the NHS. Participants felt the contract was introduced for financial, political and managerial reasons rather than improving patient care. The initial high uptake of the new dental contract should not be viewed as indicating a high level of approval of its content.

INTRODUCTION

In April 2006 changes to the delivery of NHS dental care were introduced through the implementation of locally sensitive dental contracts, drawn up between providers and primary care trusts (PCTs). Prior to the introduction of this new contract, dentists had worked under a largely unchanged General Dental Services (GDS) contract since 1948, with the exception of pilot Personal Dental Services (PDS) schemes initiated in 1998 to investigate new ways of working. The new contract was heralded as being a shift towards preventive-based care in dentistry, as outlined in *NHS dentistry: options for change*,[1] following the recognition that the existing contract needed to change to reflect changed disease levels and expectations of patients.

Under the arrangements of the new contract a new system to measure dentists' activity, the Unit of Dental Activity (UDA) and a new system of patient charges were introduced. The UDA system ended the traditional non-cash limited fee-for-item arrangement and introduced a cash limited system based on delivering agreed levels of dental activity for an agreed price. The new system for patient charges simplified the old system of charges for individual treatments and replaced it with a system based upon three charge bands that depend upon the complexity of treatment.

The aim of this study was to understand the beliefs, views and perceptions of key stakeholders about the new dental contract before its introduction. Specifically, we wanted to gain from stakeholders at baseline an understanding about why they thought the new contract had been introduced, their perceptions of the process of implementing the new contract, and their views about the content and likely impact of the contract. The main objective was to identify at baseline what was liked and disliked about the change to the new contract and the process of implementation and identify early problem areas that key stakeholders envisaged. This information will be helpful for understanding changes over time in the way the contract is viewed, the development of future quantitative evaluations, and for the administration and future modification of the new dental contract.

METHOD

The study was a qualitative study using face to face interviews with dentists and

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primary care trust dental leads. Ethical approval was obtained from the Multicentre Research Ethics Committee for Wales in November 2005 and Research Governance approval was subsequently secured from participating PCTs.

A purposeful sample was constructed of practice principals that had practices working under the GDS system, practice principals that had practices working under the PDS system and PCT dental leads. The Dental Practice Board was asked to randomly select from all PCTs in England five in which fewer than 5% of practices had moved into PDS and five where over 50% of practices had moved into PDS. The dental leads from these ten PCTs were invited to participate. The Dental Practice Board was also asked to select 20 practice principals from these PCTs, ten principals from GDS practices and ten from PDS practices and these were also invited to participate. In drawing up the sample the aim was to obtain a cross-section of relevant stakeholders.

The interviews were all conducted by the same trained fieldworker (KP). The interviews were semi-structured and were piloted on a small group of general dental practitioners before the fieldwork began. The interviews included questions that were biographical, work related and ones that were specifically about the new contract. Each interview began by asking participants to describe their career and then explored their views about their current working practice. The interviews then focussed on the new dental contract. Participants were asked about their beliefs about why the contract had been introduced, their views about the process of implementation of the contract, and their views about the content of the contract and how this might affect the delivery of dental services. Participants were given opportunities to express their views in detail and each was asked at the end of their interview if they wanted to add anything to the transcript that might help our understanding of their opinions. The interviews were carried out in January – March 2006, prior to the introduction of the new contract in April 2006.

The interviews were recorded and the content of the recordings were analysed separately by three researchers. Recordings of the interviews were divided among the researchers so that each interview was independently analysed by at least two different individuals. As the subject matter was not taboo or embarrassing it was assumed that the participant's responses reflected their actual views. Each researcher used a systematic and iterative method of analysis which was based on the constant comparative method.[2] Open codes were produced from the data which were grouped into organising categories, and then into themes relating to the following: participants' views about their current working arrangements, the reasons for implementing the new dental contract, the process of contract implementation, and the content of the contract. After the initial individual analysis of the interviews was completed, a group meeting was held to discuss and compare key findings. At this stage a decision was made that similar themes were emerging and that additional interviews would not be undertaken. After a further analysis of the interviews in light of the emerging themes a second meeting was held to reach a consensus about the key findings to be presented.

RESULTS

Of the 30 dental professionals contacted, eight PDS practice principals, three GDS practice principals, four PCT leads (PDS) and four PCT leads (GDS) agreed to participate in the study. A total of 19 interviews were therefore conducted. The practice principals interviewed were a mixture of male and female dentists; all had at least ten years experience of dental practice. Five of the dental leads reported that they had dental qualifications and three had backgrounds relating to the organisation and administration of the NHS.

The practice principals were on the whole positive about their working arrangements prior to the introduction of the new dental contract. Most of those working under the pilot PDS schemes reported that it allowed more time with patients, that incomes were steady and that care could be focussed more on patient needs. Many of the dentists reported that changing from a GDS system to a PDS system did not fundamentally alter the way that they practised dentistry and one specifically stressed that his dental activity had remained the same. Among the PDS dental leads a fall in clinical activity among some dentists was considered an important problem. One suggested that it was the fall off in dental fees that ended the PDS system. Despite these worries many of the PDS dental leads felt that the PDS system could have been made to work, that dentists were happier and that most worked in a committed professional manner.

The three practice principals working under the GDS scheme liked the flexibility in treatment choices and the feeling of autonomy about their work. According to these dentists the main problems with the GDS system were that fees were too low or did not accurately reflect the time needed for certain treatments, that the system does not adjust for new developments and is complicated with too many treatment codes. It was noted that although dentists had to work fast it was possible to earn a good standard of living once the practice was fully established.

'A busy schedule day is not a problem ... With time and with experience you try to do the best job you can regardless of whether a patient is private or NHS ... but if it was funded better you would be able to spend more time with your patients.' [17, GDS practice principal]

'It's a good system but fees need to be tweaked a little bit.' [19, GDS practice principal]

Irrespective of job role the participants believed that the new dental contract was introduced for similar, financial, managerial and political reasons. The main financial theme was cash limitation. All participants mentioned cash limitation either at a local or national level. At the national level the participants thought that the Government wanted to limit and then reduce the total spend on dentistry. Some suggested that there was an agenda to further limit spending on NHS dentistry by forcing dentists into the private sector. A range of participants mentioned a hidden agenda of forcing dentists out of the NHS and some were very angry.

'Labour want dentistry private.' [18, GDS practice principal]

'The government is giving NHS dentistry a slow lingering death.' [2, PDS practice principal]

Many of the dental leads suggested that the contract was introduced to have

closer control over the dental budget not only in terms of its limitation but also on purchasing of services. On the whole the dental leads were positive about this aspect of the contract and whilst acknowledging difficulties reported that it might help them to better fit dental services to population needs.

Dental access was raised by nearly all the participants as a reason for introducing the new contract, but the predominant view among the participants was that the new contract arrangements would not solve access problems. Indeed many of the participants thought that dental access would get worse and provided explanations about how the new payment system mitigated against seeing new patients. One practice principal explained that patients that missed appointments cannot be charged and that these patients will soon find themselves excluded.

Many participants had negative views about the process of implementation of the contract. These were grouped under three themes: inadequate timescales, poor information and a lack of negotiation. The participants felt that the timescale for implementing the contract was too short and many felt it was rushed. For example, dentists reported that there was insufficient time to read and study the contract before having to sign it. Many also reported a lack of adequate information about the changes but the most important reason for a negative perception was participants felt that the contract was foisted upon them with little consultation or negotiation. There were examples from dental leads and the practice principals of dentists grudgingly signing or signing the new contract in dispute. The only positive aspect reported was that some dental leads and dentists believed the implementation process had built a relationship between GDPs and their PCT for the first time.

'150 pages of contract have to be read in a short period of time, signed up to and returned. So many dentists now are signing in dispute with a whole long list of clauses which they dispute.' [16, dental lead GDS]

'The timescales have been so tight. The information from the department not timely. It all feels like it is being forced through.' [15, dental lead GDS]

In terms of the content of the dental contract, the UDA was singled out for criticism. Negative views were grouped under the theme's unfairness, inaccuracy and inappropriateness. Most participants felt that the UDA system was unfair and that there were winners and losers depending upon the initial calculation and negotiation. There was also a concern that the UDA was fundamentally unfair because dentists would be paid a different amount for the same tasks. *'The UDA should be the same across the country'* [18, practice principal GDS]. Some dental leads and practice principals raised concerns about the initial calculation of the UDA and suggested that they were inaccurate. One dentist felt the target was set too high and was worried about having to cut appointment times. Another believed that their previous hard work had now been penalised in the calculation of the UDA.

'To hit six UDAs an hour I need to cut patient time down.' [2, practice principal PDS]

'Always worked at a high pace and that's been a problem, because now my UDA totals are high.' [6, practice principal PDS]

A number of participants mentioned that some UDA values were inappropriate as complex procedures were not allocated sufficient UDAs. There was a widespread view among dental leads and practitioners that the UDA system and accompanying charge system might lead to certain treatments and certain patients being favoured over others. In general there was an opinion that simple treatments would be favoured over more complex treatments.

'Will it be ethical? For example, regarding UDA values being the same for extraction as for root filling.' [14, dental lead, GDS]

When asked about the new system for dental charges many of the practice principals had a negative view about the three bands because they thought it unfair to patients. The main perceived source of unfairness was for patients who attended regularly and had good oral health. It was recognised that these patients would face higher charges and some felt that longstanding patients would not be getting good value and might even be deterred from attending regularly. Many of the practice principals pointed out specific faults in the new system, one example being the same charge for one filling as for several fillings. The only positive responses to the new charge system were that it was simple and might be easy to administer.

'It's a tax on teeth, the four minutes of time I spend with them I've got to charge £15.50 ... I'm talking about people who have been coming for years and years.' [6, practice principal PDS]

An important issue for all participants was that the new contract had not been tested. Nearly all the participants explicitly mentioned this and felt that this was a mistake. All participants speculated about areas in which problems might occur with the new contract arrangements. The practice principals were mainly concerned about UDA targets and values, the impact that patient charges would have on certain groups of patients and the impact that a fixed contract would have on their autonomy and business decisions. The dental leads expressed concerns about dental charge revenue and the impact the new dental contract will have on dental access, recruitment, and retention of NHS dentists. A number of specific problems were raised by both groups; these included the lack of clarity about what happens when a dentist fulfils their UDA target, the relationship between recruitment of dentists and UDA values, the treatment of patients with complex needs and difficulties in recruiting dentists or expanding services once the contact value had been fixed.

'...you get paid say 1,000 UDAs a month but you finish your UDAs in three weeks. What happens then? Do you say fourth week is private only....For argument's sake, you are an NHS patient you have toothache I do a root canal or extraction on the NHS but then you want a white filling not a silver filling. Do you say to them, this is the NHS hour come back in the private hour? It does not work that way.' [19, practice principal GDS]

When asked what they expected to happen in two or three years' time many of the participants expected more dentists to move out of the NHS and into the private sector. Most of the practice principals indicated that they would see how

the contract was working but if they were unhappy would think about moving their practices into the private sector. One of the practice principals put it quite simply, *'If it goes wrong go private'* [3, practice principal PDS]. The dental leads also believed that more dentists would go private but expected this to be a gradual shift and noted that this would not occur in all areas. One explained that only a certain number of people will pay for private dentistry and that in many areas there will always be a need for NHS dentistry.

DISCUSSION

The main aim of this study was to record the views of key stakeholders immediately prior to the introduction of the new contract, so, to ensure timeliness, the scope of the study was limited to views about the new dental contract and 19 participants were initially interviewed. The analysis was descriptive and looked to summarise themes around a number of issues relating to the introduction of the new dental contract. It found similar themes and issues were reported by the participants and although it is unknown if saturation of some categories was reached, it was believed that interviewing more participants would not have changed the main findings. Additional interviews to further probe the key findings would have been desirable but could not have been completed before the contract was introduced. Therefore the study is limited but the findings are nevertheless informative.

This study provides possible reasons why many in the dental community did not welcome the new dental contract. First the dentists in this study did not have compelling reasons to want new contractual arrangements. Many of the dentists reported liking working under the PDS system and those working under the GDS system felt that the GDS system had flaws but also benefits. Second, there was a widespread distrust of the actual reasons for introducing the new dental contract. Many of the participants believed that the Government had a hidden agenda. Third, all the participants felt that the contract was rushed through and many felt there was insufficient time for proper negotiations. Finally there was a widespread feeling that the new contract arrangements had not been adequately tested to ensure that they worked.

Major changes to working terms and conditions can lead to worries and dissatisfaction.[3] In these interviews many of the practice principals were concerned about a loss of autonomy and the overall funding of their practices. Timely information and an opportunity to talk about the changes might have been helpful in relieving anxieties. However, all the participants reported that the new dental contract was rushed through and indicated that there were failings in the provision of information and in negotiations with some dentists. Both practice principals and dental leads reported that the contract had been foisted upon them and this inevitably led to a certain amount of negative feeling. However, it was not the implementation process itself but the fact that a contract that had not been thoroughly tested that most concerned the participants.

The issue of not testing the new contract was central as nearly all the participants believed, that the new contract was flawed. Both groups provided convincing scenarios in which the new contract arrangement would not benefit patients. For example, some participants indicated that the UDA and dental charge system would favour certain patients and treatments over others and that the system would militate against new patients that required complicated treatments. The reporting of these scenarios strongly suggest that the negative views held by many of the participants about the new contract were not irrational and linked to a fear of change but were the result of considered reflection.

The range and complexity of potential problems foreseen by the participants in this study indicates a need for a thorough and comprehensive evaluation of the new system. The study also indicates some potential areas for evaluation. For example, a number of the participants believed that the new charge system was unfair. Equity is an important aim of government health policy[4] and the issue of whether the new patient charge system reinforces a health inequality should be evaluated.

Probably the most worrying finding in this study was the view that the new dental contract would lead to general dental practitioners leaving the NHS. The practice principals interviewed wanted to continue to provide NHS dentistry and were prepared to give the new contract time but were not prepared to accept major changes that would erode their quality of working life. It was clear that if they experienced major problems with the new contract many would consider leaving the NHS. There was also a belief among some that there is a hidden agenda to force NHS dentists into the private sector. Surveys commissioned after the introduction of the contract indicate widespread dissatisfaction with the contract[5] and unless steps are taken to reassure dentists and listen to their concerns there is the potential that many more dentists may leave the NHS.

In PCTs two styles of management can be found. A directive style that challenges the prevailing norms and values of clinicians, and is often found among senior managers who are driven principally by the imperative to deliver a political agenda, and a facilitative style that works with the prevailing cultures found in general practice, attempting to facilitate change from within rather than forcing change from outside.[6] It seems clear that a directive style was used to implement the new dental contract and perhaps it is now time to try a facilitative approach.

To conclude, many of the participants in this study were not positive about the new dental contract, all believed there were failings in implementing the new contract and all could suggest numerous potential problems with the contract. The initial high uptake of the new dental contract[7] should not be viewed as indicating a high level of approval of its content.

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