Response to Welsh Government Inquiry into Dentistry

Dyfed Powys Local Dental Committee

26th August 2018

1. Dyfed Powys Local Dental Committee is the statutory body that represents dentists across the Dyfed Powys region, covering Hywel Dda and Powys Health Boards. We welcome the opportunity to respond to this consultation and would welcome the opportunity to provide oral evidence as required.
2. We discuss each key theme in turn over the course of our response.
3. **The Welsh Government's dental contract reform;**
4. In Wales a new model of dental contracting is being piloted. The present contract model involves the widely discredited Unit of Dental Activity (UDA) (Steele J. 2009. NHS Dental Services in England. http://www.sigwales.org/wp-content/uploads/dh_101180.pdf. Accessed 29th July 2018), a metric which does not measure anything other than itself. It does not encourage prevention and punishes dentists for taking on high needs patients with the chair time and materials required to treat the patient costing way in excess of the payment received for said dental treatment. The UDA serves the interests of health board accountants more than patients.
5. Dyfed Powys Local Dental Committee welcome the efforts made to provide contract reform in Wales but feel they do not go far enough. We wish to see a system which truly empowers dentists and their teams to deliver prevention to their patients, but also accept the necessity for treatment where prevention fails.
6. At present, those practices engaged in the initial stage of the most recent version of contract reform provide 90% of their UDA target for 100% of their contract value in exchange for completion of data on patient risk factors and clinical need – via a spreadsheet. We feel that 10% is not an adequate amount of time for the proper completion of this data. We would urge a maximum of 70% of UDA target at this stage to be able to collect the high quality data which is requested by Welsh Government as part of the contract reform process.
7. We are concerned that contract reform will be stifled by Local Health Boards who are more concerned by their finances than participating within contract reform which could have profound impacts on the health of the people of Wales. This includes general health as links between good oral health and good general health are growing and often underestimated (NHS Choices. 2015. The health risks of gum disease. https://www.nhs.uk/live-well/healthy-body/health-risks-of-gum-disease/. Accessed 29th July 2018). We all underestimate at our peril the impact that good oral health has on good general health.

8. A key element of contract reform involves skill mix – that is the use of extended skills dental nurses, dental hygienists and dental therapists to carry out some of the work which is presently carried out by dentists. We admire the sentiment but know that especially in rural areas, where practices are in converted houses with no room to expand, that this model of skill mix cannot work. It may suit the city based practices with multiple surgeries but is not suitable for all. Indeed, we have seen that within the contract reform pilots in England, that, when initially dentists were replaced by therapists on a cost basis alone, the practice owners found that the dentists were far more effective and efficient and so looked to re-replace the therapists with dentists. Additionally we know that especially in rural areas; huge value is placed on the dentist – patient relationship and a key focus of this is their ability as a generalist – providing all of the relevant treatment. A move to skill mix will erode this relationship. We must preserve the general dentist working in general practice; they are the cornerstones of dentistry and any reformed contract must be built around them.
9. Patients are keeping their teeth for longer, whilst this is a sign of progress it presents a set of challenges which must be addressed as part of contract reform. These patients, so called the heavy metal generation (typically aged over 50) have multiple large fillings, crowns and bridges which will require ongoing maintenance and replacement, this will be both time consuming and expensive. Dentists are the most suitable members of the dental team to carry out this work.
10. The principles of prudent healthcare are often directed at healthcare professionals but not toward patients. We note we live in a cash limited system and any reformed system must focus on patient responsibility for their own health. Most dental conditions are entirely preventable with good home care. Welsh Government must not hide behind the claim that everything is available to all when there is only a fixed budget. Contract reform must come alongside a public campaign of patient responsibility for their own oral health.
11. **How 'clawback money' from health boards is being used;**
12. Clawback is driven by the present contract arrangement and damages dental practices, reduces patient access and contributes to high levels of stress amongst dentists and their teams.
13. We are aware that not all clawback monies are re invested into dentistry and instead go back to health boards to plug budgetary holes elsewhere. This loss of money from the dental budget impacts on access to services, as often there are dentists who have extra capacity they are not able to use. With the growing evidence base linking oral health to general health (NHS Choices. 2015. The health risks of gum disease. https://www.nhs.uk/live-well/healthy-body/health-risks-of-gum-disease/. Accessed 29th July 2018), especially relating to cardiac and stroke risk, diabetes and pregnancy outcomes amongst others, now is the time for government to invest in dental services, which in turn will help reduce the burden on the health service as a whole.

14. A more appropriate use of clawback monies would be for health boards to allow those dentists who can to overperform – that is provide work in excess of their contract value, and be paid for this. At present dentists are not always paid for such overperformance. In some cases the overperformed amount can be taken off the target for the following year, however in many cases this does not happen and the dentist is not paid for this extra work. This is clearly demotivating and causes dentists to question the question the fairness of the NHS contractual arrangements, both for themselves and patients.
15. **Issues with the training, recruitment and retention of dentists in Wales;**
16. Training: Graduates from Cardiff Dental School are graduating with little clinical experience, this is placing additional burdens on Foundation Trainers who have had to move roles from mentors to educators.
17. Recruitment of dentists across Dyfed and Powys has historically been and remains challenging. There is evidence of practices closing and returning NHS contracts due to the inability to recruit dentists, with a recent example in Knighton of a dentist who had to return his NHS contract because he was unable to recruit a dentist who would be able to provide this service. A dental practice in Builth Wells closed in August 2018 as it was unable to recruit a dentist, this not only creates a problem for patients but places additional strain on an already squeezed GP's, whom patients incorrectly see as a replacement for their dentist. This places GP's in a compromised position as they are forced to treat dental problems, for which they are not competent nor indemnified. Getting dentistry right will benefit the NHS as a whole.
18. Recent evidence from the British Dental Association (British Dental Association. 2017. Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2018/19. https://bda.org/dentists/policy-campaigns/campaigns/Documents/BDA-evidence-DDRB-2018-19-FINAL.pdf. Accessed 29th July 2018) shows that around two-thirds of those practices who tried to recruit have experienced problems in doing so. This is clear evidence of a recruitment problem, as the toxic environment of NHS dentistry is putting dentists off a potentially rewarding and fulfilling career choice, with over 60% of dentists stating they would not recommend dentistry as a career choice. Additionally we are noting increasing difficulties recruiting all members of the dental team, including hygienists and therapists into an NHS environment.
19. Retention: The present NHS dental environment is viewed as toxic by dentists young and old, centered around a pernicious target driven contract, where you are judged first on figures and are at the whim of commissioners, set within an environment of the fear of litigation and ever rising patient expectations and demands. This environment and the ever increasing volume of bureaucracy is reducing morale (British Dental Association. 2017. Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2018/19. https://bda.org/dentists/policy-campaigns/campaigns/Documents/BDA-evidence-DDRB-2018-19-FINAL.pdf. Accessed 29th July 2018) and is pushing hard working and dedicated dentists out of the NHS. If Welsh Government are serious about trying to mitigate a recruitment and retention crisis they must make NHS dentistry a positive environment.

20. Statistics submitted by Welsh Government to the Doctors and Dentists pay review body (Welsh Government. 2018. Review body on doctors' and dentists' remuneration evidence from the Welsh Government's health and social services group for 2018-19 https://gov.wales/docs/dhss/publications/180221evidence-ddrben.pdf. Accessed 29th July 2018), claim that numbers of dentists in Wales have gradually increased. We refute this, as these figures show a head count – not whole time equivalents. We are seeing more part time working, primarily centered around a feminisation of the profession.
21. **The provision of orthodontic services;**
22. Orthodontic services in Hywel Dda are in a deep and worsening crisis. Waiting lists were non-existent when the present system of contracting was imposed in 2006. The volume of Units of Orthodontic Activity (UOA) contracted for was based on then historical data and has always been inadequate to meet the need in the population.
23. Problems have been compounded as UOAs have been withdrawn from non-specialists, and not replaced in specialist practice. The choice for patients and referrers has been reduced, as three former specialist practices have been whittled down to one, and local specialist services in the hospital and community dental services scrapped. Patients fortunate to be offered treatment are forced to travel further for their care, often beyond the means or their families. One single provider of orthodontic services is not appropriate for the delivery of orthodontic care.
24. Waiting times for orthodontics now exceed four years and patients are suffering harm as a result. Non - sedentary families who move into or out of the area are particularly badly affected. Harm to patients can take several forms including:
    1. Dental impaction or pathology identified and treated late can result in tooth resorption and unnecessary tooth loss.
    2. Treatment times are often extended when therapy is started late. Myo-functional therapy is optimal for some patients but may not be possible when a patient's skeletal growth slows, due to the long wait times resulting in missing out on the growth spurt.
    3. Cooperation potential often reduces as older patients develop social or educational interests, this can compromise outcomes.
    4. Older patients moving away for work or education may fail to satisfactorily complete, or even to start, a course of treatment. Patients aspiring to join the services can have their long-term dental health particularly badly compromised
25. **The effectiveness of local and national oral health improvement programmes for children and young people.**
26. Designed to smile has shown a reduction in tooth decay amongst children in Wales (British Dental Association. 2017. Designed to Smile refocus welcomed by dentists but greater investment still needed. https://bda.org/news-centre/latest-news-articles/%E2%80%98designed-to-smile-refocus-welcomed-by-dentists-but-greater-

investment-still-needed. Accessed 29th July 2018). Dyfed Powys Local Dental Committee support its continuation and expansion amongst primary school age children.

27. Despite this we see far too many children and families suffer from the consequences of tooth decay, days of missed school, work and nights of sleep loss which are, ultimately all preventable, and impact most on the most vulnerable.
28. It is well evidenced that sugar frequency is key in the development of tooth decay. Public education and responsibility into the oral impacts of sugar are key in reducing the needless volume of tooth decay which blights our nation.

James Davies
Chairman

Tom Bysouth
Secretary

On behalf of Dyfed Powys Local Dental Committee