WRITTEN EVIDENCE FOR HEALTH, SOCIAL CARE AND SPORT COMMITTEE; NATIONAL ASSEMBLY FOR WALES INQUIRY INTO DENTISTRY 2018

Evidence has been requested in the following areas

- The Welsh Government's dental contract reform;
- How 'clawback money' from Health Boards is being used;
- Issues with the training, recruitment and retention of dentists in Wales;
- The provision of orthodontic services;
- The effectiveness of local and national oral health improvement programmes for children and young people.

1. The Welsh Government's dental contract reforms

We see the emphasis on assessing the oral health risks and needs of individual patients, effectively communicate these to patients, working with them to jointly produce agreed outcomes, and increase the skill-mix of the dental workforce as a positive reform.

However, it is essential that these are fully assessed in the current prototype practices and found to be beneficial to the population as a whole before they are rolled out country wide. Any failure to fully assess the benefits of the reforms and ensure they help in improving the oral health of Wales would be foolhardy. Introducing a contract that is flawed would put back the oral health of the nation, and might nullify some of the benefits seen from Designed to Smile (see point 5 below).

2. How 'clawback money' from Health Boards is being used

It is unclear how the Health Boards are using 'clawback money' within their areas. It is essential that these monies remain within dentistry and used to support those areas of the community that are most in need. It has been shown by appropriate targeting of resources (e.g. Designed to Smile) that there can be large improvements in the dental health of the population. Any 'clawback money' should be targeted at the highest need areas, to support patients in obtaining good dental start to life thus reducing the future need for dental intervention.

3. Issues with the training, recruitment and retention of dentists in Wales

Information regarding training (Undergraduate, Foundation, Core and Speciality training) in dentistry is available from the Dental School in Cardiff and the Postgraduate Dental Deanery. Information regarding recruitment and retention of the dental workforce outside of training posts is difficult to ascertain as there is a lack of data regarding the workforce. This is not only a problem in Wales, but also UK wide. Part of the remit of Health Education Improvement

Wales (HEIW) which commences in October 2018 is the development of workforce intelligence and workforce planning for NHS Wales. It is hoped that this will address some of these problems.

We are aware that post-qualification, if a dentist undertakes Foundation training in Wales then a significant number of them (approx. 60%) remained in dental posts in Wales.

Currently the Welsh Government matches the number of Dental Foundation training posts with the undergraduate intake number at Cardiff University (the only Dentist undergraduate training centre in Wales) but the demand from patients seeking dental treatment in Wales outstrips the supply of dentists. Increasing the number and funding of Foundation Dentists in Wales would increase the workforce and help retain dentists post training in Wales.

Within the UK over the past 4 years there have been insufficient Foundation training posts to allow all the UK Dental School graduates to have training places. All dentists in the UK have to complete Foundation training if they wish to work within the NHS General Dental Services and therefore the lack of places means that there are graduates who cannot work within the NHS once qualified. Increasing the number of places would improve access to NHS dental care and long-term benefit the workforce numbers and provision of care to patients.

After Dental Foundation, the next stage of training posts (Dental Core Training) has thrown up different issues for dental services in Wales. The main ones is the difficulty to recruit suitable candidates for these positions. Feedback from potential trainees shows that a key reason is the pay differences between Wales and other parts of the UK (see table below). As dental trainees leave University with some of the highest student debt figures of all professions, to take a pay cut from Foundation Dentistry in other parts of the UK to come to Wales in unattractive, as is the fact that pay progression is uneven.

Speciality training places (to allow eligibility for Consultant posts) suffer from the same pay problems that exist at Dental Core training level. It would take a trainee to year 8 Specialty Registrar (minimum 11 years qualified) in Wales to overtake the pay of a Core Trainee Year 3 (minimum 4 years qualified) in England.

The comparative UK pay scales are shown below:

UK Foundation & Dental Core Trainee Pay Scales 2017-18

	Foundation	Dental Core						
Year		Min/0	1	2	3	4	5	6
Wales[1]	31,044	28,783	30,665	32,548	34,430	36.311	38,194	40,076
England[2]	31,355	-	36,461	36,461	46,208	-	-	-
Scotland[3]	31,281	29,361	31,281	33,201	35,121	37,041	38,960	40,880
N Ireland[4]	30,211	27,798	29,616	31,434	33,251	35,069	36,887	38,705

UK Dental Specialty Trainee Pay Scales 2017-18

Year	Min/0	1	2	3	4	5	6	7	8	9
Wales[1]	30,606	32,478	35,094	36,676	38,582	40,491	42,399	44,307	46,215	48,124
England[2]	46,208									-
Scotland[3]	31,220	33,131	35,799	37,412	39,358	41,305	43,251	45,197	47,144	49,091
N Ireland[4]	30,302	32,156	34,746	36,312	38,200	40,090	41,980	43,868	45,757	47,647

[1] http://www.wales.nhs.uk/documents/2017-04-06%20-%20Pay%20Circular%20M%26D%28W%29%201_2017.pdf

[2] http://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/FINAL-Pay-and-Conditions-Circular-MD-12017.pdf

[3] https://bda.org/Scotland/SCHDS/PublishingImages/Pages/Pay-Circular-Information/NHS%20Circular%20PCS(DD)2017%201%20-%20Pay%20and%20Conditions%20of%20Service.pdf

[4] https://www.bma.org.uk/advice/employment/pay/juniors-pay-northern-ireland

4. The provision of orthodontic services

There appears to be inequity in the provision of Orthodontic services across the Local Health Boards and in relation to other dental speciality services. Some areas of Wales, such as Cwm Taf have no specific specialist Orthodontic Services within the General Dental Services (GDS) and patients obtain their treatment through the Community Dental Services within the Health Board, via small contracts with non-specialist General Dental Practitioners, or by using the services of other Health Boards (Cardiff and Vale). This can result in inconvenience to patients in both time and travel to obtain the services. Other areas such as Cardiff and Vales, Aneurin Bevan, Abertawe Bro Morgannwg and Betsi Cadwaladr appear to be well served with Orthodontists in the GDS.

There appears to be a disproportionate amount of GDS monies spent on Orthodontics throughout Wales when there is still a high unmet need for routine dental services particularly in areas of high need.

5. The effectiveness of local and national oral health improvement programmes for children and young people

The original Designed to Smile oral health programme has been a real success with published referred papers on the improved outcomes in children's oral health. The programme has targeted areas of social and economic deprivation and in the absence of water fluoridation is an effective means of getting fluoride in the form of varnish in contact with children's teeth. Over the past the ten years the prevalence of tooth decay in 5 year olds in Wales has fallen from 47.6% in 2007/08 to 34.2% in 2015/16, a statistically significant fall of 13.4%.

However, dental decay requiring multiple extractions is still the number one reason why five-to nine-year-olds are being admitted to hospital and it is a preventable disease and addressing this issue should be a priority for the Welsh Government.

Despite this initiative the number of teeth affected by decay remains higher in Wales than in other parts of the UK and ongoing preventative work is required. The caries rates for children in Wales continue to lag behind those in England with 22% of 5-15 year olds living in Wales having extensive tooth decay (with 5 or more teeth missing, decayed of filled), compared to 12% in England. Continuing work in this area is essential.