THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee's inquiry into dentistry in Wales.
Contact:	[redacted] Policy and Research Officer, Welsh NHS Confederation. [redacted]
Date created:	24th August 2018

Introduction

1. The Welsh NHS Confederation welcomes the opportunity to respond to the Health, Social Care and Sport Committee's inquiry into dentistry in Wales. The Welsh NHS Confederation represents the seven Local Health Boards and three NHS Trusts in Wales. We support our members to improve health and wellbeing by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

Overview

2. In 2016-17, £171.6m was invested in dentistry services in NHS Wales.[i] Over five million units of dental activity (UDAs) were carried out, which represents approximately 2.4 million individual NHS dental courses of treatment.[ii]

3. The Welsh Government's *Together for Health: A National Oral Health Plan for Wales 2013-18* set the direction for oral health and dental services improvement in Wales. The plan also sets out the Welsh Government's vision for reducing inequalities in dental health in Wales, particularly among children and young people, which is where the greatest improvements have been made since the Plan was published in March 2013. The 2016 – 17 Annual Report[iii] for the Plan, which provides an overview of the key challenges for dentistry in Wales, highlights that access to timely services and adjusting working arrangements to accommodate the new dental contract is a priority area.

4. In March 2017, the Welsh Government published *Taking Oral Health Improvement and Dental Services Forward in Wales: A Framework outlining priorities for dentistry and a future work programme*. This framework sets out the key priorities for oral health improvement and dentistry in Wales in the short to medium term. It also outlines a future work programme that will inform the update of the Oral Health Plan for Wales.

5. The key themes within *Taking Oral Health Improvement and Dental Services Forward in Wales* are broadly consistent with the terms of reference of this inquiry, which we will respond to below.

Terms of Reference

1. The Welsh Government's dental contract reform

6. The current General Dental Services (GDS) contract, introduced in April 2006, remunerates dentists an annual contract value in return for providing an agreed level of UDAs. General Dental Practitioners (GDPs) say that working towards an activity target is like 'being on a treadmill', and the desire for a new contract has been well-documented.

7. In July 2018, the Welsh Government released a written statement[iv] providing details of the contribution that oral health services will make in achieving whole system change and the vision set out by *A Healthier Wales*,[v] the Welsh Government's Long-Term Plan for Health and Social Care. In this written statement, the Welsh Government reiterated their commitment to achieving this whole system change through contract reform.

8. Contract reform allows Health Boards to adopt a more preventative approach to the planning and delivery of services. This is because the 2006 GDS contract requires the delivery of UDAs as proxy for counting dental treatments, which in practical terms means that there is no incentive for dentists to deliver preventative care, or take on patients with greater needs, because remuneration for providing ten or more fillings is the same as it would be for a single filling. Furthermore, while UDAs are considered the main measurement of dental performance under the 2006 contract, they do not provide assurance of the quality of service being delivered.

9. Phase one of the contract reform programme commenced on 1st September 2017. Health Boards across Wales selected and supported a number of dental practices within their localities to take part in the programme. Having a handful of practices in each Health Board take part in the programme, rather than immediately rolling out the programme to all dental practices, was a positive step because a key concern raised about the 2006 contract was that it had not undergone a pilot study before being rolled-out. The number of practices in each Health Board that participated in phase one of the contract reform programme was broadly proportionate to their population bases – e.g. three in Aneurin Bevan University Health Board (UHB), three in Cwm Taf UHB, four in Abertawe Bro Morgannwg UHB etc. Since phase one commenced, Health Boards have received expressions of interest from significantly more dental practices across their areas to take part in the programme. One of the aims of the contract reform programme is to have at least 10% of dental practices in Wales testing out the new contract by March 2019.

10. Practices participating in the contract reform programme are required to undertake the Assessment of Clinical Oral Risks and Needs (ACORN) toolkit for each patient over a 12-month cycle during their routine appointment. At this appointment, the dental team use the toolkit to lead patient discussion and provide oral health advice/education to the patient and explain any preventative treatment that they may benefit from. Our members welcome this approach as it supports patient engagement, improves patient knowledge of oral health so that they can be partners in their treatment, and encourages a preventative approach to oral health.

11. In accordance with the aims of the programme and the support of their respective Health Boards, dental practices that took part in phase one of the contract reform programme have adjusted their working practices, supporting more effective use of Dental Care Professionals (DCPs), including dental nurses, hygienists and therapists, in the delivery of dental care and treatment to patients.

12. Our members highlight that a further benefit of the contract reform programme has been the reduction, rather than the elimination, of the UDA target by 10%. This has eased both time and financial pressures on dental practices, which in turn has enabled them to complete and submit clinical profiles on all patients assessed and treated under the ACORN toolkit. In June 2018, Public Health Wales NHS Trust produced and shared the initial cut of the practice-based patient and practice profiles drawn from the data collected by the practices. More detailed profile information to support decision-making (factoring in practice size, contract value etc) is anticipated from year-end returns, but early indications show that Health Boards and practices can be confident in the further reduction of UDA targets. Looking ahead, the objective will be to use these more detailed findings to secure more appropriate patient access to dental services and improve oral health outcomes.

13. While Health Boards are generally positive about the reformed contract programme, there are some concerns. Some Health Boards are reluctant to approve more dental practices onto the contract reform programme because reducing contracted UDAs means a reduction in the amount of patient charge revenue (PCR) the Health Board receives. While it is positive that the Welsh Government has committed to provide additional funding should Health Boards achieve the 10% UDA target by March 2019, this funding will only cover the anticipated shortfall in PCR of the practices within each Health Board that are already on the contract reform programme (rather than all dental practices within a given Health Board area). Approving more practices onto the contract reform programme therefore poses a risk to a Health Board's financial position as a significant reduction in PCR will impact service provision at practices on the contract reform programme, as well as the much larger number of practices that are not. Some Health Boards have also reported a fall in patient numbers at those practices that are taking part in the contract reform programme.

14. Some dental practices are reluctant to take part in the contract reform programme as they do not believe that the 10% target to undertake the ACORN toolkit is a reasonable proportion for their contract to be adjusted. This is due, at least in part, to a limited understanding in some dental practices about the contract reform programme and the positive early outcomes that Public Health Wales NHS Trust have reported. It is recognised therefore that further engagement activities are required by the Welsh Government and the NHS to address this. There needs to be a transparent, consistent all-Wales approach to further expansion of the contract reform programme, particularly from March 2019 onwards, and practices should be measured against an agreed set of key performance indicators.

15. It is also noted by our members that the geographical spread of dental practices on the contract reform programme is patchy, with few practices on the programme located in

areas with the highest levels of deprivation. Oral health is closely associated with deprivation.[vi] People living in the most deprived communities in Wales have the worst oral health in Wales so further work needs to be done in these areas to improve access.

16. It is not easy to monitor the changes to working practices facilitated by the contract reform programme within Health Boards' existing dental contract management processes. While this is not considered an issue of urgent concern as those that are part of the programme are fully committed to this approach, a broader roll-out of the contract reform programme would likely require a review of each Health Board's performance monitoring processes and tools to achieve effective implementation.

17. Finally, Health Boards are aware that not all dental practices, particularly those that are single-handed and/or operating in small premises, are able to accommodate additional staff (such as hygienists, therapists and dental nurses) and embrace the multi-disciplinary approach upon which a holistic model of service depends. A key challenge in securing wider take-up of the contract reform programme will be to support and convince smaller practices that they will be in a position to work effectively under the new arrangements.

2. How is 'clawback' money being used by Local Health Boards?

18. The 2006 GDS contract requires Health Boards to pay dental practices 100% of their contract if they have delivered at least 95% of contractual activity as expressed in UDAs. This is the percentage of activity that must be delivered if a practice is to avoid the Health Board 'clawing back' funds. Of the £171.6m invested in dental services in Wales in 2016/17, £6.5m of this was recovered for underperformance (clawback money). This represents 3.8% of the total.[vii]

19. Where a recurring underperformance has occurred below 95%, Health Boards will arrange to meet with the provider to negotiate a more manageable contract target. If this results in a contract reduction, Health Boards will reinvest these funds in other areas of need. This allows Health Boards to offer the withheld funding to other primary care dental practices or hospital-based dental services during the financial year so that funding is not lost to dentistry as a whole. It is also at Health Boards' discretion to pay contractors for over-performance of up to 105% against their contract. The challenging financial environment has meant that this has not happened in recent years. Health Boards have also found that the removal of the potential reward for over-performance was a disincentive for many contractors to achieve more than the 95% required to avoid clawback money and many primary care dental practices have achieved significantly less than this with consequent clawbacks required by the Health Board.

20. Health Boards are using clawback money to invest in primary care dental services and making these services more accessible to vulnerable patient groups. For example, some Health Boards have invested their clawback funds to support improved access to services for people with dementia and people with learning disabilities, as well as a dental conscious sedation service.

21. From a staff perspective, clawback funds are being used to fund Fluoride Varnish courses. The course helps to develop dental professionals through working in a dentist practice environment and attending classroom-based lessons and assessments. Using clawback money, these courses are offered to general dental practices for their nurses to attend free of charge.

22. Health Boards are also using clawback funds to support the preventative agenda by developing initiatives aimed at children and young people. This includes purchasing toothbrushes, toothpaste and child-friendly drinking cups, to encourage children to stop using bottles, for Health Visitors to give to children under three years of age.

23. As highlighted previously, it must be remembered that delivery of the UDA target does not necessarily equate to good access to services and/or quality of dental care. We would emphasise that dental services across Wales should adopt the principles of chronic disease management with an emphasis on person-centred, co-ordinated care that supports the patient to self-manage.

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

24. Overall, Health Boards are not facing serious challenges in recruiting and training dental staff when compared to other professionals within the primary care sector. The Wales Deanery has shown that Welsh domiciled students entering Cardiff Dental School generally become dental foundation trainees in Wales, and as a consequence, usually remain in Wales as general dental service performers.

25. However, there are a number of caveats to this. Firstly, recruitment challenges are dependent, to some extent at least, on a Health Board's proximity to Cardiff and the Cardiff University School of Dentistry, with dental practices in the North, particularly in rural areas, reporting the biggest challenges. This is true not only for dentists, but also dental nurses, hygienists and therapists. Indeed, some dental specialities do not exist outside the Dental School in Cardiff. There is a need to develop more intermediary services as part of specialty-led managed clinical networks. This should be linked to opportunities for dentists and Dental Clinical Practitioners to upskill, potentially with a view to managing their own practice in future. At the heart of this must be a sustainable specialist workforce to drive standards, innovation and quality. The newly established Health Education and Improvement Wales is well-placed to support this process.

26. The length of time it takes to become a fully qualified dentist (at least five years at dental school and a subsequent two years at a dental practice) means that student debts are a serious barrier for many people wishing to follow a career in dentistry, particularly for those who wish to work in the NHS (rather than the private sector). Frequent 'altering' of pension benefits has also reduced the number of people entering the system.

27. Costs of training and student debt are accentuated for non-UK citizens. The Welsh NHS Confederation and our members continue to highlight the uncertainty around the rights of EU citizens currently living in Wales and the UK due to Brexit as a barrier to recruitment.[viii] This is true also of EU citizens currently living in mainland Europe who may

be discouraged by the financial implications of moving to the UK to study and/or practice dentistry, as well as the availability of support grants, scholarships and bursaries.

28. Dentistry is following the same trend as other primary care professionals in the sense that newly qualified dentists seem more unwilling to commit to long term or extensive NHS involvement and are less interested in becoming practice owners. Our members report that younger dentists tend to prefer part-time work, particularly for those who trained in urban areas and are therefore more attracted to the lifestyle opportunities offered by town and city environments.

29. In addition to training, there are also retention issues due to increases in practicing costs. This is impacting dentists who would usually retire but would like to continue practicing one or two days per week but are finding that it is no longer cost effective to do so.

30. Finally, our members say that a handful of specialist dental services, particularly paediatric dentistry, special care dentistry and oral surgery, experience the greatest recruitment challenges. We recommend that resources for specialty training posts be targeted on population need, access and impact. Greater involvement from Welsh Government, particularly in relation to public engagement campaigns, may prove to be a useful vehicle for developing specialist training programmes in the future.

4. The provision of orthodontic services

31. The majority of NHS Wales orthodontic treatment is provided to 12-17 year olds, but currently not every Health Board provides the same level of service. For example, while Cwm Taf UHB has an orthodontic service as part of its Community Dental Service, the Health Board does not have specialist practices for orthodontics and so patients needing those services are required to travel to Cardiff and Vale UHB.

32. Assessment of need and the provision of orthodontic services should be considered as part of overall dental services planning and within the context of high prevalence of untreated active tooth decay in Wales' child population. In 2016/17, almost 30% of 12-year olds had at least one permanent tooth that was decayed, missing (extracted due to tooth decay) or filled. Access to effective prevention and remedial dental care for these children should be prioritised.

33. Health Board Primary Care Teams are working to improve orthodontic services by focusing on three key priorities: identifying patterns of inappropriate referrals; planning and delivering appropriate and targeted interventions; and addressing current high waiting times. Waiting times for orthodontic treatment in primary care settings are dependent on the referral acceptance criteria of both primary care-based orthodontic services and consultant-led services delivered through hospital settings.

34. For Health Boards that provide orthodontic services, waiting times for treatment are a key challenge. It has been suggested that this is due, at least in part, to the number of inappropriate referrals to orthodontic services, which can sometimes be considered a 'catch all' when another service may be more appropriate. Health Boards are taking

positive steps to addressing this issue through the Orthodontic Managed Clinical Network (OMCN). Under this network, Health Board Primary Care Teams gather the latest waiting time statistics within their Health Boards and share this will all dental staff with the aim of influencing referral practice. Data suggests that children under the age of 11 are among those most-frequently referred to orthodontics when another service would be more appropriate to address their needs. An electronic referral management system (eRMS) is set to be rolled out across Wales by 2019, which will aim to improve the quality of referrals being made to orthodontic services. Abertawe Bro Morgannwg UHB and Hywel Dda UHB are designated 'early adopters' of the eRMS and both Health Boards anticipate using the system by the end of 2018.

35. We would recommend that the data generated by the eRMS also be used to analyse equity in use of specialist dental services, patient experience, patient outcomes, and identify areas where improvements are needed within each Health Board.

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

36. Long term trends from the late 1980s to the present day highlight a steady and consistent reduction in both the prevalence and average experience of dental decay among children in Wales. Comprehensive data sets for each Health Board are available via the Welsh Oral Health Information Unit (WOHIU) at Cardiff University.[ix] The unit provides independent professional advice, quality assurance, data cleaning, data verification, data analysis and a reporting service on behalf of the Welsh Government and is commissioned by Public Health Wales NHS Trust.

37. On a national level, Health Boards across Wales are supportive of Designed to Smile,[x] the Welsh Government's national oral health improvement programme to improve the dental health of children in Wales, which was introduced in 2009. According to the WOHIU, levels of dental decay among children in Wales are at their lowest since records began. In the five years leading up to 2016/17, the average percentage of children in Wales with at least one decayed or missing tooth had fallen from 45.1% to 29.6%.[xi] In some Health Boards, the reduction has been even more significant, down from 47% to 28.9% in Abertawe Bro Morgannwg UHB, for example. Some Health Boards have carried out information analysis to see which social groups have seen the greatest improvements in oral health, and early indications show that these are mainly to be found in the most deprived social groups. It is emphasised that the involvement of Designed to Smile in nurseries and schools has been critical to the programme's success and Community Dental Services are well-placed to build on these positive outcomes.

38. The Designed to Smile programme mainly targets schools in the most deprived areas, (e.g. schools within the former Community First areas) but some Health Boards have funded designated Primary Care Teams to attend primary schools that fall outside these areas too by working with Healthy School programme co-ordinators and local authorities. This has proved to be an effective way of engaging young people around oral health, hand out free toothbrushes, drinking cups and toothpaste and support prevention.

39. Health Boards are also working on a local level to improve dental health among children in Wales, for example, through the North Wales Local Oral Health Plan. Betsi Cadwaladr UHB's strategic document for community dental services, *Services for Smiles*, specifically highlights the importance of oral health programmes for children and young people and the Health Board has committed to tackling oral health inequalities in its strategy '*Living Healthier, Staying Well*'.[xii]

40. At Aneurin Bevan UHB, the Primary Care Team has worked with Designed to Smile Team to develop a 'child referral pathway', which aims to improve access to dental services with local dental practitioners for children. Seven dental practices across the Health Board receive direct referrals from the Designed to Smile team, which may be instigated by Health Visiting, Flying Start or Designed to Smile teams. Children are given a unique patient code on referral so that they can be tracked through the system to monitor attendance at appointments.

41. The effectiveness of local approaches to oral health improvement is exemplified by the "Baby teeth DO matter" programme at Cwm Taf UHB. This programme focuses on children living in the Merthyr Tydfil area, where the Health Board say 56.5% of children under the age of five have dental decay. A local project is currently underway in three dental practices in Merthyr Tydfil, where a dentist or dental therapist visits baby clinics to speak to parents of babies and toddlers to emphasise the importance of good dental health, support prevention and increase awareness of the services available locally. The results to date have been extremely positive - in 2017/18, the number of 0-2 year olds who attended a dental appointment at dental practice increased by 39.53% in the Merthyr Tydfil locality. Cwm Taf UHB also report an increase of nearly 17% among children of the same age group across the Health Board as a whole.

42. Despite the success of Designed to Smile and local initiatives however, inequalities in children's oral health persist. Public Health Wales NHS Trust say that 42.2% of five-year olds in the most deprived areas have tooth decay, compared to just 22.3% of five-year olds in the least deprived areas. In 2013/14, 20.2% of three-year olds in the most deprived quintiles already had tooth decay experience. Those from the most deprived areas are further disadvantaged due to their poorer access to dental services as well. To address these inequalities, it is important that professionals work collaboratively and recognise the benefits of a multi-disciplinary approach to oral health improvement.

Other comments

43. In addition to the information highlighted above, the Welsh Ambulance Services NHS Trust (WAST) also plays a key role in supporting and providing advice to people who have dental health concerns or questions through NHS Direct Wales service.

44. NHS Direct Wales, which is part of WAST, is a health advice and information service available 24 hours a day. For patients living in the Abertawe Bro Morgannwg UHB area and Carmarthenshire areas, dental advice is accessed via the 111 service.

45. The call volume NHS Direct Wales receives in relation to dental issues is significant, with over 56,000 calls relating to dental matters between 1st August 2017 – 31st July 2018. This equates to 23% of all calls. This is consistent with previous years, with dental issues regularly featuring in the top three reasons for calling the NHS Direct Wales and 111 services.

46. Through NHS Direct Wales/111, the WAST provide dental helplines for Abertawe Bro Morgannwg UHB, Betsi Cadwaladr UHB, Hywel Dda UHB and Powys Teaching Health Board. The dental helplines include dental clinical assessment, access to Dental Access Clinics or Emergency Dental Services based on access criteria determined by the British Dental Association and respond to general information queries. The online symptom checkers includes those for dental symptoms and dental service information is available for the health information team and the service directory.

Conclusion

47. Health Boards across Wales are positive about the ambitious vision for dental services that the Welsh Government has established in recent years. Feedback from dental practices that are currently piloting the contract reform programme are overwhelmingly positive, and while challenges around access continue, the situation across Wales is steadily improving. This has been made possible thanks to multi-disciplinary working within and between Primary Care Teams and supporting the preventative approach as outlined by the Parliamentary Review of Health and Social Care and *A Healthier Wales.*

---

[i] Welsh Government, August 2017. NHS Dental Statistics in Wales, 2016-17
https://gov.wales/docs/statistics/2017/170831-nhs-dental-services-2016-17-en.pdf
[ii] ibid.
[iii] Welsh Government, 2018. Together for Health: A National Oral Health Plan for Wales Annual Report 2017-18. https://gov.wales/docs/dhss/publications/a-national-oral-health-plan-for-wales-annual-report-2017-18.pdf
[iv] Welsh Government, July 2018. Written Statement: A Healthier Wales – The Oral Health and Dental Services Response.
https://gov.wales/about/cabinet/cabinetstatements/2018/59764150/?lang=en
[v] Welsh Government, July 2018. A Healthier Wales: our Plan for Health and Social Care
https://gov.wales/topics/health/publications/healthier-wales/?lang=en
[vi] The British Dental Association. Oral Health Inequalities Policy
https://bda.org/dentists/policy-campaigns/research/government/leg-regs/pub-health-reform/Documents/oral_health_inequalities_policy.pdf#search=inequality
[vii] Welsh Government, July 2018 Together for Health: A National Oral Health Plan for Wales Annual Report 2017/18 https://gov.wales/docs/dhss/publications/a-national-oral-health-plan-for-wales-annual-report-2017-18.pdf
[viii] Welsh NHS Confederation Policy Forum, June 2018. The key issues for health and social care organisations as the UK prepares to leave the European Union.
[ix] Welsh Oral Health Information Unit
https://www.cardiff.ac.uk/research/explore/research-units/welsh-oral-health-information-unit
[x] Welsh Government/ NHS Wales. Designed to Smile
http://www.designedtosmile.org/welcome-croeso/welcome/
[xi] Welsh Oral Health Information Unit. June 2018. Picture of Oral Health 2018: Dental Epidemiological Survey of 12 Year Olds 2016-17
https://www.cardiff.ac.uk/__data/assets/pdf_file/0019/1201465/Full-Report-Oral-Health-2018.pdf

[xii] Betsi Cadwaladr University Health Board. Our Strategy for the Future, https://docs.wixstatic.com/ugd/a68b79_d5cfb8c42b2a4df69fad108a2c13c730.pdf