National Assembly for Wales
Health, Social Care and Sport Committee

Dentistry in Wales
Consultation Responses

September 2018

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D01
Ymchwiliad i Ddeintyddiaeth yng Nghymru / Inquiry into Dentistry in Wales
Ymateb gan Unigolyn
Response from an individual

Dear Sir / Madam

Re: Consultation regarding Dentistry in Wales: Provision of Orthodontic Services.

I am the Chair of the Local Orthodontic Committee in North Wales and I am also a Consultant Orthodontist at [redacted], North Wales.

The Local Orthodontic Committee is a group who represent and include all orthodontic providers in North Wales both in the primary and secondary care sectors.
As a Consultant Orthodontist I work within secondary care in the hospital orthodontic service.

Based on my involvement with orthodontics in North Wales I would like to highlight to the inquiry my considerable concerns about orthodontic staff shortages at all levels within our region and also the large demand for our services. We have been understaffed for a considerable amount of time and staffing levels are set to get worse as our most senior consultant is due to retire and our newest consultant has recently resigned to take up a post in England.

The consultants in the hospital service are unendingly generous giving their own personal time to ensure we provide the best service we can for our patients. This is above and beyond anything else I have seen whilst working in other areas of the UK.

In North Wales, we have a strong Orthodontic Managed Clinical Network and an inclusive Local Orthodontic Committee which helps us communicate well and use all our resources effectively.

However, what we crucially need is support and recognition from the Welsh Government for the hard work being done and real investment into our specialty for the future.

First impressions count in every aspect of an individual's life and as basic as it sounds a simple smile has the power to make the difference. Orthodontic services deliver a chance of equality to patients with significant dental and/or facial deformity. Orthodontic treatment can take 2-3 years to complete but can contribute to a person's wellbeing on a physical and psychological level for life.

I strongly believe the population of North Wales should continue to have this service and further investment made so timely access to treatments can be made. At present we are struggling to keep waiting lists down to two years and it is likely if we can't recruit and retain staff as has happened historically waiting times will become much worse.

Realistically, our region is remote compared to other areas of the UK and we need to be able to offer incentives to recruit and retain orthodontic providers. We need help from the Welsh Government to make this happen.

Please take the contents of this email into consideration when making your decisions regarding future orthodontic services for the people of North Wales.

Kind regards

D02
Ymchwiliad i Ddeintyddiaeth yng Nghymru / Inquiry into Dentistry in Wales
Ymateb gan Fwrdd Iechyd Prifysgol Hywel Dda
Response from Hywel Dda University Health Board

Hywel Dda University Health Board

Social Care and Sports Committee Inquiry into Dental Services (Comments to be submitted by 22 August 2018)

The Welsh Government Dental Contract Reform

The Health Board has participated in Phase 1 of Dental Contract Reform and has plans in place to meet the target of 10% of practices participating in the programme from October 2018. The Practices participating in the programme to date have provided positive feedback. The Health Board has received some interesting data from Public Health Wales which was collected between January 2018 and March 2018. The All Wales data for Quarter 4 2017/18 only indicates that there is scope to change the focus of how often patients are seen based on their individual clinical and oral health needs. The level of risks on oral health from medical, social and past dental history at all Wales is that an average 87% of the patients have low risk from these categories with the average figure for Hywel Dda being at 78%. The proportion of patients categorised as Red, Amber and Green for tooth decay, gum health and other dental conditions at all Wales average was 19%, 20% and 61% respectively. For Hywel Dda the figures were 8%, 12% and 80%. However, more data over a longer period of time is required in order to open discussions with Practices in order to inform transformation.

These conversations will be clinically led through leadership provided by the Health Boards Associate Medical Director for Dental Services, which was considered to be a key role for investment by the Health Board to support the strategic development of dental services.

Engaging with patients will be key to their understanding of Dental Contract Reform in Wales and what it means for them as individuals. It is imperative that there is a national publicity campaign or national communications strategy to address this, giving consistent messages across Wales. The Assessment of Clinical Orals Risks and Need (ACORN) is an important driver for informing the dialogue between dental professionals and patients. The care pathway will be based on the patients' oral health needs and patients will be informed of their individual responsibilities in terms of their own oral health. If ACORN is carried out consistently it shouldn't then matter who the patient sees within a dental practice as long as the patient understands the appropriateness of being treated by a multi-disciplinary team, then the same messages should be delivered around making every contact count. The culture needs to be developed and embedded in practice so that the patient understands why they are visiting a dental team rather than a named dentist. There is no reason why all Dental Practices couldn't undertake Phase 1 of the programme to inform the oral health needs of the population for Wales and to change the behaviour regarding recall intervals to create capacity to see more patients; however this will need consistent messaging to patients and the profession as the historical NICE Guidance on recall intervals has been challenging to implement.

Phase 2 of the scheme will be more challenging to roll out across all practices. Contract reform is heavily dependent on increasing the skills mix in general practice however the current General Dental Services (GDS) contract has not been supportive in this way of working, necessitating significant remodelling of the workforce which will require an investment of time and resources to upskill existing staff, as well as supporting the increase in training numbers for the wider dental team as well as the re-education of patients.

Many Practices will be constrained in their participation of Phase 2 by their infrastructure not enabling an increase chair capacity. For those Practices who are ready and able to work at Phase 2, the development of the scheme is not happening quickly enough. We need to be careful that the commitment and drive from practices involved in the current contract reform programme is not lost by a decrease in momentum for rolling out Phase 2 and subsequent development of the Contract Reform programme. This is the area where Cluster working could provide the opportunity for collaboration across Dental practices in providing collaboration in terms of training and upskilling staff, sharing key posts across a group of practices, and the leadership for the delivery of strategy and planning. Consideration as to how this could be incentivised needs to be included in reform discussions.

As Dental Contract reform expands consideration also needs to be given to the governance around the monitoring process, with key parameters being set nationally to provide a consistent approach for all participating Dental Practices and Health Boards.

How 'clawback money' from Health Boards is being used

For all new dental activity (regardless of where the funding has been identified) the Health Board is required to go out to use formal procurement processes to invite expressions of interest from parties who may be interested in providing Dental Services. This is done in accordance with the Health Board Standing Orders and Standing Financial Instructions, and EU procurement legislation and the national dental contact. As a result of this process Dental Contractors submit bids to the Health Board setting out the levels at which they feel able to deliver under a contract with the Health Board. The end result of this process is that the Health Board will contract with the tender winners to provide levels of activity that the Dental Contractors have set out in their bid.

The Health Board will expect the Dental Contractor to provide patient activity at the levels to which they have agreed when they sign the Contract; based on this the Dental Contractor is paid in monthly instalments to provide a dental service at the Contract level. The Health Board monitors activity on a monthly basis to ensure that the Dental Contractors meet the activity targets as per the Regulations. If a Dental Contractor is unable to meet 95% or more of the activity that they have been contracted to provide then the Health Board has a fiduciary duty to recover on over payments that have been made to them. Whilst the Health Board wants to support the investment into dental services and the development of service provision it has a duty to ensure that public money is spent prudently particularly given the current climate of financial austerity.

The term 'clawback money' is an unfortunate description for Health Boards enacting clearly defined national contractual management arrangements in line with Regulations to ensure correct governance

for the management of Public Funds. In year funding being returned to the Health Board can derive from the following three areas:-

- Financial recovery due to a Dental Practice not delivering 95% of their contracted Units of Dental Activity (UDAs). This funding is non-recurrent and usually not identified until the end of the financial year and therefore accounted within the Health Board Accounts;
- GDPs who have had 2 remedial notices and as a result have their contracts permanently rebased;
- The GDPs request a rebase due to circumstances within the business and this can be on either a recurrent or non-recurrent basis.

The way in which the Health Board deals with financial recovery from Dental Contractors will depend upon the nature of the recovery and whether it is a one-off event or represents a permanent reduction in the funding within a Dental Contract. In the case of a permanent Contract reduction the Health Board makes every effort to re-provide the activity for patients by going out to Tender for replacement dental services. This is not always an easy process as it is not always possible to find Contractors to redeliver the service due to recruitment issues in rural West Wales. Furthermore, established Practices often cannot cope with significant increases in activity without additional infrastructure investment. The 2006 Contract removed the Health Board's ability to invest in Dental infrastructure and pump prime the expansion of local practices.

The level of financial recovery in relation to performance that can be reinvested is further restricted by the following issues:-

- The final performance outturn against contracted activity is not fully understood until June of the following Financial year once all FP17's have been submitted for payment;
- The Health Board is required to go out to tender for the provision of any services in excess of £25k as set in the Health Board's Standing Orders and Standing Financial Instructions which are based on the standard model set out by Welsh Government;
- Resource accounting rules issued by Welsh Government require Health Boards to estimate Contract under performance and account for this in the financial year to which it applies. As a result, if Health Boards invest under performance in subsequent financial years, when we have established the true level and recovered the cash from contractors there is a potential to spend more that our resource limit so breaching Welsh Government resource accounting rules.

Greater than expected levels of financial recovery of dental contracts has occurred in both 2015/16 and 2016/17. The vast majority of this relates to underperformance by one corporate provider accounting for in excess of 94% of the total recovery in these 2 financial years. The business model which the Corporate Company has developed to provide services does not appear to be stable in the Hywel Dda area where they have experienced problems with recruitment and retention of qualified dentists despite offering higher associate rates and Golden Hello's. In Hywel Dda, the National Corporate Dental Company holds 11 General Dental Contracts representing 19% of the total contracts and 45% of the Health Board total expenditure on Dental Contracts. This deterioration in the provision of general dental services may be a

legacy prior to the introduction of the new contract when significant numbers of dental practices surrendered their NHS commitment in favour of private dental services.

Issues with training recruitment and retention of Dentists in Wales

The Health Board has provided comments on this point in the context of the whole dental team as key to delivering the Contract Reform model will necessitate practices working as a multi-disciplinary team.

Health Boards need to undertake regular dental workforce analysis in order to create a baseline database to inform service planning, training at a national and local level, and to identify potential service continuity issues from retirements. There is an all Wales analysis of the dental workforce from 2011 available however this now needs reviewing as it is considerably out of date. It would be advantageous if this could be carried out nationally.

Dentists - In order to improve recruitment and retention Health Boards need to consider training Dentists with Enhanced Skills (DES). Hywel Dda has issues with attracting Specialists into the area and is considering funding post foundation core training posts in primary care supported by the Deanery. Dentists who have just finished Dental Foundation Training often want to develop specialist expertise and build confidence in practice. The approved training practices could be the current training practices or consideration could be given to larger practices who are high performers who may have capacity/need for another dentist. The Health Board has considered the potential to introduce training pathways where the dentist works chairside for four days in practice and one day working alongside a specialist to support DES accreditation. The challenge in Hywel Dda will be finding Practices with the appropriate level of mentorship and training skills to take this forward.

15% of dentists currently are from the EEA and 5% are from outside the EEA. There is a significant fall off in EEA dentists coming to work in the area and this is potentially as a result of the uncertainty regarding Brexit and the current poor exchange rate. Without this workforce there needs to be an assurance that there are sufficient training places available within the UK and a commitment national that the Train Work Live programme is expanded to include Dentist and other dental care professionals.

Whilst there is national recognition of the sustainability of general medical services much less focus is given to the potential recruitment and retention issues of dentists and the impact that this can have on service provision and service development.

Dental therapists - The service will require an increase in the number of therapists being trained in the future in order to deliver a multi skilled approach to the delivery of care under Contract Reform or support the sustainability of services where there are issues due to dentist recruitment. In Wales currently, there are not enough therapists graduating to meet the potential demand or the pace of change needed to deliver contract reform. If training is funded from the NHS resources then Wales needs a way of securing the commitment of the individual to the NHS for a period of time. The current restrictions on claiming funding for services provided by therapists under the NHS contract need to be reviewed as multi skilled working will be difficult without this. We understand that this may be being reviewed as part of introducing the electronic FP 17 (Services claim form) and would welcome this change.

Dental Nurses - Dental Nurses can be trained to undertake a range of extended duties and a proportion of the workforce will already have the qualifications but are not fully utilising their skills to the maximum benefit. Additional skills in signposting to other healthcare services (smoking cessation, diabetic services) can be gained quite easily as the baseline knowledge is often there as a result of individuals having undertaken an oral healthcare qualification. Access to training needs to be improved by Health Board area; one of the reported barriers to Dental Practice training is the location and availability of the training. Staff often fund their own courses and the cost of travelling expenses is often one cost too much.

Integrated learning - Cluster projects across could encompass areas such as prescribing, 111/telephone triage training, Health Care Advice and sign posting, smoking cessation, Lift the lip, 1000 Lives +, frail and elderly care etc. could all be delivered to integrated professional groups within Clusters. The Health Board is supporting appropriate dental engagement at a Cluster level and currently has just below 50% representation across our Clusters.

Genera Dental Services engagement events - The Health Board has raised the issue of how new Practices can be developed in the area and already supports Practices with recruitment options, however feedback from current service providers has highlighted:

- There was a view that the service could lose considerable expertise over the next few years due to retirements. One of the main barriers to dentists returning to work part time is that of the cost of indemnity cover so a suggestion is a scheme to support this that may encourage retention of skills through affordable part time working. This is currently being considered as part of the GMS contract discussions and therefore consideration should be given nationally as to whether or not this could be expanded to include the dental profession;
- Providing pump priming to assist with setting up either new or additional infrastructure to enable service development and modernisation;
- Increased financial recognition in areas of unmet need to support the dental resources needed to get patients orally fit (we fully recognise that this would need to be based on robust data);
- Introduce Golden Hello's, particularly for newly qualified Dentists who have incurred student debt;
- The Oral Health Promotion lead has been invited to attend a meeting with a group of dentists to provide information on the Local Oral Health Plan and to support practice audit around the use of Fluoride Varnish, it is hoped that this type of integration will be further developed;
- Cluster working to provide peer engagement and leadership and sub cluster working for Dental Practices.

In order to consider any of the above, careful thought would need to be given to the criteria used for the schemes and the governance structure supporting them. In addition to this whilst Health Boards can consider schemes on a local basis consideration would need to be given to any impact such schemes could have across Wales.

Community Dental Services also experience recruitment issues due to the NHS pay scales for Dentists being relatively poor compared to those offered in the Private Sector. There is a lack of career development due the restrictions placed on posts by funding constraints.

The provision of Orthodontic Services

The Health Board has recently reviewed its provision of Orthodontic Services based on population need compared to its current contracting levels. The population needs have changed since this exercise was last undertaken in 2011 and this has resulted in the Health Board commencing a tendering process for a new orthodontic contract with increased activity levels which will require a considerable investment from the Health Board.

The tendering process will afford the Health Board an opportunity to consider the value of Unit of Orthodontic Activity (UoA) rate and align the rate to a level similar to those set in England and in other parts of Wales where similar work has been undertaken. The challenge will be whether interested providers will be able to attract Orthodontic Specialists prepared to work in West Wales.

Since 2015 the Health Board has been experiencing growing waiting times for access to Orthodontic Services and the increased contract activity from April 2019 will start to address this. In addition to this the Health Board will review the opportunity to undertake waiting list initiatives with non-recurrent in year funding to remove the waiting list backlog. The Health Board is currently out to tender for a waiting list initiative which will remove up to 300 patients from the waiting list.

The Wales Strategic Advisory Forum for Orthodontics (SAFO) has issued guidance on the management of Orthodontic Services and the Health Board has found this guidance very useful. It would be useful if there was guidance issued centrally regarding the appropriate length of wait to access orthodontic services.

The issue for the Health Board is that investment of funds into Orthodontic services means that the Health Board has less investment available to improve access into General Dental Services to improve the Oral Health of the population.

The clinical threshold used in order to assess patients for eligibility to NHS care could be reviewed and limited to Index of Orthodontic Treatment Need (IOTN) scores of grade 4 and above.

The introduction of E-referrals will greatly support the understanding the actual demand for orthodontic services compared to need based on population demographics. E-referrals will assist the management and validation of waiting lists for Orthodontic Services going forward. The Health Board would welcome a national statement on General Dental Practices being trained on using the IOTN and support in telling parents/carers when their child does not meet the criteria and cannot be referred.

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

The Designed to Smile (D2S) team were provided with a new Welsh Index of Multiple Deprivation list in July 2017, this dictated a further expansion into the third quintile of deprivation. In numbers this meant an additional 80+ schools and pre schools were to be approached and taken on from September 2017, and it is expected that by December 2018 all targeted settings will be tooth brushing daily.

The Welsh Government return for 2017 to 2018 records a total of 275 schools and pre schools participating with a total of 11000 children tooth brushing every day. Last year Hywel Dda recorded a decrease in caries of 21%, this was the highest recorded in Wales.

A new fluoride varnish protocol has been developed by the Oral Health Promotion Manager and this is going to be piloted in September 2018. This will ensure that all school pupils within the D2S programme will have fluoride varnish applied twice a year.

The Oral Health Promotion (OHP) team attended the first Designed to Smile symposium learning event which provided the opportunity to meet other D2S teams across Wales and share best practice and feedback.

The team in Hywel Dda have developed a training presentation for use across Wales to deliver a one hour continuing professional development sessions to local General Dental Practices engaged in the Dental Foundation Training programme.

The national D2S lead recognised that whilst the emphasis of D2S targets those children in the foundation phase, there needs to be something in place to support those pupils around Year 6 before they make the transition to secondary school. It is around this time that pupils start to make choices around diet and unfortunately can “undo” the good work of the fluoride intervention in previous years. A resource has been produced which is presently under consultation with the local Education Department; if approved it will provide teaching staff with two lessons as power points to deliver to Year 6 pupils and will cover all key messages as advised in Delivering Better Oral Health Version 3 inclusive of smoking.

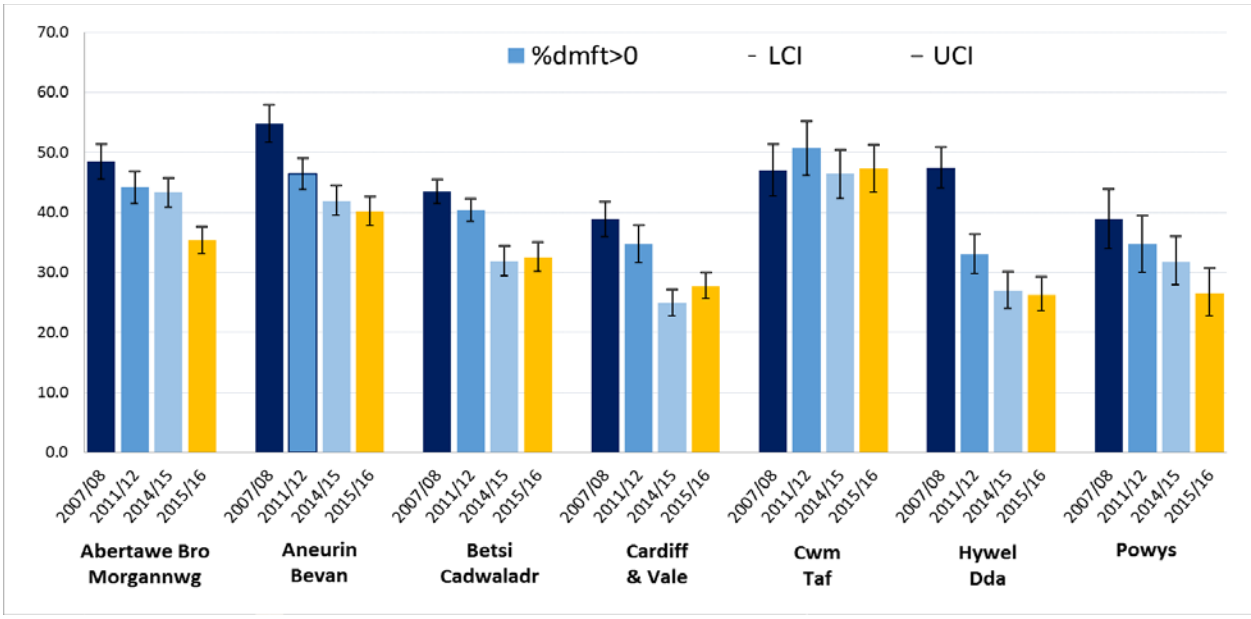
The team continue to collaborate with the wider health and education departments to include training with school nurses, health visitors, flying start, Public Health Wales, local colleges, drug and alcohol services and the All Wales Healthy School Scheme etc.

0-3 year olds

The Oral Health Promotion team deliver standardised training to Health Visiting teams to include Flying Start clusters. The Welsh Government return 2017 to 2018 evidenced that 1875 home packs were given to children aged 0-2 via the Health Visitors along with 900 Tommee Tippee cups. The links between the D2S team and the Health Visiting teams are well established ensuring key messages are delivered at source to the parent and the family.

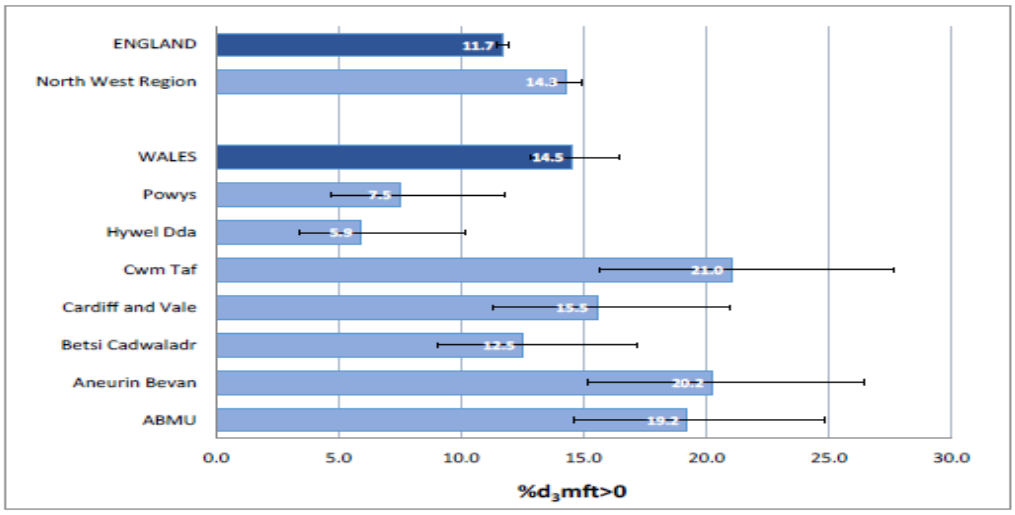
A plan is also in place to support the mouth care needs of women in early stages of pregnancy. This will see the Oral Health Promotion team delivering training to community midwifery teams along with resources to be able to provide items to pregnant mothers to ensure that they are informed of the importance of maintaining oral hygiene during pregnancy; it is anticipated that this will help to prevent pregnancy gingivitis due to hormonal changes, thus improving overall health and wellbeing. The team will attend antenatal clinics for women who are in the second and third trimester to provide advice to the mother about how to look after both their own and their child's teeth in early infancy. This piece of work will compliment the D2S programme and also Public Health Wales's First 1000 Days initiative.

Needs data



The above graph shows that unfortunately the decrease in prevalence of children with caries hasn't been seen across all Health Boards in Wales. Pockets of high need and high caries rates persist, and whilst Hywel Dda has seen a significant improvement, work needs to continue with early years to improve intervention.

Figure 1 Proportion of 3 year olds with at least one tooth affected by decay (% with $d_3mft>0$*)



The graph above shows that 14.3% of 3 year olds in Wales presented with dental caries. Whilst Hywel Dda presents below the national average we can't become complacent, the work needs to continue to ensure that a consistent drop in caries is achieved across all areas of deprivation.

Conclusion

Whilst there is considerable work ongoing to improve the oral health of the Hywel Dda resident population. There is further work that needs to be done locally and nationally to continue to improve how services are developed, to deliver prudent healthcare whilst harnessing the need for a changing skill set and workforce to ensure that residents have access to the best care possible. Hywel Dda Health Board has welcomed the change that the Dental Contract Reform programme has brought and is keen to ensure that this maintains the momentum that is imperative to enable service change and improved oral health for its population.

Health, Social care and Sport Committee

Inquiry into Dentistry in Wales

A response by Welsh Dental Committee

The Welsh Government's dental contract reform

The current GDS contract has no incentive to treat patients with high needs, in an ideal world the low needs patients would balance out the high needs patients but in practice this is impossible to achieve and hence practices are sometimes reluctant to accept new patients because of their potential need. That said it is difficult to balance any remuneration system as it is inevitable that some operative procedures will take less time than others.

GDS contract reform is in general supported by WDC. This will provide practitioners with the opportunity to develop new ways of working including the potential to skill mix within the dental team. It is anticipated that practitioners will welcome the focus away from Units of Dental Activity as the sole measure for activity. More meaningful data is expected at the beginning of 2019 to evaluate the success of the programme. However, it is vital that any reforms have embedded the ability to accurately assess quality and performance.

How 'clawback money' from health boards is being used

Anecdotal evidence would suggest that there is variation on how recovered money due to underperformance is used by health boards. Strict ring fencing would ensure that funds intended to be used on dentistry are actually spent on dental services. That said capacity of some practices to use additional funding is limited for example due to recruitment difficulties. Health boards should be encouraged to use recovered funds to develop alternative models of delivering dental services, for example in some areas salaried general dental practitioner posts may be more attractive. There are examples where this has been successful.

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

Training pathways may need to be reviewed including entry to dental school. Local students from lower socio economic back grounds may not have the same advantages than students in private schools and it may be sensible to offer some applicants alternative pathway into getting into dental school such as completing a “pre-year”. Increasing the number of local applications may also increase the number of Welsh speakers. Developing training pathways to enhance the skills of the workforce are also being encouraged and it is anticipated that progress in the next few years will help to develop dentists and DCP’s with additional skills.

Policy over the last few decades has also led to recruitment difficulties, for example there has been an increasing number of dentists working part-time. Dentists who have recently retired who formally were happy to practice a few sessions a month are no longer willing to do this as the current requirements to practice are financially prohibitive for the level of remuneration that a few sessions would generate. Increasing requirements and the nature of the contract have resulted in an ever increasing number of the workforce to move away from providing NHS care. In fact anecdotal evidence would suggest that many dental therapists and hygienists can earn considerably more in the private sector than a qualified NHS dentist. Altering pension contributions and benefits further increases the move away from NHS dental practice.

Recruitment into the community dental service improved following the 2008 contract. In addition the difference between the English system and the Welsh system was considered advantageous for Wales. The investment in past years by WG into the community dental service was also welcomed and had a positive effect on recruitment. However negative changes such as a reduction in pension benefits will erode the momentum achieved and result in increasing difficulties in recruitment.

There continues to be a significant recruitment and retention issue in relation to specialists and the move towards community based specialist services. Welsh Government should look to prioritise and invest in the development of the smaller dental specialties outside the Dental Hospital. This should be driven by the need of the population with current resources relocated if necessary.

Substantive and training positions should have a significant if not completely community based element to them.

Welsh Government should establish and develop a programme for intermediary dental services. This would encourage GDPs to upskill, remove pressures from specialist services and provide a framework for career development. This would help with retention of young dentists.

The provision of orthodontic services

There have been various debates around orthodontics for several years. Orthodontic practice is generally accepted as being more lucrative than general dental practice. However in order to practice a formal specialist qualification is usually required which does involve a significant period of further study. If there was no NHS funded orthodontic treatment then children from lower socio economic backgrounds would be unlikely to afford the cost of private treatment which would almost certainly be in the thousands. This would effectively "label" poorer children via their malocclusion and disadvantage them in life.

That said remunerating GDS orthodontic contracts at the start of the treatment means that regardless of the outcome the orthodontist will get paid in full. It would be sensible to link the final payment with an independent and robust outcome measure to ensure satisfactory results and value to the tax payer.

It may also be an appropriate time to look at the health benefits of orthodontic therapy based on the IOTN since it can exclude patients who's need may be high and vice versa.

Orthodontic managed networks are now established in Wales but they can on occasions work as a provider network rather than in the wider benefit of the population and dental services.

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

Designed to Smile was introduced to get teeth in contact with fluoride by establishing brushing as the norm for these children. Before the programme there was little change in the caries rate for young children. Since it was introduced we have seen large falls in

decay rates for 5 year olds in a short timescale. In 2021 we expect to collect data to demonstrate whether there is a longer term impact of D2S on caries in the permanent teeth of 11-12 year olds.

GDS contract reform will allow a focus on 0-3 years as well in addition to the community dental services, general dental practices through the programme will be able to step up on the level of prevention. There is a need to expand this programme to other vulnerable groups.

D04
Ymchwiliad i Ddeintyddiaeth yng Nghymru
Inquiry into Dentistry in Wales
Ymateb gan Age Cymru
Response from Age Cymru

Consultation response
Dentistry in Wales
Welsh Assembly
August 2018

Introduction

Age Cymru is the leading charity working to improve the lives of all older people in Wales. We believe older people should be able to lead healthy and fulfilled lives, have adequate income, access to high quality services and the opportunity to shape their own future. We seek to provide a strong voice for all older people in Wales and to raise awareness of the issues of importance to them.

We welcome the opportunity to respond to the Health, Social Care and Sport Committee's consultation on dentistry in Wales.

Older people and the future work programme

We recognise that the main emphasis of Welsh Government's document, "Taking Oral Health Improvement and Dental Services Forward in Wales: a Framework outlining priorities for dentistry and a future work programme" is on dental services for children and young people. However, we welcome the recognition on page 4 that:

> "Wales has an aging population with many older people now retaining natural teeth. Some have complex medical needs with comorbidities and many will become dependent on others for aspects of daily living that others take for granted – such as brushing teeth. There is an opportunity to address disease levels and risks within adult population groups with the focus and effort which has been shown to be effective in young children."

We welcome Welsh Government's recognition of the need to shift the emphasis to a more needs-led preventive-focussed approach and better align dental services to patient and population need, and the recognition that improving oral health and effective preventive dental services contributes to hygiene and nutrition for all, including dependent older people. We welcome the intention to horizon scan and discuss plans for population oral health improvement action in other age and vulnerable groups, embed the improvement of oral health as everyone's business in Wales, and for the initiative to evolve to be a national programme integrated with other Public Health Wales and Welsh Government activity and action for, in time, other age groups. We call on Welsh Government to ensure that older people are a priority within this expanding scope.

We welcome the intention that contract reform: should facilitate dentistry to better engage with primary care clusters and the wider patient care agenda, for example care of people with diabetes, smoking cessation, alcohol abuse and mouth cancer; demonstrate more effective and efficient use of available resources so that people who most need active and complex treatment can get it; allow staging of care that promotes prevention, stability and

self-care to improve outcomes particularly in higher needs disease active patients, and free up dentist time that could be directed to new patient access and/or more complex cases. We call on Welsh Government to ensure that dental services for older people are a high priority within this wider agenda.

Access to dental services for older people

Access to dentistry for older people is still a low priority in the NHS. In particular, action is required to ensure that older people in residential care have access to the same standards of healthcare services as the wider community.

The Welsh Government must provide stronger direction to care homes in Wales to improve access to health and care services for residents, such as regular access to dentists, as well as other primary care clinicians.

Preventative health care services play a key role in promoting the health and wellbeing of older people. Access to dentistry, among other services, goes right to the very heart of our ability to lead active and rewarding lives. Work supported by the Social Services Improvement Agency identified that earlier interventions and a reablement approach to supporting people with dementia, incontinence, podiatry, dental needs, strokes and falls can result in maintaining independence at home and delay the need for high-end residential care.[1]

We support the use of technology such as the Dental Imaging Exchange (PACS) which enables radiographs, clinical images and 3D scans to be shared between clinicians in different locations and reduces the distances some patients have to travel to appointments.

Engagement of older people in service commissioning and design

We welcome the statements that there is flexibility within the existing contract to accelerate transformational change by describing what good looks like, include need and outcome measures worked up jointly with clinicians and contract managers, and make better use of existing resources to benefit patients.

However, we disagree with the assumption that any of this can be achieved without including the patient perspective. The views and needs of older people must be reflected in the commissioning and provision of preventative services, including dentistry. The third sector and public must be included in the development of local planning and commissioning strategies to improve appropriate preventative service provision across Wales.

Cost implications

Finally, we are concerned that any effect of increased access by a higher proportion of patients from groups exempt from paying for dental care – which would include many older people – on the maintenance of Patient Charge Revenue should not be used as an excuse for inaction or for increasing charges. The cost of dental treatment is already a barrier to treatment for some older people. That barrier must be removed, not extended.

We note that Welsh Government states that the step approach to contract reform, the current position whereby health boards continue to exceed their patient revenue targets, and the flexibility in setting the targets, help offset the risk and that service change will release efficiencies directed to more access for a given total contract value. We would not, therefore, wish or expect to see access to dental services for older people remain static or decrease, and would not wish or expect to see any additional charges for dental care for older people.

We hope these comments are useful and would be happy to provide further information if required.

[1] SSIA/John Bolton (2011) Better Support at Lower Cost, Section 4: Prevention.

D05
Ymchwiliad i Ddeintyddiaeth yng Nghymru / Inquiry into Dentistry in Wales
Ymateb gan Iechyd Cyhoeddus Cymru
Response from Public Health Wales

Health, Social Care and Sports Committee, National Assembly for Wales

Call for Evidence: One Day Inquiry on Dentistry in Wales

Public Health Wales welcomes the opportunity to contribute to the Committee's inquiry on Dentistry in Wales. Oral health is an important part of overall health and well-being. Tooth decay and 'gum diseases' (periodontal diseases) are highly prevalent but potentially preventable conditions. Relentless focus on prevention through services and public health programmes, together with a greater focus on the wider determinants of health, is required to reduce the burden of dental diseases in Wales.

Despite consistent improvements in the oral health of children in Wales, around 7,000 children per year still undergo dental extractions under general anaesthesia as a result of tooth decay. This situation highlights the need for further and continuing efforts to reduce sugar consumption, more effective prevention in the community and primary dental care to reduce true demand for dental general anaesthesia. It also highlights the need to develop appropriate care pathways and a broader range of dental services such as conscious sedation services to reduce unnecessary use of general anaesthesia in dentistry.

We have structured our response in line with the Terms of Reference (TOR) of the inquiry.

1. NHS General Dental Service (GDS) Reform Programme (also known as Dental Contract Reform)

1.1. In 2017 Welsh Government published *Taking oral health improvement and dental services forward in Wales*. This document highlighted that NHS GDS dental contract reform was one of three national priorities for dental care in Wales. More recently, an oral health policy document was published, *The Oral Health and Dental Services' response, A Healthier Wales: Our plan for health and social care* which re-iterated Welsh Government's commitment to the NHS GDS reform programme.

1.2. Why is NHS General Dental Service reform needed?

1.2.1. The limitations and challenges of the current NHS GDS system in Wales are well known. The current contract requires the delivery of Units of Dental Activity (UDAs), as proxy for counting dental treatments. Current system provides no incentives for dental teams to deliver preventive care or to take on patients with high needs. The remuneration for providing ten or more fillings is the same as the remuneration for providing a single filling. Tooth decay and 'gum diseases' (periodontal diseases) are highly prevalent, but potentially preventable, chronic conditions. Focussing on treatment of diseases without prevention is an inefficient use of NHS resources. Dental services should adopt the principles of chronic disease management with emphasis on person-centred, co-ordinated care and supporting patient self-management through a co-production approach. Health Boards also need to evolve in terms of how they monitor and performance manage dental contracts, with a greater focus on markers of quality dental care (including prevention) and patient outcomes.

1.2.2. There should also be consideration of how to allocate dental resources in order to provide care for individuals and groups with the greatest dental need. A substantial proportion of NHS GDS resources are spent providing routine 'check-ups' every 6-9 months for patients who are at low risk of dental disease. Currently dentally 'healthy' patients are advised to attend for a 'check-up' every 6 months, while many people who need and want dental care cannot access it. This is an example of the Inverse Care Law in action and arises because current NHS GDS arrangements do not incentivise the provision of dental care to high need patients. This has implications for all ages including the future generations of Wales. In 2016/17, 15.5% of 12 year olds in Wales had active tooth decay. Without prevention and access to effective treatment, these children are at risk of becoming a generation of young people whose oral health, quality of life, and possibly economic productivity are negatively impacted by dental disease. Changes in the GDS need to focus on reducing the inequity in 'dental access' across socio-economic groups and to incentivise dental providers to prioritise and provide quality care for high need patients.

1.2.3. The most prudent use of public healthcare resources requires the full utilisation of the skills of all members of the dental team, and not rely on dentists to provide all preventive care and treatment. It is important to learn from international experience as well as national initiatives that have made better use of 'skill-mix'[1] as we reform the GDS in Wales. Many countries have utilised skills of dental therapists to provide dental care to children and such model of care has had positive impact in increasing access to a large number of children and in reducing amount of untreated tooth decay in children.[2]

[1] Skill-mix' is a term that is used within dentistry to describe a model of care where the whole of the clinical team is fully utilised in delivering dental care.
[2] Nash et. al. (2014). A review of the global literature on dental therapists, Community Dentistry Oral Epidemiology, 42;1-10.

1.3. Public Health Wales and the NHS GDS Reform Programme

1.3.1. Public Health Wales (PHW) provides dental public health expertise to Welsh Government, health boards and other key stakeholders in Wales. Public Health Wales' Dental Public Health team hosts the NHS GDS Reform Programme. We are working closely with the Welsh Government (Dental Policy), dental services (teams), health boards and other stakeholders to develop a NHS GDS Reform Programme. A multi-stakeholder steering group has been established to ensure programme development and improvement is informed by a pooled expertise from multiple oral health stakeholders.

1.3.2. The current objectives of the NHS GDS Dental Reform Programme are to:

I. Involve key dental stakeholders to develop a NHS GDS Dental Reform Programme and adopt a continual improvement model.

II. Ensure dental services undertake an assessment of the oral health risks and needs of individual patients at least once a year using a standardised toolkit and utilise the information to:
   a. Understand what matters to patients
   b. Effectively communicate level of risk and need to patients (or their carers) and work with patients in making them understand changes they can make to prevent dental diseases
   c. Agree on the oral health outcomes patients want to achieve over a period of time or after a course of dental care.
   d. Utilise the principles of shared decision making in formulating a preventive dental care plan
   e. Monitor changes in the 'risk and need' of patients who receive ongoing care from the service.

III. Improve the delivery of evidence-based prevention and treatment.

IV. Support the implementation of dental recalls intervals based on oral health risk and need

V. Increase the use of skill-mix in NHS General Dental Services in Wales

VI. Encourage clinical teams to develop a culture of continuous quality improvement to ensure enhanced patient quality and safety.

VII. Encourage dental teams to establish productive working relationships with other primary and social care services

VIII. Evaluate and understand the changes in key activities, outcomes, and establish quality indicators to inform ongoing improvement of NHS GDS and development of primary dental care.

IX. Understand the changes that are required to reduce inequity in dental care use, and improve dental access amongst individuals who have high dental need but currently cannot /do not access dental care

X. Inform any changes required in the national dental contracts, associated legislations and other relevant programmes (e.g. workforce training and planning) or systems in place to facilitate ongoing quality improvement.

1.4. One of the lessons learned from the introduction of the current NHS GDS Contract in April 2006 is that wholesale 'big bang' national changes often have unforeseen adverse consequences, many of which only become apparent in the years following the change, as new patterns of working become embedded in the system. There is a history of wholesale changes in the GDS, many of which have had unanticipated negative sequelae including impact on access and/or type of treatments provided. It is important for the NHS GDS Reform Programme in Wales to be given sufficient time to test, evaluate changes and understand their impact on different, interconnected elements of the system.

2. How 'clawback money' from health boards is being used

2.1. Under the current NHS GDS system, dental contract holders are given total annual contract value in twelve instalments and in return are required to deliver their contracted annual Units of Dental Activity (UDAs) targets. As a general rule, practices will have to deliver at least 95% of their contracted annual UDAs target to avoid 'claw back

of money'. There are multiple reasons why dental practices fail to deliver their contracted annual UDA targets. Delivery of UDA target does not mean good access and/or good quality care. We have already highlighted limitations of the current UDA based system in the previous section and why we need to move away from total focus on delivery of UDAs.

2.2. Instead of looking at 'clawback money' from dental practices in isolation, it is important to analyse and interpret the overall primary dental care budget made available, actual expenditure, trends in spending over the years and trends in the level and equity of dental access. It is also important to understand what happens to dental underspend/'claw back money' and if any General Dental Services funding has been used to develop other dental services especially intermediate and specialist dental services in primary care.

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

3.1. The development and ongoing improvement of NHS GDS cannot be considered in isolation without comprehensive dental workforce planning. The national NHS GDS Reform Programme and local integrated dental service planning within health boards need to be closely aligned with planning and training the dental workforce.

3.2. Difficulty in recruiting and retaining dentists able to provide high quality care is a problem for dental providers in some areas of Wales, especially in remote and rural communities. This has a negative impact on access to dental services in these areas. These difficulties are expected to be made more intense if the arrangements following Britain's departure from the European Union limit the inward migration of dentists from these areas. In 2017, there were 6,689 European Economic Area (EEA) qualified dentists registered in the UK General Dental Council. In 2012, EEA

graduates accounted for 15% of dentists in Wales but a substantially higher proportion in Powys and Hywel Dda.[3]

3.3. We know a significant proportion of the prevention and treatment activities[4] currently provided by dentists, especially those for children, could be delivered by the wider dental workforce, collectively known as Dental Care Professionals (DCPs). Current dental contractual arrangements and associated legislations restrict and/or discourage full use of the dental skill-mix, especially relating to dental therapists.

3.4. Some Community Dental Services (CDS) and GDS providers have successfully tested greater utilisation of dental therapists in Wales. The Designed to Smile national child oral health improvement programme delivered by the Community Dental Services also uses the additional skills of dental nurses in to provide preventive treatment. There is a huge potential for the utilisation of the additional skills of dental nurses, hygienists and therapists in dental services in Wales which should help to increase access to prevention and dental care. There is some evidence that practices with dental therapist provide a more preventive-focused approach to oral health-care delivery, with dentists left to complete more complex work, and that patients are equally happy after seeing a dentist or dental therapist.[5]

3.5. In parallel with the contractual and legislative changes needed to remove the barriers preventing the full use of 'skill-mix' in the GDS, there also needs to be a plan to train greater numbers of highly skilled DCPs in Wales. NHS Wales and bodies responsible for education also need to ensure access to additional skills training for

[3] National Leadership and Innovation Agency for Healthcare, An analysis of the dental workforce in Wales, 2012
[4] General Dental Council, Scope of Practice, September 2013.
[5] Barnes *et.al*. (2018), General Dental Practices with and without a dental therapist: a survey of appointment activities and patient satisfaction with care, The British Dental Journal, 225;53-58.

existing DCP workforce in line with the planned changes in the GDS and CDS. There is also an ongoing need to communicate with patients and the public about the role of DCPs in the dental team, particularly as their skills are utilised more widely within the dental system.

3.6. Health boards will need to be innovative when planning dental care for their local population, especially in rural areas. Some health boards have tested a model of salaried practitioners in areas where they have been unable to attract GDS providers. Additional incentives may be required to recruit and retain dentists and DCPs in those parts of Wales where dental services need to be developed and/or where recruitment and retention has been an issue. Measures should be explored to attract more local students to the dental training courses in Wales and retain them following undergraduate and postgraduate training.

3.7. There is also need for workforce planning for specialist dentists and dentist with enhanced skills (DES). Availability of funding for the training of specialist dentists and DES should be aligned with local and national dental workforce planning. This workforce planning needs to include the recruitment and retention of locally trained highly competent specialists. The changing population (older adults with complex dental and medical needs) means that the specialist workforce also needs to work together within a team using the skill-mix model.

3.8. There is also need for specialist and consultant-led services currently delivered from secondary care settings, to work more closely with primary dental care, so that patients receive seamless care when they require services from both general dental practices and specialists/consultants in secondary care. The recruitment (and training) of specialist dentists in certain dental specialties needs to be considered a high priority. We understand that there are currently

unfilled posts in key roles (eg. Consultant in Restorative Dentistry in Betsi Cadwaladr University Health Board, Specialist in Paediatric Dentistry in Aneurin Bevan Health Board).

4. The provision of orthodontic services

4.1. It is important to consider provision and utilisation of intermediate and specialist/consultant dental services (including orthodontics) alongside the provision of urgent and routine general dental care available for the population of Wales. Consideration of the whole dental system and integrated planning at local, regional and national level is important to avoid fragmented dental speciality specific planning and provision.

4.2. In a resource limited system, prioritisation is a reality, and integrated planning is important to improve value of dental care.

4.3. Some of the questions to consider are:

4.3.1. What is the level of access to urgent dental care (including Out of Hours) and routine general dental care for children and adults including for those with dental anxiety and phobia?

4.3.2. What is the variation in level of dental access for urgent and routine dental care) across socio-economic groups and vulnerable groups in the society (the Inverse Care Law)?

4.3.3. What is the provision of intermediate (provided by dentists with enhanced skills in different clinical specialities) and specialist dental services (e.g. paediatric dentistry, endodontics, periodontics, prosthodontics, orthodontics, oral medicine, oral surgery etc) in each heath board and does it meet the need of the population?

4.3.4. What are the trends in service utilisation (primary and specialist care) in each health board?

4.3.5. What outcomes (patient reported and clinical) do dental services achieve for the patient population they serve and

what is the variation in patient outcomes between health boards?

4.4. The majority of NHS orthodontic treatment is provided to 12-17 year old children. Assessment of need and the provision of orthodontic services should be considered as part of the overall dental services planning, and within the context of high prevalence of untreated active tooth decay in the child population in Wales. 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, which indicates missed opportunities for prevention or dental care. Access to effective prevention and remedial dental care for these children should be prioritised.

4.5. The orthodontic speciality has well understood evidence-based acceptance criteria for NHS orthodontic treatment (based on Index of Orthodontic Treatment Need) and agreed standards in treatment outcomes. Various factors impact on the waiting time for orthodontic treatment e.g. treatment of mild malocclusion (i.e those who do not qualify for the NHS orthodontic treatment), inappropriate and misdirected referrals, referral of a child to multiple orthodontic service providers, repeat orthodontic treatments, transfer of orthodontic care in middle of treatment from one practice to another practice etc. Local waiting times for orthodontic treatment in primary care are also dependent on referral acceptance criteria of both primary care-based orthodontic services and consultant-led services delivered through hospital settings.

4.6. Currently primary care-based orthodontic services are not able or do not provide reliable information on:

- number of patients waiting for assessment ,
- number of children who have been assessed, qualify for NHS treatment and motivated to undergo long orthodontic treatment,

- referral to assessment waiting times and
- assessment to ‘treatment start’ waiting times.
- reasons for incomplete/abandoned courses of orthodontic treatments

4.7. It is important for General Dental Practitioners to have access to the information outlined above so that they can have an informed discussion with parents (and children) regarding waiting time variation between service providers, alongside information on current oral health status, NHS treatment eligibility criteria, risks and benefits of orthodontic treatment, availability of local orthodontic services, and travelling time involved.

4.8. A recent study carried out in South East Wales found that primary care-based specialist orthodontic services in the area overall achieved good clinical outcomes. However, 4% of the patients in the study sample who received orthodontic treatment should not have received NHS orthodontic treatment based on NHS orthodontic treatment criteria. Some children go through a second course of treatment while others are waiting for the first course of treatment.

4.9. The system should not have to rely on ad hoc audits/studies to understand the outcomes achieved by dental services. Collection of information on treatment outcomes (clinical and patient-reported) should be integrated into the existing information system. Claim forms submitted by NHS orthodontic services could be modified to collect information on the clinical outcomes achieved by the service providers.

4.10. An E-referral system for dentistry has been funded by the Welsh Government and has recently been procured by the NHS Wales Informatics Service (NWIS). When health boards fully implement the E-referral system, it is expected that it will help health boards will

have information to improve on many challenges outlined above. The E-referral information system should be designed to provide reliable information to parents/patients, referring practitioners, specialist service providers. The data generated through this system could also be analysed to understand equity in use of specialist dental services, patient experience, outcomes, and identify potential areas improvement for each service/health board.

4.11. National orthodontic contract changes and outcome focussed commissioning with emphasis on greater utilisation of skill-mix (e.g role of orthodontic therapists) will be required to improve value of orthodontic care. Workforce supply of orthodontic therapists needs to be considered as a part of wider dental workforce planning.

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

5.1. The Dental Surveillance Programme collects information on dental health of five and twelve year olds, as part of a regular cycle of dental surveys.[6] Whilst recent surveys have shown that dental health of children in Wales is improving (Fig 1 and 2), tooth decay is still highly prevalent. National survey results showed that 34% (2015/16) of five year olds and 29.6% (2016/17) of twelve year olds in Wales had experienced of tooth decay.[7]

[6] Results of these surveys can be obtained from http://www.cardiff.ac.uk/research/explore/research-units/welsh-oral-health-information-unit

[7] Experience of tooth decay = At least one tooth has obvious active tooth decay or has dental filling or is missing (extracted due to tooth decay)

Figure 1: Trend in experience of tooth decay in five year old (school year 1) children in Wales.

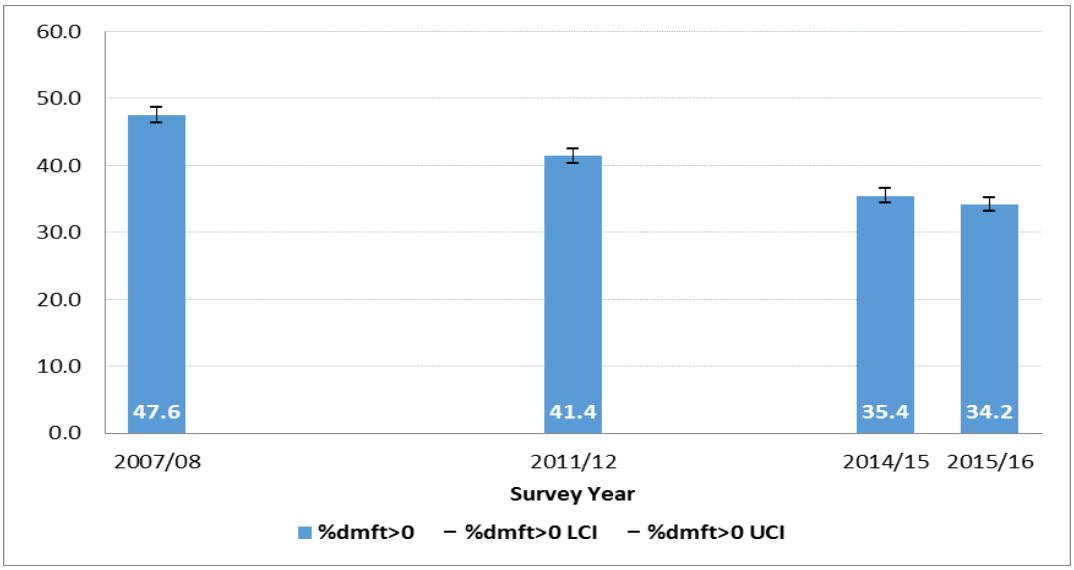
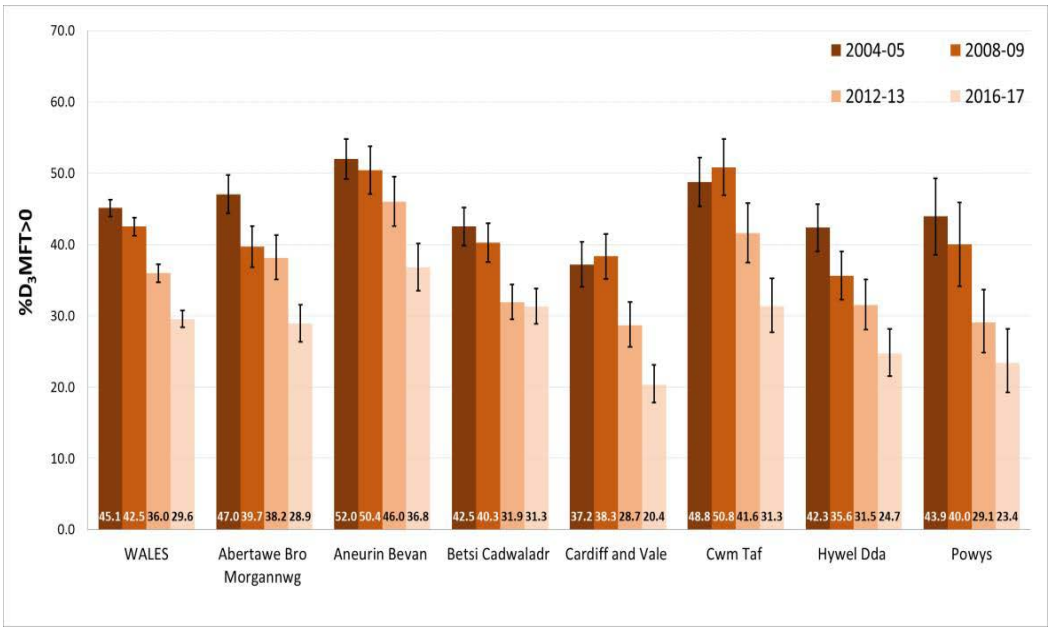


Figure 2: Trend in experience of tooth decay in 12 year old children in Wales.



5.2. Whilst the provision of evidence-based preventive interventions and dental care by dental professionals should form a central tenet of

GDS, without population-level public health interventions, it will be challenging to achieve large scale improvement in the oral health of the Welsh population.

5.3. Designed to Smile (D2S) is a national targeted child oral health improvement programme which delivers evidence based interventions to young children (0-5 years) in Wales. It is essentially a programme that brings children's teeth in contact with fluoride through supervised toothbrushing and application of high strength fluoride (fluoride varnish) in nursery and primary school settings in deprived areas in Wales. Data show that not only are children living in deprived areas more likely to have tooth decay, they are also least likely to regularly attend dental services.

5.4. The target population of Designed to Smile is these children. Designed to Smile provides a 'safety net' for these children by delivering evidence-based preventive interventions e.g. fluoride varnish applications out with traditional dental services settings to reduce dental health inequalities and reduce the effect of the Inverse Care Law.

5.5. Welsh Government has committed to the continuation of Designed to Smile programme (Oral Health and Dental Services' Response, A Healthier Wales) and Public Health Wales is fully supportive of continuation of the programme and will continue to provide Dental Pubic Health expertise to the programme. In the years since Designed to Smile was first piloted (national roll out in 2010/11), tooth decay in children living in deprived areas has declined for all quintiles of deprivation and inequality in prevalence of tooth decay has not widened. It is worth remembering that the benefits of public health interventions such as this will incrementally increase with its ongoing delivery. The impact of Designed to Smile on children's

dental health will continue to be monitored through planned dental surveillance programme.

5.6. A social gradient still persists in childhood tooth decay experience, with 42.2% of 5 year old children in the most deprived areas having decay, compared to 22.3% of 5 year old children in the most affluent areas. In 2013/14, 20.2% of three year old children in the most deprived quintiles already had tooth decay experience. These children from deprived areas are further disadvantaged due to their low access to dental services (of which there could be a number of barriers). The Designed to Smile budget has to remain ring-fenced and focussed on targeting children who are at high risk of tooth decay with provision of oral health promotion to all children through the health visiting service and other services/programmes targeted to the same population.

5.7. Tooth decay is also associated with social and commercial determinants of health. Hence, the success of preventive efforts delivered through dental services and oral health programmes like Designed to Smile is also dependent on social and commercial determinants of health. In simplistic terms, preventive efforts of dental services and Designed to Smile programme can be negated by high consumption of sugary diet and drinks (which also affects childhood obesity in Wales).

5.8. Improvement in dental health of children will also require a broad programme of measures to reduce sugar consumption in the population:

- lowering the amount of free sugars in food and drinks including through use of taxation and levies;
- restricting the marketing and promotion of sugar-containing products;

- reducing the amount of sugar-containing food and drinks sold;
- advising, educating and helping people to consume less sugar;
- reducing the amount of sugar produced

5.9. Health Boards, working with their Public Service Board and Regional Partnership Board partners, will need to ensure they have a comprehensive programme to reduce sugar consumption in their area. There should be some actions with urgency in this area, starting with commitment from the Public Service Board and Regional Partnership Board partners to ban/reduce sale of unhealthy high sugary drinks and food (including food high in salt and saturated fat) in their premises and adopting healthy food catering and healthy workplace policies.

5.10. There is evidence that sugar consumption is higher among people from more deprived communities in the UK. Reducing sugar consumption therefore has a key part to play in reducing oral health inequalities between different communities and population groups. Healthy food choices for those in food poverty are often restricted due to their higher cost and large number of promotions on high sugar foods. This leads to greater price differences between healthy and high sugar foods[8]. Governmental (Welsh Government and UK) policies and appropriate legislations will be required to reduce sugar consumption so that the average population intake of free sugars does not exceed 5% of total dietary energy for age groups from 2 years upwards as recommended by the Scientific Advisory Committee on Nutrition.

[8] British Association for the Study of Community Dentistry (BASCD) Position statement on recommended actions to reduce the consumption of free sugars and improve oral health.

Welsh Government's Dental Contract Reform

The current General Dental Services Contract introduced in April 2006 remunerates dentists an annual contract value in return for providing an agreed level of Units of Dental Activity (UDAs). It is well documented that General Dental Practitioners (GDPs) are not happy with the current contract as they feel working towards an activity target is like 'being on a treadmill'. Also some GDPs are reluctant to accept new patients because they don't know the extent of treatment patients may require. UDAs are allocated based on courses of treatment and dental treatment is categorised in the various bandings, so for example a dentist would receive the same number of UDAs whether the patient needed 1 filling or 5 fillings. Also UDAs are the main measurement of dental performance but does not give assurance of the quality of the service.

Cwm Taf University Health Board (UHB) is supportive of Dental Contract Reform and 3 dental practices were approved for the 1st phase in September 2017 and at least 1 additional practice will commence later this year. Therefore 10% of dental practices in the UHB area will be operating under Dental Contract Reform this year.

The UHB is currently reluctant to approve more dental practices as reducing contracted UDAs by 10% also reduces the amount of patient charge revenue (PCR) the UHB receives; the dental allocation is given to Health Boards net of PCR any shortfall in income has an impact on the UHB's financial position. Additional funding has been agreed by Welsh Government should Health Boards approve a minimum of 10% of dental practices. This additional funding only funds the estimated shortfall in PCR for 4 dental practices so it is a risk to the UHB's financial position should it approve more. Any significant reduction in PCR will have impact on other primary care dental services.

One of the criticisms of the current GDS Contract is that it wasn't tested before its introduction in 2006.Therefore the UHB consider it important to pilot Dental Contract Reform on a small number of practices so lessons can be learnt not only in relation to any risk around funding but also the risk assessment process, to which there have already been several changes since Phase 1 was introduced in September 2017. There also needs to be the ICT infrastructures in place to support the new way of working and currently not all dental practices are computerised.

If the % of UDAs is further reduced under new contract a decision is required on how dental contracts are to be monitored to ensure probity and value for money. When the current contract was introduced it took several years before a process was fully agreed and implemented. GDPs need to be fully aware of what is expected from the start in order to avoid any misunderstanding.

The emphasis of Dental Contract Reform is prevention and also use of a different skill mix of staff within the practice. However, feedback from some dentists is they are concerned how this will work in a single surgery or small practice, where they may not have sufficient space to accommodate other practitioners. When the UHB initially sought expressions of interest to participate in Dental Contract Reform, very few practices were interested. Therefore a barrier for extending the number of practices will be convincing dentists that they will be able to work effectively under the new arrangements.

As the number of practices working under the new contract increases, there also needs to be a public awareness campaign. If the new ways of working are not publicised then it is a concern that there is risk of an increase in patient complaints.

How 'clawback money' is used

The General Dental Services Contract states that a Provider is only able to carry forward a maximum of 5% shortfall in UDAs to the following financial year, therefore any breach of contract greater than 5% requires repayment of funding to the UHB.

From the mid-year position in each financial year (i.e. 30th September) the UHB closely monitors activity, comparing actual performance each month to the expected levels of achievement. As the current contract started April 2006 the UHB now has 12 years of trend data to aid the monitoring process.

The UHB communicates with Providers during the financial year when there are concerns that the practice is likely to under achieve against their contract. Occasionally Providers will inform the UHB that they are expecting to fail to achieve 95% of UDAs and will agree for funding to be withheld during the financial year. This allows the UHB to offer the withheld funding to other dental practices or to invest in other dental services during the financial year so funding is not lost to NHS dentistry.

However, the majority of dental providers do not agree to a temporary reduction to their contracts during the financial year, even when the UHB considers that they will almost certainly not meet the contract target. As the UHB has 12 years of trend data, a judgment can be made during the year on the likely financial outcome so a decision can be made whether to invest in other dental services during the financial year.

The UHB currently has GDS contracts with 35 general dental practices for the value of £13m. Every financial year since the introduction of the GDS Contract

some dental providers in Cwm Taf have not met their contract targets; the number and value of repayment has varied each year. The UHB does not look for savings on GDS Contracts but when funding is repaid, it reinvests:

- Offering additional UDAs to other practices when funding is released during the financial year which has resulted in additional UDAs being invested in Merthyr Tydfil and in Cynon Valley
- Purchased equipment in order to commence a Minor Oral Surgery (MOS) service and sedation service for anxious patients in Primary Care.
- Arranging additional Primary Care MOS sessions on weekends to reduce the waiting list.
- Approving improvement grants for a number of dental practices to make them more accessible for disabled patients
- Purchasing hearing loops for every dental practice's reception desk along with Sonido hearing devices for use in surgeries.
- Funding three Fluoride Varnish courses and offered to all general dental practices for their nurses to attend for free
- Purchasing toothbrushes, toothpaste & drinking cup for Health Visitors to give all under 3 year old children
- Resources required for the campaign "Baby Teeth DO Matter"

Recovery of funding for 2017/18 underperformance is estimated to be 2.2% of the total GDS Contracts but the UHB has not yet completed the end of year review process yet so this may not be the actual amount recovered.

Cwm Taf UHB has an approved IMTP therefore the dental budget is no longer ring-fenced. However the UHB is committed to improving the oral health of Cwm Taf patients and does not have an access problem with more than half of dental practices accepting new NHS patients. When funding is repaid due to breach of contract the UHB takes the opportunity to fund new dental initiatives, as described above.

Issues with training, recruitment and retention of dentists in Wales

Recruitment is not currently a problem for the majority of dental practices in Cwm Taf and this is probably due to its proximity to Cardiff and the Dental School. However the corporate practices have reported that they experience problems recruiting dentists and this could be due to Brexit with European graduates less interested in coming to the UK. As with General Medical Practice, it has been suggested that younger dentists seem unwilling to commit to long term or extensive NHS involvement and don't appear to be interested in becoming practice owners; preferring part-time working so as to have work life balance. As the current GDPs retire this may become more of an issue with possibly less experienced dentists unwilling to provide treatment traditionally carried out in primary care.

With the introduction of Dental Contract Reform and more use of a varied skill mix in dental practices there need to be a workforce plan to ensure there is sufficient supply of these individuals to support dental practices.

The provision of orthodontic services

There are no orthodontic specialist practices in the Cwm Taf UHB area and historically patients have always travelled to the specialist practices in Cardiff. When the current contract was introduced in 2006 funding was given to the Health Board based on historic spend in dental practices rather than based on patient population. Cwm Taf UHB therefore has little influence on orthodontic contracts as approx. £750k of funding for Cwm Taf patients sits with Cardiff & Vale (C&V) UHB.

There are concerns over the length of the waiting times for treatment as the UHB has been informed that referral to treatment is approximately 2 years. A recent survey of the waiting lists in C&V practices show that there are over 8,000 new patients with a further 1,700 patients assessed and on review waiting to start treatment. There have been previous reviews of orthodontic services undertaken which have stated that there is sufficient provision in Wales so there will be no further investment into the service.

It has been suggested that these long waiting lists are due to dentists referring patients too early for treatment and an audit of new patient referrals undertaken by the SE Wales LOC in 2015 showed 15% of patients had been referred early. This is an evitable consequence of long waiting lists.

The Managed Clinical Network for Orthodontics introduced a referral form in an attempt to reduce inappropriate/early referrals but this does not seem to have had any impact on reducing the number of referrals to the service. Although the quality of referrals showed positive improvements. It is hoped the electronic referral management system (eRMS) to be introduced across Wales by March 2019 will continue to improve the quality of referrals but ultimately the bottleneck is in treatment capacity.

In Cwm Taf there are orthodontic specialists working for the Community Dental Service but they do not accept referrals from GDPs. Currently CDS is managed by C&V UHB but will transfer to Cwm Taf UHB in April 2019. The service will then be reviewed as to how it can work more closely with the hospital orthodontic service.

Patients tend to be referred to the hospital service even though they do not meet the criteria for complex treatment as parents from the most deprived areas are not able to travel to Cardiff as no transport. This then has an impact on the hospital treatment waiting lists, particularly in Prince Charles Hospital, which is currently 2 ½ to 3 years.

In Cwm Taf there are 3 dentists with enhanced skills (DWES) in orthodontics who work in primary care practices. The 3 DWES work with the hospital consultants and would be able to treat more patients but are limited by their contracted Units of Orthodontic Activity (UOAs). They have a very small number of UOAs based on their earnings during the reference period prior to April 2006.

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

Designed to Smile (D2S) started in 2009 and teams visit primary schools to introduce tooth-brushing and fluoride varnish to young children. The D2S Team visit schools in the Community First areas but the UHB also funds a team to visit all the other primary schools not covered by D2S. So every primary school in Cwm Taf has the opportunity to introduce supervised tooth-brushing and fluoride varnish in schools. Unfortunately not every head teacher will agree for this oral health improvement programme to be in their school. The majority of schools participating are fully engaged with the initiative and the programme forms part of their accreditation under Healthy Schools Award.

The most recent survey of 5 year old children shows that across Wales there has been a significant improvement in children's oral health in the last 10 years. However this improvement was not seen in Cwm Taf. What we don't know is would the levels of decay have increased if it wasn't for the current oral health programmes in place? The UHB has made it a priority to improve children's oral health and since September 2017 has now introduced a fluoride varnish programme for those schools not covered by D2S.

Since April 2017 the UHB now funds toothbrushes/toothpaste for Health Visitors to give babies/toddlers twice per year. They also provide the child with a free drinking cup to encourage the child to stop using a bottle.

Is it a factor that children's oral health in Cwm Taf hasn't improved because the number of children accessing dental services has decreased over the years? In 2009, 36,271 children attended a dentist in the previous 2 years however by 2017 that number had reduced to 35,158.

In an attempt to increase the number of children attending a dental practice, the UHB decided to pilot an initiative 'Baby Teeth DO Matter' in the Merthyr Tydfil locality (56.5% of under 5 year old children have dental decay). The UHB has not invested from the UDA contract into this initiative, other than a small amount to pay for advertising and promotion. There are currently 3 dental practices in Merthyr Tydfil involved in the pilot and they are linked with GP practices. A dentist or dental therapist visits the baby clinics to speak to parents of babies/toddlers to encourage attendance at a dentist. The 3 dental practices had their contracted UDAs reduced by 5% but their annual contract value remained the same. The 5% funding was used to pay for the dentist or dental therapist to attend sessions at the GP practices.

The pilot is only currently in Merthyr Tydfil but the awareness campaign has been publicised throughout Cwm Taf.

The pilot started in April 2017 and during 2017/18 the number of children attending a general dental practice has increased:

- Total number of children increased by over 1,500 children (4.48%)
- Total number of 0-2 year old children in UHB (target age group of campaign) increased by 16.9%
- Total number of 0-2 year old children in Merthyr Tydfil (where Baby Teeth DO Matter is piloted) increased by 39.53%.

The most recent survey of 12 year old children shows that in Cwm Taf there has been an 18.5% reduction in the % of children with decayed, missing or filled teeth compared to the 2008/09 survey. So D2S has been effective in reducing the levels of decay in 12 year old children.

The UHB needs to continue with prioritizing children under 3 years of age and this will be aided by the refocus of the D2S programme. There is no one initiative alone that will improve children's oral health but parents need to hear consistent messages from all healthcare professionals.

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

D08

Ymchwiliad i Ddeintyddiaeth yng Nghymru / Inquiry into Dentistry in Wales

Ymateb gan Goleg Brenhinol Pediatreg a Iechyd Plant

Response from the Royal College of Paediatrics and Child Health

Health, Social Care and Sport Committee one-day inquiry on dentistry in Wales: Evidence from the Royal College of Paediatrics and Child Health (RCPCH), August 2018

About the RCPCH

The Royal College of Paediatrics and Child Health (RCPCH) is responsible for training and examining paediatricians, setting professional standards and informing research and policy. RCPCH has over 18,000 members in the UK and internationally with over 500 in Wales. We work to transform child health through knowledge, research and expertise, to improve the health and wellbeing of infants, children and young people across the world.

For further information, please contact [redacted]

Dentistry and child health

Good oral health is essential for children's overall health and wellbeing. In our State of Child Health (SOCH) report of 2017, we set out the evidence around children's oral health across the UK, comparing data between nations where possible[1].

Despite tooth decay being almost entirely preventable, tooth decay is the most common single reason why children aged five to nine require admission to hospital. Multiple tooth extractions can also result in the need for a child to go under general anaesthetic[2].

Poor oral health can have a major impact on a child's physical health and their quality of life, including:

- Pain
- Infections
- Altered sleep and eating patterns
- School absence
- Need for dental extraction (with the potential for subsequent dental problems later in life)

In addition, children's dental and oral health can be a strong indicator of general health and wellbeing and can be a way of detecting issues from poor diet and risk of obesity to neglect.

[1] Royal College of Paediatrics and Child Health (2017). *State of Child Health* p. 46 – 48 Available at: https://www.rcpch.ac.uk/sites/default/files/2018-05/state_of_child_health_2017report_updated_29.05.18.pdf

[2] For evidence on the need for anaesthetic in England (we are not aware of Wales data), see Faculty of Dental Surgery (2015). *The state of children's oral health in England*. Available at: https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/report-childrens-oral-health/

A Healthier Wales[3] sets out the Welsh Government's vision for health services in the future. A key component of this plan, which we welcome, is the need for investment in prevention to support people to stay well. It also sets out the case for services to work together as a single system.

It is essential that children and young people's health is considered as a whole, with oral health a vital component and that paediatric and community dentistry services operate accordingly. With this in mind, we take this opportunity to highlight issues of concern to paediatricians in Wales and urge the Committee to consider its inquiry in the broader context of child health.

Reduction in consumption of high-sugar foods, particularly drinks is key. National actions to reduce sugar in children's food should be accompanied by conversations with children and parents about reducing and replacing high-sugar foods and drinks.

Children's oral and dental health in Wales and the UK

Since the early 1990s there has been an increase in the proportion of 5-year-olds with no obvious tooth decay across all four nations. At the time of publishing SOCH, the comparable data available suggested that tooth decay was a particular problem for Welsh children, compared with the rest of the UK: the proportion of 5-year-old children with no obvious tooth decay in 2013 was 69% in England, 68% in Scotland, 60% in Northern Ireland and 59% in Wales. Improved oral health since 2003 was most noticeable in Scotland (23% increase) and Northern Ireland (21%)[4].

Data published by the Welsh Government since then suggest that progress is being made. In June of this year, Welsh Government announced that "the Welsh Oral Health Information Unit report… shows that the percentage of children experiencing obvious tooth decay has dropped significantly from 45% in 2004/05 to 30% in 2016/17"[5] (note that the sources used for SOCH data were the Children's Dental Health Survey for England, Northern Ireland and Wales and the National Dental Inspection Programme for Scotland). This suggests that the Designed to Smile programme is having a positive impact. However, for an almost entirely preventable condition, we believe that 30% remains alarmingly high and that in line with the principles set out in A Healthier Wales, further action is required to prevent children from experiencing tooth decay.

Access to dentists

We understand that research carried out by the British Dental Association (but not yet published) shows that only 28% of dental practices are currently accepting children and young people as new NHS patients in meaningful terms. Even within that 28%, many patients will wait weeks or months for an appointment.

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[3] Welsh Government (2018). *A Healthier Wales: our Plan for Health and Social Care*. Available at: https://gov.wales/topics/health/publications/healthier-wales/?lang=en

[4] RCPCH, 2017, p46

[5] Welsh Government (2018). *Health Secretary welcomes reduction in child tooth decay*. Available at: https://gov.wales/newsroom/health-and-social-services/2018/59732995/?lang=en

There are worrying socio-economic inequalities leading to health inequalities: in SOCH, we reported that 5-year-olds living in the most deprived areas of England, Northern Ireland and Wales were at least three times more likely to experience severe tooth decay than their peers living in the most affluent areas[6]. All children should therefore have timely access to dental services.

Paediatrics and dental health

Currently, there are few formal networks between dentists and paediatricians, so when paediatricians treat patients who would benefit from routine dental services, paediatricians can do little more than advise them or their parents to seek a dentist in their area and provide a phone number. However, those children and families will then be in the same situation as any other family looking for an NHS dentist. There is not usually a formal referral pathway.

Feedback from paediatricians suggests that there is inconsistency around referral pathways for children who require more specialist services. Our conversations with the BDA suggest that fewer practices which offer specialist services for children with, for example, neurodevelopmental disorders, mental health problems or learning difficulties, are accepting new NHS patients. One member has told us that for these groups, he has found it easier to successfully refer to the appropriate service. It may therefore be that referral via a paediatrician is sometimes a route into services which may otherwise be difficult to access. However, another member reports to us that it has never been clear to her as a community paediatric registrar what her referral routes are and that she has "come across families who have children with additional needs and accessing specialist paediatric dentists is difficult for them… I have written letters before to community dentistry but hear nothing back".

A final issue to consider is that children's oral health can be an indicator of neglect. Dental neglect can be considered a form of child abuse through neglect. Paediatricians and dentists do work together on this: one of our members told us that she had recently delivered level 2 child protection training to undergraduate dental students about this link and how dentists can work closely with their local child protection teams and paediatricians. However, there is evidence that better links between paediatricians and dentists would be beneficial. An article (co-authored by Dr David Tuthill, RCPCH Officer for Wales) in the British Dental Journal highlights that "dentists require specific training to identify concerning child protection injuries" and proposes that "multidisciplinary training with dentists and paediatricians would be of benefit when considering child protection issues". The paper found that "there remains a worrying lack of knowledge about thresholds for action [on child protection issues] among dentists. Doctors and nurses have minimal training in, or knowledge of, dental health in children, thus precluding appropriate onward referrals"[7].

The issues around referral pathways and training for dentists and paediatrician therefore warrant further consideration.

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[6] RCPCH 2017, p47

[7] Olive, Tuthill, Hingston, Chadwick and Maguire (2016). Do you see what I see? Identification of child protection concerns by hospital staff and general dental practitioners. *British Dental Journal*, Volume 220. Available at: https://www.nature.com/articles/sj.bdj.2016.331

Recommendations

Ongoing development, implementation and evaluation of national oral health programmes for children and young people, building on Designed to Smile.

All children should receive their first check-up as soon as their first teeth come through and have timely access to dental services for preventative advice and early diagnosis, with targeted access for vulnerable groups.

Children need timely access to both primary and specialist dental care to reduce the likelihood of serious complications following early tooth decay.

Good oral hygiene and reduced sugar consumption, coupled with access to timely primary dental care, are important for reducing tooth decay in children.

We would like Welsh Government to explore the option of fluoridation of public water supplies across Wales, particularly in areas where there is a high prevalence of tooth decay.

NHS Wales, Welsh Government and Health Education and Improvement Wales (HEIW) should ensure that all health care professionals, including dentists, can make every contact count by having conversations with their patients (whatever their age) about reducing and replacing high-sugar foods and drinks.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Inquiry into Dentistry in Wales

1.0 The Welsh Government's dental contract reform

1.1 Aneurin Bevan University Health Board (ABUHB) is fully engaged with the dental Contract Reform Programme (CRP) and selected three practices to take part in phase 1 of the programme, which commenced on 1st September 2017. A further five expressions of interest from practices have been received to take part in the programme from October 2018, resulting in 10% of the total General Dental Services (GDS) contract population taking part.

1.2 Practices participating in the programme have to undertake the Assessment of Clinical Oral Risks and Needs (ACORN) Toolkit for each patient over a 12 month cycle at their routine appointment. At this appointment the dental team uses the toolkit to lead patient discussion and provide oral health advice/education to the patient and explain any preventative treatment that they will benefit from. The dental team will continue to provide this information to patients but the programme is about raising awareness of oral health issues and how patients can help manage their own oral health needs in between their dental appointments to allow stabilisation of treatments.

1.3 The Health Board (HB) welcomes this approach, as it supports patient engagement and focuses on the education and prevention aspects to oral health as well as providing the necessary treatment.

1.4 There is some reluctance from practices to take part in the programme as they do not feel that 10% to undertake the ACORN Toolkit is a reasonable proportion for their contract to be adjusted. Whilst those participating in the programme have acknowledged the benefits of undertaking the toolkit and the positive approach to providing prevention and education, there is still uncertainty within the wider dental community. Further engagement and understanding of the programme is required. Consideration to a national public/patient awareness campaign of the contact reform programme is also required.

1.5 The HB is keen to expand the programme but needs to ensure that there is a transparent and consistent approach, which is agreed at an all Wales level, when developing the programme and how practices should be measured against key performance indicators.

1.6 Taking part in the programme will allow access rates to increase as over time, patient recall time intervals will extend allowing practices to accept new patients. It is anticipated that child access rates will improve. Between September 2017 – June 2018, there has been a 6% increase in access across the three practices taking part in the programme compared to the previous years activity rates.

1.7 At present there are no practices participating in the areas of most need, Caerphilly and Blaenau Gwent. ABUHB recognises that high incidences of poor oral health is linked to poor access to provision of dental services. Significant investment has been made in these two areas, as well as Torfaen and Newport over a number of years to improve access.

1.8 The programme aims to increase the total number of fluoride varnish applications in children, which will help reduce the number of children who have dental decay – therefore reducing the need for dental care, which in turn may reduce the need for general anaesthesia.

1.9 It is extremely beneficial that practices taking part in the programme can now submit their ACORN data using FP17w forms.

1.10 We are still in the initial stages of this programme however the first cut of data for each of the three practices is proven very useful and supports discussions with the dental teams. It provides a snapshot of the number of patients who have undertaken the ACORN Toolkit and provides a clear overview of the clinical needs of patients for each practice. The individual practice report highlights that there is scope to implement extended recall intervals. It is recognised however, that more data over a longer period of time is required.

1.11 The HB is keen to expand the programme and has established two task and finish groups to discuss and explore the opportunities that the programme can support in relation to increasing 'high street' access, prevention, child access and to explore the possibilities of working collaboratively with Neighbourhood Care Network (NCN) colleagues by developing integrated clinical pathways.

1.12 The HB is in the early stages of discussing the development and/or how the following clinical pathways can be implemented: Cardiac, Diabetes, Stroke, Oncology and Dementia. It is envisaged that a suite of service level agreements will be developed which dental practices can choose to participate in, in conjunction with the themes identified by the NCN.

1.13 It is recognised that practices participating in the programme need approximately six months to embed ACORN Toolkit and a further 12/18 months to capture the majority of patients. The next phase of the programme with these practices needs to be established to ensure that the momentum and engagement continues.

1.14 The programme highlights the importance of utilising a multi-disciplinary skill mix within practice to deliver the programme effectively. There are challenges in relation to delivering this which includes, training programmes, time, capacity, space, funds and regulations.

1.15 Many smaller practices have expressed concerns that the programme delivery is more achievable for larger practices, in terms of working from bigger premises which helps when adapting their working requirements and skill mix. Some practices operate from converted houses or have limited scope to

expand and are therefore restricted when considering enhancing their skill mix/multi-disciplinary team. Consideration could be given to an Improvement Grant Scheme.

1.16 Introducing a new way of working has highlighted the disparity between dental practices with regard to their Units of Dental Activity (UDA) rate. Approximately 60% of contracts have a UDA rate which is less than the HB average of £26.00. The majority of these practices are situated in areas of highest patient need. The programme does not directly address this, however the HB is exploring ways how this can be addressed using contract reform as the vehicle.

1.17 There is potential that practices that underperform at year end may be more likely to take part in the programme as the percentage tolerance level is reduced. Whilst the HB works with practices to ensure contracted activity is achieved, where financial clawback is applied, the HB re-invests this within dental services.

2.0 How 'clawback money' from Health Boards is being used

2.1 In accordance with Paragraph 84 of the General/Personal Dental Services (G/PDS) Contract and guidance issued by the Welsh Government (WG) (NHS Dentistry *Revised guidance: primary care dental contracts - Advice on managing end of year issues*) the HB applies the agreed principles to all G/PDS contracts at year end.

2.1.1 Activity below 95% - there will be a financial claw back by the HB. Where a recurring underperformance has occurred below 95%, the HB will arrange to meet with Providers in order to negotiate a more manageable contract target. This may result in a contract reduction, which will be reinvested in areas of need.

2.1.2 Activity 95% to 100% - generally the HB will arrange to carry forward this under-performance against the following years contract ie the contracted UDA/Unit of Orthodontic Activity (UOA) level will increase with no corresponding increase to the financial value of the contract. However, where previous carry forward has been agreed and not met, the HB will arrange to meet with providers in order to make financial recovery or negotiate a manageable contract target.

2.1.3 Activity 100% to 105% - the HB will arrange to carry forward this over-performance to the following years contract ie the contracted activity will reduce with no corresponding decrease to the financial value of the contract.

2.1.4 Activity >105% - there will be no financial or UDA/UOA adjustment to the following years contract.

2.2 The HB monitors contracts and meets with providers regularly, especially where a potential underperformance is identified. The HB works with providers seeking a plan on how the activity can be achieved. The opportunity to temporarily reduce the UDA target is offered and assurance provided that if the target can be met the contract will be fully reinstated.

2.3 In the event that the provider in unable to meet the UDA target a more manageable target is agreed.

2.4 Where a financial clawback is agreed, the provider is advised that a repayment plan can be agreed where monthly installments are made.

2.5 The HB is committed to improving dental services and aims to invest any clawback monies into primary care dentistry.

Since 2014, the HB has significantly invested in the following areas:

2.6.1 'High Street' Access
2.6.2 Primary Care Minor Oral Surgery
2.6.3 Primary Care Orthodontic Service
2.6.4 Prison Dental Services
2.6.5 Urgent Access
2.6.6 Dental Domiciliary Service.
2.6.7 Procured dental/medical equipment.

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

3.1 Workforce data is currently collated as part of the annual contract review process. However a more robust process is required to inform succession planning, recruitment campaigns and to inform training needs/placements.

3.2 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 GDS performers. Further recruitment campaigns are required to help increase interest in dental students to remain Wales.

3.3 ABUHB has nine Dental Foundation Training practices. The HB is supportive of these practices and encourages other suitable practices to take part, not only to develop trainee dentists but to also help increase 'high street' access within the area. There has been a decrease in the number of Dental Foundation Training practices across the HB.

3.4 The Community Dental Service (CDS) experience difficulties in attracting suitable Specialists, particularly for Paediatric, Restorative and Special Care Dentistry. It is recognised that approximately 40% of the current CDS workforce will be retiring in the next 10 years. It has been highlighted that

there is reluctance from dental trainees to work in CDS premises due to the restrictions that they impose. This issue has been acknowledged by the HB and will form part of the Estates Strategy.

3.5 The CDS is looking to recruit a Specialist in Paediatric Dentistry in CDS to support GDS and training. It is envisaged that training opportunities can be identified for dental providers and performers to enhance their skills to qualify as a Dentist with an Enhanced Skill (DES).

3.6 The HB will support training for GDS practice nurses on how to apply fluoride varnish. The HB will support the possibility of incentivising practices to undertake the necessary training in order for skills to be enhanced and more preventative treatment to be undertaken on the population.

3.7 There are plans to fully utilise the CDS Dental Therapists to provide Direct Access employed by the Health Board to work with Flying Start and Health Visiting teams to identify children 0-5 years old who are not accessing general dental services. The therapists can undertake dental check-ups, provide preventative treatment and dental care for children under 5 years at the Flying Start hubs utilising the Designed to Smile (D2S) Mobile Dental Unit. In addition, the CDS Dental Therapist will sign post patients to their nearest dental practice to receive ongoing dental care.

3.8 The HB employs an Oral Health Improvement Practitioner (OHIP) to:

3.8.1 Provide oral health training to Domiciliary Dental Service (DDS) users and their carers (in line with guidance issued by British Society for Disability and Oral Health as recommended

3.8.2 Deliver fluoride based prevention to DDS users following the Delivering Better Oral Health Toolkit (DBOH)

3.8.3 Work with DDS users, their carers and the DDS providers to ensure planned care does not turn into unscheduled/unplanned care

3.9 The DDS provider refers patients to the OHIP to continue preventative oral health advice/treatment.

3.10 The HB is exploring the possibility of employing an OHIP to work with vulnerable children and adults – linked with NCNs, Care Navigators, Flying Start Teams and School Nurses to support children gaining access to local dental services, identifying children absent from school with dental problems as a priority. It is hoped that this will increase preventative treatment for children under 5 years.

3.11 As part of the GDS Quality and Patient Safety (QPS) group, the HB facilitates an annual Continued Professional Development programme for dental teams. Topics discussed are collaboratively agreed with members of the GDS QPS and Gwent LDC.

3.12 The HB has established an Integrated Oral Health Group (IOHG) which is chaired by the Associate Director for Integration and Innovation, which consists of HB officials and representation from Public Health Wales, LDC, Community Health Council and Health Education and Improvement Wales (HEIW). The HB has developed a good working relationship with the HEIW.

3.13 The Health Inspectorate Wales (HIW) inspect all dental practices. It would be useful for the training courses relating to these areas be available for dental teams to attend to help support practices when undergoing a HIW inspection.

4.0 The provision of orthodontic services

4.1 The HB commissions nine PDS Primary Care Orthodontic contracts and provides Secondary Care Orthodontic services from two Hospital sites.

4.2 The Primary Care Team (PCT) collate waiting time lists from all orthodontic providers on a quarterly basis and issue this information to all dental practitioners. Access across the HB ranges between 3 to 25 months from referral to assessment and 6 weeks to 24 months from assessment to treatment.

4.3 The HB has non-recurrently invested in to Primary Care Orthodontic Services which has significantly reduced the waiting lists as an additional 200 patients were able to receive treatment over a two year period.

4.4 Secondary Care Orthodontic access across the HB ranges between 14 weeks from referral to assessment and 54 weeks from assessment to treatment.

4.5 Since 2015 the HB monitors the Primary Care Orthodontic contracts against the Key Performance Indicators which is reviewed by the HBs Independent Dental Advisors and ratified by the Orthodontic Managed Clinical Network. This information is shared with all orthodontic providers.The Orthodontic Managed Clinical Network (OMCN) developed a transfer and appeals policy which the HB has adopted.

4.6 Between 2008-16, a review of orthodontics was undertaken and recommendations highlighted for HBs to consider. The nine contracts are due to expire on 31st March 2019. The PCT has reflected on the recommendations made within the report, worked collaboratively with other HBs and the OMCN to develop a service specification. A formal tender process will commence.

4.7 The HBs average UOA is £67. The HB will commission orthodontic services based on £56, in line with Betsi Cadwaladr University Health Board. The full primary care orthodontic budget will be committed and will increase access immediately. It is recognised that increasing routine child access may impact on the referral rate to orthodontics.

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

5.1 It is positive to report that Designed to Smile has reduced decay in 5 year olds by 14% as at the last 5 year old survey. The recent 12 year old survey has shown a steady decrease in decay but the HB has the highest number of untreated decay in comparison to other HB areas; 24%. In addition, the highest number of people accessing urgent dental care is 16-45year olds.

5.2 There is still further work to do in relation to oral health improvement in children as identified in the recent publication of the Dental Epidemiological Survey of 12 Year Olds 2016/17. This will be discussed at the Oral Health Promotion Steering Group (OHPSG) and Integrated Oral Health Group (IOHG). The CDS is undertaking the Dental Epidemiological Survey of 18-25 Year Olds.

5.3 The PCT and D2S Team have worked collaboratively to develop a 'child referral pathway' in order for more children to access dental services with local general dental practitioners. 7 practices within the HB area now receive direct referrals from the D2S Team which may be instigated by Health Visiting, Flying Start and/or D2S Teams. Children are given a unique patient code on referral in order to be tracked through the system in case they 'did not attend' appointments. The aim of this pathway is to allow as many children as possible to access mainstream dental services.

5.4 The HB purchased 80 Hall Crown Kits and will be providing training to all practices via the CDS Dental Therapists in 2018/19 where a kit will be provided to a practice.

5.5 The CDS Team is training in 'Making Every Contact Count' (MECC). This training needs to be tailored and rolled out to all GDS providers.

5.6 The HB is working collaboratively with the OHPSG and local authority colleagues to support the healthy schools campaign, in order to help raise awareness of oral health issues and prevention.

5.7 The HB continues to promote the DBOH toolkit, at every opportunity with GDPs. GDS practices looking to develop preventive models should be given evidence based Oral Health Improvement Programmes.

5.8 The HB has contributed to the 111 Dental Programme to agree principles for what is deemed an appropriate length of time for a child to access routine, urgent or emergency dental treatment.

5.9 The CDS has raised concerns in relation to the possible introduction of patient charges for CDS vulnerable adults and the negative affect this may have.

General Dental Council response to a call for evidence by the National Assembly for Wales' Health, Social Care and Sport Committee on dentistry in Wales

Introduction

1. The General Dental Council (GDC) is pleased to have the opportunity to provide its views to the one-day inquiry by the Health, Social Care and Sport Committee of the National Assembly for Wales.

2. The GDC has noted the terms of reference of the inquiry, and this response is confined to those matters falling within the ambit of the GDC's powers. To this end, this response concerned with the issue of the training, recruitment and retention of dentists in Wales.

Background

3. The National Oral Health Plan for Wales 2013-18[1] was published in March 2013. Amongst other things, the plan noted that:

- Access to dentists was highly variable depending on area
- There was a critical need to keep dental services affordable
- There was considerable variability in access to specialist services in both primary and secondary care
- There needed to be monitoring of the dental workforce by each Health Board, to map current and assess future need
- Recent regulatory changes introduced by the GDC had supported the increased scope for a greater skill mix within the dental team

4. The Plan described a course of action to address the points above; as far as the monitoring of the dental workforce was concerned, the Plan set out that:

Each Health Board should monitor its dental workforce in relation to current and future needs. There has been a major expansion in the training of dental care professionals which, together with the regulatory changes undertaken by the GDC, have greatly increased the scope for skill mix within the dental team. Health Boards need to have regard to succession planning; skill mix reviews; education and training; recruitment and retention; CPD; and career development. Clearly, local planning of dental services allows the NHS to develop the most appropriate services and target resources to where they are most needed. Currently available data in relation to the dental workforce in Wales is variable, and there is a need to improve the quality of the information available.

Current position

[1] https://gov.wales/docs/phhs/publications/130318oralhealthplanen.pdf

5. In a recent document (March 2017) outlining priorities for dentistry and a future work (Taking Oral Health Improvement and Dental Services Forward in Wales)[2], it was noted that there had been an improvement in oral health in Wales but that access to dental services remained highly variable. In addition, it noted that recruitment and procurement to attract more dentists is also challenging in some areas.

6. Specific and comprehensive information relating to a registrant's role or type of employment is not routinely collected or held by the GDC. Registrants who are subject to fitness to practise proceedings do provide information about their place of work. However, information about how the majority of registrants are employed is not held, and where this data does exist we cannot guarantee that it is current. Nevertheless, we understand from informal discussions that access to dental services in Wales remains variable, particularly in rural areas.

7. There have been no significant developments relating to the training of dentists in the last five years. However, in keeping with steps taken to modernise regulation of dentists, there has been a reform of the way that Continuing Professional Development is deployed to support the maintenance and development of professional knowledge, skills and insights in dentists. A revised Continuing Professional Development system for dentists commenced on 1 January 2018.

8. There is a well-established dental school in Cardiff, which typically produces 70 – 75 qualified dentists each year who then move to training posts. The number of dentists trained in Wales and funding for training is determined annually by Welsh Government. However, the GDC is not required for delivery of its statutory functions to monitor how many graduates remain in Wales, nor whether they remain the primary or secondary care sector nor the extent to which they undertake private practice. Instead, we understand that a more accurate picture is likely to be available through the commissioning arrangements for dental services, in which the Health Boards have a keen interest.

9. In view of the fact that the Welsh language is used on a day-to-day basis in many parts of North and West Wales, we consider that it would be helpful if there were initiatives to incentivise and attract suitable potential Welsh speaking undergraduates from these areas to train at Cardiff Dental School and then for graduates to receive further incentives to return to these areas to practise.

10. We have noted that a clear exposition of the benefits of improved access to a more flexible dental workforce in Wales is set out in "Taking oral health improvement and dental services forward in Wales"[3]. The approach described supports enhanced clinical dental practice and a greater focus improving clinical effectiveness and patient outcomes, together with the use of the whole dental team to drive forward oral health improvement throughout the whole life course by generating and communicating clear messages on prevention, all with the intention of decreasing the future demand for services.

[2] https://gov.wales/docs/phhs/publications/170815oralhealthen.pdf
[3] https://gov.wales/docs/phhs/publications/170815oralhealthen.pdf

11. We understand that there are plans to increase the training capacity for dental care professionals in Wales. We recognise that this will provide greater opportunity in due course to enhance the flexibility of working within dental teams in Wales, creating more scope for qualified dentists to focus on providing services that only they are legally permitted to carry out.

Overall Conclusion

12. The GDC recognises the clear benefits that arise from the publication of a clear strategic direction for oral health for the population in Wales, which includes planning for the provision of dental services and an explanation of the workforce that is needed to deliver this. We also believe that the regular reporting of progress in implementing the strategy assists everyone in assessing the relative priorities (and making suitable judgements about resource use) and in evaluating the successful outcomes as well as areas where continuing intervention is still needed.

13. We note that the Chief Dental Officer in Wales has taken a clear lead in communicating (in Welsh Health Circular WHC (2018) 019 – Getting the balance right in Wales) arrangements for the effective and proportionate investigation of complaints against dentists who practise in Wales. This sets out the model by which the public, the dental profession, health boards and the GDC will have confidence that dental performance which causes concern can be identified promptly and dealt with proportionately to protect patients and support GDC registrants. This resonates strongly with a programme for right touch regulation being developed within the GDC and will led to much greater clarity for patients and the public in general.

14. We intend to continue to work closely with the Welsh Government as we develop our programme to reform and modernise the system of regulation for the dental team. We have noted that there has already been highly constructive response to our consultations (both formal and informal) and we value the insights and experience that colleagues in Wales can bring to how any new arrangements will evolve. In particular, we will continue to make a collective assessment of the impact of the outcome of negotiations associated with the UK's exit from the European Union and the current and future impact on the provision of preventative and dental treatment services not just in Wales but more widely in the UK.

General Dental Council
London
August 2018

D11
Ymchwiliad i Ddeintyddiaeth yng Nghymru / Inquiry into Dentistry in Wales
Ymateb gan Bwyllgor Orthodontig Lleol De-ddwyrain Cymru a Rhwydwaith Clinigol Orthodontig a Reolir De-ddwyrain Cymru
Response from South East Wales Local Orthodontic Committee and South East Wales Orthodontic Managed Clinical Network

Health, Social Care and Sport Committee

CONSULTATION: Inquiry into dentistry in Wales

Response by the South East Wales Local Orthodontic Committee and South East Wales Orthodontic Managed Clinical Network

Terms of reference

- Provide information relating to the progress made to improve the efficiency and effectiveness of the orthodontic services delivered in Wales, with reference to recommendations made in the reports by:
    - Health, Wellbeing & Local Government Committee 2011.
    - Prof Stephen Richmond in 2016
- Training, recruitment and retention of orthodontic workforce
- Waiting times for appointments and treatment.

Orthodontics has been thoroughly scrutinised in 2 previous Welsh Assembly Government inquiries

Health, Wellbeing & Local Government Committee
Inquiry: Orthodontic Services in Wales 2011

The Committee made 17 recommendations related to the Welsh Assembly Government (WAG), Local Health Boards (LHB), Managed Clinical Networks (MCN) and the General Dental Council (GDC).
All the recommendations within the compass of the LHBs and MCNs have been acted on and most related to WAG.
Following on from this report:

- MCNs already in a fledgling stage were established across Wales providing a forum for clinicians and LHBs
- Establishment of the Strategic Advice Forum for Orthodontics (SAFO) in 2012 providing advice from the MCNs to the Chief Dental Officer and establishing a uniform approach to orthodontics across Wales.
- As a result WAG guidance issued to LHBs re contracting
- Assess and repeated review stopped
- Small orthodontic contracts progressively eliminated by LHBs
- Dentist with a special interest (DwSI) accreditation introduced resulting in accredited and monitored Dentists with enhanced skills (DwES) and the elimination of a number of inappropriate contracts
- Arrangements set in place for on-going outcome monitoring through the MCNs and LHBs
- Establishment of common referral forms for each of the three MCN areas. These forms being amalgamated to provide the basis of an all Wales form for the Electronic Referral Management System (eRMS)

Recommendations not progressed:

- Those recommendations involving additional funding
- Those matters relating to the GDC
- Penalties against persistent poor referrers

Health & Social Care Committee
Inquiry: Orthodontic Services in Wales 2014

The Committee made 6 recommendations essentially confirming previous recommendations and reinforcing those related to commissioning.
Following on from this report:

- After a robust procurement process, led by the NHS Wales Informatics Service, FDS Consultants have been awarded the contract to provide eRMS. Phase 1 will be working in SW Wales imminently and introduced across Wales in early 2019
- It is hoped that waiting list management and patterns of inappropriate referrals will be facilitated by the introduction of eRMS
- Major recommissioning exercises have taken place in North Wales, are ongoing in South East Wales and are due in South West Wales.

Stephen Richmond Orthodontic Report 14th December 2016

It should be noted that a number of statements in this report are not accepted by the majority of clinicians who did not have the opportunity to comment or offer insight on the conclusions that were reached, based purely on data, until after its publication

L. Conclusions
• "There has been a substantial reduction of performers from 133 to 82 in Wales (2008-09 to 2015-16). There should be further consolidation in Betsi Cadwaladr, Abertawe Bro Morgannwg and Cardiff and Vale UHBs to improve efficiencies."
"The inefficiencies in Cardiff and Vales UHB may be due to too many performers that may be attracting referrals that are inappropriate to fulfil their contracts."

The calculations leading to these statements may not have recognised that the practices in Cardiff and Vale undertake treatment for the majority of Cwm Taf UHB patients.
A recent survey of waiting lists in the C&V specialist practices revealed

- *New patients: 8224*
- *Patients seen, assessed and on review waiting to start treatment: 1832*

This does not suggest "too many performers"

• "A small survey of 26 performers in South East Wales using the Index of Orthodontic Treatment Need suggests that 4% of orthodontic treatment undertaken does not meet the mandatory entry requirement. The outcome of orthodontic treatment is reported to be over 80% reduction in PAR score (a good outcome of orthodontic treatment). The level of unnecessary orthodontic treatment as well as the quality of orthodontic treatment should be recorded for all performers in Wales"

The complete results for this survey, that was an MScD research project (and set against standards previously established by Prof Richmond) were:

- *80.5% reduction in PAR v >70% standard*

- *50.5% greatly improved v >40% standard*
- *1.2 % worse/no different v <5% standard*

It is agreed that 4% of treated patients being below the cut off point for NHS treatment is not acceptable. The current cut off is IOTN 3 with an aesthetic component (AC) of 6 or higher. The aesthetic index is relatively subjective and a clearer cut off of IOTN 4 might be appropriate.
In an audit undertaken by SE Wales LOC in 2011 only 24 out of 617 new patients were in the category IOTN 3 with AC 6-9.

- "There are still a large number of "Assess and review" contracts which appear to have little value and should cease."

Agreed and this is already the situation in SE Wales MCN

M. Recommendations
Welsh Government
• "The Welsh Government in association with the various dental authorities and the Orthodontic Strategic Advisory Forum should lay out a clear strategy for orthodontics in Wales for the next 5 years."
Areas covered: Skill mix, delivery setting, access, contracting, communication and data management.

All these matters are generally in hand through SAFO.
It should be noted that if significant changes are to be made to skill mix (especially a move to a therapist based model) significant investment will be required to alter the premises of many practices. This cannot be done while only having short term contracts. Personnel changes should ideally be made through natural wastage or would otherwise have to be made through redundancies amongst highly trained specialists. Ideally, therefore, Health Boards should be looking at 10 year contracts but with a clear understanding of the pattern of practice at the end of that period.

Health Boards
• Orthodontic contracts should be based on "Assess and accept" only.
• The practice of "Assess and review" should cease unless there is a clear indication.
• Ensure that there are contracts that reflect population provision in each Unitary authority and cross border flows are fully accounted for with robust pre-determined contracts.
• The Health Boards should monitor the performers according to key performance indicators, specifically the number of patient receiving active orthodontic treatment and whether these patients fulfil the orthodontic entry requirements as well as assess the outcome of treatments assessed by the PAR Index.
• The number of Performers in each Health Board should match the likely need of the local population (as close as possible to expected numbers) and/or needs of the population in nearby Unitary authorities in other Health Boards.
• The data obtained relating to orthodontic treatment in the GDS/PDS is improving. More resources should be allocated to document orthodontic provision in other settings.

All these matters are generally in place within SE Wales MCN area.
Hospital patient management systems are generally not up to the task and require investment

Orthodontic providers/performers

• Performers should routinely accept patients above the orthodontic treatment threshold and deliver average treatment outcomes consistent with 70% reduction in PAR scores.
Agreed

• Waiting list data (specifically date of birth, post code and date placed on waiting list) should be routinely collected and reported annually to the Health Boards.
eRMS will facilitate this

• Re-treatments should be undertaken through the private sector.
Agreed for patients who have allowed their result to relapse.
There are, however, a small cohort of patients who have had poor treatment, been unlucky with adverse growth etc. and have a legitimate call on re-treatment. These cases have to be assessed on a case by case basis and cannot be subjected to a blanket ban on access to NHS services.

Training, recruitment and retention of orthodontic workforce

This is a national rather than specific SE Wales issue.
National recruitment in orthodontics has led to the appointment of excellent trainees but not necessarily those with a commitment to a future in Wales.
The cost of training in Cardiff is also becoming an issue taking into account the Specialist Registrar (StR) salary structure in England v Wales, and the fact that Cardiff University has the highest training fees in the UK, the overall loss in "net income" for a trainee in Wales could be as much as £23k/annum for each of the three years of their training when compared to the cheapest training programme in England and is about £12k even compared to training in London.
This effect becomes exaggerated for those trainees going on to consultant training that involves a minimum of two further years at FTTA grade. Recruitment at this level is difficult across the UK.
There will be at least two consultant retirements in SE Wales in the next two years with real concern re recruitment.

Waiting times for appointments and treatment

Waiting lists are approached differently in Specialist Practice and Hospital settings

Specialist Practice. Hold long new patient waiting lists but when seen patients, if ready, normally start treatment within a few weeks. This does create some uncertainty regarding the resource implications of these waiting lists. An audit of 719 new patients undertaken by SE Wales LOC in 2015 following the introduction of the common referral form showed:

- 8% of referrals were inappropriate
- 10% of referred patients were below the NHS cut off of IOTN 3.6

Current Specialist Practice waiting lists for SE Wales MCN area:

- New patients: 10,868 Waiting time 6 – 30 months
- Patients seen, and on treatment W/L or pre-treatment review: 2,521

Hospital Units. Have short new patient waiting lists as a significant part of their role is advisory to GDPs, Specialists and other medical and dental specialities. Other than their teaching role treatment is normally only offered to patients requiring complex, usually multidisciplinary, management. These treatment waiting lists, for patients with the highest treatment need, are generally long due to inadequate treatment resources.

Current Hospital waiting lists for SE Wales MCN area:

- New patients: 485 Waiting time 12 – 26 weeks
- Patients seen, assessed and on treatment W/L, or pre-treatment review, or awaiting multidisciplinary clinic appointments: 1573
  Waiting time 30 – 43 months

Community Dental Service (CDS). Provide specialist level care for those patients who would otherwise have difficulty accessing specialist services.

Current CDS waiting lists for SE Wales MCN area:

- New patients: 120 Waiting time 4 months
- Patients seen, assessed and on review waiting to start treatment: 49
- Treatment waiting lists: 152 Waiting time 6 – 15 months

Summary:

- The orthodontic speciality – through involvement and cooperation of both clinicians and health boards – has taken on board the recommendations from previous inquiries and can be seen as an example of good practice for other specialities
- Orthodontics is the only dental speciality that has
  1. National agreed objective measure of treatment need and clear guidelines regarding patients eligible for NHS treatment
  2. Internationally accepted objective measure of treatment outcome and quality along with established monitoring arrangements
- Despite this there are long waiting lists across all sectors
- The bottleneck for waiting lists is not new patient waiting list management but in treatment capacity across all sectors

Peter Nicholson
Chair South East Wales Local Orthodontic Committee
on behalf of South East Wales Orthodontic Managed Clinical Network

Faculty of Dental Surgery at the Royal College of Surgeons

Written evidence to Health, Social Care and Sport Committee inquiry into 'Dentistry in Wales'

Summary

1. There have been significant improvements in children's oral health in Wales in recent years. The Designed to Smile scheme has played an important role in this, and we view the initiative as an exemplar in oral health prevention programmes.

2. The Welsh Government have announced plans to refocus Designed to Smile, and we are very supportive of proposals to increase the programme's engagement with hard-to-reach groups. However, it is important to recognise that there may be pockets of need amongst older cohorts, such as late teenagers, as well as very young children – Designed to Smile should ultimately seek to expand its reach amongst older age groups where the level of need justifies this.

3. In addition, the impact that Designed to Smile has had in embedding supervised tooth brushing in schools is one of the programme's central achievements, and something we believe should continue even after its resources are refocused onto 0-5 year olds. Health Boards have a key role to play in this through their oral health strategies, and we would urge them to ensure sufficient funding is available to enable schools to maintain this vital work.

4. Access to specialist paediatric dental care has historically been a challenge in Wales, with both community and hospital-based services under pressure. We welcome the Welsh Government's announcement of additional investment to improve this situation, but it is essential that this now delivers improved outcomes for children across all Health Boards. There is also a need to improve access to other dental specialisms, such as restorative dentistry and oral medicine.

5. In terms of the dental workforce, there is a risk that Wales may struggle to recruit good quality candidates for dental roles due to higher rates of pay in England. This is an issue that will need to be addressed as Wales looks to build a sustainable dental workforce for the future.

Introduction

6. The Faculty of Dental Surgery at the Royal College of Surgeons welcomes the opportunity to contribute evidence to the National Assembly of Wales' Health, Social Care and Sport Committee inquiry into 'Dentistry in Wales'. The Faculty is a professional body committed to enabling dental surgeons to achieve and maintain excellence in practice and patient care. We represent over 5,500 specialist dentists across the United Kingdom, around 130 of whom are based in Wales. The majority of our members provide patient care in primary, secondary or community care settings, or hold key public health roles.

7. The Faculty has been campaigning about the need to tackle child tooth decay for a number of years. While our main focus to date has been on England we retain a strong interest in developments in Wales, particularly given the significant improvements in standards of children's oral health that have been achieved in recent years, which have been attributed to the impact of the 'Designed to Smile' scheme. We have therefore focused our submission primarily on the fifth strand of the Committee's inquiry, on 'the effectiveness of local and national oral health improvement programmes for children and young people'. In addition, we have also made some comments on the availability of specialist paediatric dental care in Wales, as well as briefly discussing wider issues around the Welsh dental workforce and the introduction of the new e-referrals system.

Children's oral health in Wales

8. The Faculty welcomes the major improvements in children's oral health that have been achieved in Wales over the course of the last decade. In its recent *Picture of Oral Health 2018* report, Public Health Wales highlighted that the proportion of 12 year olds with experience of tooth decay has fallen from 45.1% in 2004-05 to 29.6% in 2016-17, with statistically significant declines reported across all seven Welsh Health Boards, demonstrating that significant progress has been made.[1] It should also be noted that this compares favourably with England, where the most recent Child Dental Health Survey indicates that 32% of 12 year olds had some obvious decay experience.[2]

9. There has been a declining trend in dental procedures carried out on children under general anaesthetic (GA) in Wales. Figures from Public Health Wales indicate that 7,340 GA dental procedures were carried out on children aged 0-17 in 2016-17 (equivalent to 1.09% of the under-18 population, or one in every 92 children). This is a fall of 21% from 9,306 such procedures in 2011-12, although it should be noted that a number of factors are thought to be involved in this. As Public Health Wales suggest, some of this reduction 'may reflect availability of GA sessions and longer waiting times and may not be associated with a reduction in need', and that that the availability of specialist paediatric dental services and conscious sedation services will also have an impact.[3]

Designed to Smile

10. The Cabinet Secretary for Health and Social Services, Vaughan Gething, has said the Welsh Government's investment in Designed to Smile and access to preventative dental services has been key to the improvements in children's oral health seen in Wales.[4] The Faculty views the Designed to Smile scheme as an exemplar in oral health prevention programmes, demonstrating that with the right approach it is possible to make significant progress in tackling child tooth decay.

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[1] Public Health Wales (2018) *Picture of Oral Health 2018: Dental Epidemiological Survey of 12 Year Olds 2016-17*, p. 4-5

[2] Health and Social Care Information Centre (2015) *Children's Dental Health Survey 2013 – Country specific report: England*, p. 6

[3] Public Health Wales (2018) *Child General Dental Anaesthetics in Wales*, p. 8

[4] Welsh Government, *Press Release: Health Secretary welcomes reduction in child tooth decay* (19 June 2018)

11. Last year's *Taking Oral Health Improvement and Dental Services Forward in Wales* framework document, published by the Welsh Government, set out plans to refocus the Designed to Smile scheme and place more emphasis on support for hard-to-reach groups. The Faculty strongly supports the proposals that included expanding the programme's engagement with general dental practice teams and other health and social care professionals to improve reach amongst those groups at greatest risk of experiencing decay:

As disease levels fall, experience of decay becomes more polarised into 'pockets' of severity so that targeting at community/school level becomes more difficult and disease experience for high risk children can be masked by reporting of average/mean levels. Dental practice teams will be supported to identify children at risk and be up-skilled to link with other health and care professionals to provide preventive care and establish a pattern of attendance for these children. D2S [Designed to Smile] teams and resources can be directed to support this as appropriate. The reduced input to older age group children will free up D2S team time to engage with general dental practice teams and other health and social care professionals.[5]

12. The Faculty recognises the challenges associated with the increasing 'polarisation' of need. In an English context, this is something we have seen evidence of with respect to the oral health of five year olds. Recently published data has shown that although the proportion of children in this age group with tooth decay has fallen consistently across the country as a whole over the last decade, bringing the average reported figure down, levels of tooth decay are now actually increasing in areas where the problem was already prevalent (such as North West England, the West Midlands and Yorkshire and The Humber). We are therefore seeing widening inequalities in children's oral health in England, even as the overall picture improves.[6]

13. We can therefore understand the rationale behind the refocus of Designed to Smile in seeking to address similar trends in Wales. The framework also sets out that as part of this, given the importance of the earliest years of life in establishing good oral health habits, the programme's resources will be increasingly targeted at 0-5 year olds with direct provision for children aged 6 and over being stepped down.

14. However, we are concerned that there may be particular 'pockets' of severity amongst older children as well, with late teenagers being one example. Consideration should therefore be given to whether a refocused Designed to Smile scheme should ultimately expand its engagement with hard-to-reach groups to encompass older cohorts as well as very young children, where the level of need justifies this.

15. In addition, the Faculty views the impact that Designed to Smile has had in embedding supervised tooth brushing within schools as a key part of its legacy to date, and are keen to see the momentum built up through Designed to Smile's work with children aged 6 and over to be maintained. We therefore welcome the commitment in the framework document that those schools that want to continue daily tooth brushing for

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[5] Welsh Government (2017) *Taking Oral Health Improvement and Dental Services Forward in Wales: A Framework outlining priorities for dentistry and a future work programme*, p. 6-7

[6] Public Health England (2018) *Oral Health Survey of Five Year Old Children 2017*; Royal College of Surgeons of England, *Press Release: Tooth decay in 5-year-olds now increasing in some parts of England* (15 May 2018)

this group will be supported to do so through Health Boards' oral health strategies, and also would urge Health Boards to ensure that sufficient funding is available to enable this.

Specialist Paediatric Dental Care in Wales

16. Separately, the Faculty is also keen to emphasise the importance of ensuring that children can access specialist paediatric dental care when they need it, an issue that has recently been made a priority for investment in Wales. Last year the Welsh Government announced additional funding for specialist paediatric dental services, and that new specialists and consultants will work closely with existing community and hospital-based services to improve the availability of specialist paediatric dental care. It was suggested this would enable an additional 3,000 patients per year to access specialist treatment, and help to reduce hospital waiting times.[7]

17. The Welsh Government's focus on this issue is very welcome, but it is important that this ultimately delivers improved outcomes. A lack of specialist and consultant paediatric dentists has meant that access to such services in the community has historically been a challenge in Wales, and anecdotally we have also been told that hospital-based services often find their capacity under strain. As noted in paragraph 4, Public Health Wales have suggested that limited availability of specialist paediatric dental services may be contributing factors to the fall in GA dental procedures in recent years, rather than just reductions in the actual level of need. In this context, it is essential to ensure that the additional investment committed in this area is built on successfully, and that it delivers improved access to specialist services for children across all Health Boards.

18. More broadly, we also feel it is important to note that action is required to improve access to other specialist dental services throughout Wales, particularly in the case of specialisms such as restorative dentistry and oral medicine.

Other issues

19. In terms of the dental workforce in Wales, one issue that has affected recruitment and retention is the differential in payscales between Wales and England. This is particularly an issue for junior dentists such as dental foundation trainees and dental core trainees, and creates a risk that Wales may fail to attract good quality candidates for dentistry roles due to higher pay levels in England. This is something that will need to be addressed as Wales looks to develop a sustainable workforce for the future.

20. Lastly, the Faculty welcomes plans to introduce an e-referral system in Wales, which is discussed in *Taking Oral Health Improvement and Dental Services Forward in Wales*.[8] We believe this has the potential to make a significant difference to the delivery of oral health care, and will prospectively improve the quality of referrals from primary to secondary care.

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[7] Welsh Government, *Press Release: 10,000 new NHS dental places to be created in Wales* (8 August 2017)

[8] Welsh Government (2017) *Taking Oral Health Improvement and Dental Services Forward in Wales: A Framework outlining priorities for dentistry and a future work programme*, p. 14-17

[redacted]

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Morgannwg
Local Dental Committee
www.morgannwgldc.org.uk

Morgannwg LDC response to enquiry by Cross Party Health, Social Care and Sport Committee on Dentistry in Wales

Morgannwg Local Dental Committee is the Statutory Committee
that represents the interests of GDS / PDS Providers and Performers
to the Abertawe Bro Morgannwg University Health Board,
in line with Welsh Statutory Instrument 2010 No. 2846 (W.234)

1. Scrutinise the Welsh Government's Contract Reform

a. The dental profession both generally and locally felt that the last General Dental Services (GDS) contract reform introduced in 2006 was not a success, both for certain groups of patients and for dentists. The general idea of the current contract reform was welcomed and supported.
GDS dentists had, since the inception of the NHS general dental services, been accustomed to being paid on a fee per item of service basis, where each item of service was paid for on an agreed scale of fees, reviewed annually, with non-exempt patients paying an agreed proportion of gross fees up to a maximum contribution which was centrally set. Various exemptions from payment were in place in general based on ability to pay and age. There were indeed problems with this; for the government there could be no limit on the amount spent on NHS General Dental Services, for the patient in many cases the patient payments were difficult to understand. As far as dentists were concerned many fees were too low, there was no fee for any preventive work, the system rewarded intervention but the contract was workable and generally successful. Superannuation was easy to track and centrally administered for each individual dentist. Payment was made monthly based on claims submitted and if claims were mistakenly made improperly then they were returned to the dentist for correction with an explanation why. Gross fees paid (including patents' charges) paid for all practice expenses and dentist income.

b. The 2006 contract (the current contract) is a fixed price contract, where regular payments of 1/12 annual contract value are made every month to cover income and expenses, and performance targets are expected to be met to avoid clawback. Patients charges based on claims submitted are retained by the practice and subtracted from the monthly payment of gross fees. The contract was introduced in April 2006, in a hurry, without piloting, without training of NHS staff and without training of dentists and their staff in aspects of administration of the contract. This lack of training resulted in much confusion relating to submission of claims, and consequent interventions from NHS staff, some necessary and some unnecessary. As mentioned previously the contract was for a fixed annual gross income for which a fixed amount of activity was expected in order to avoid clawback. Banded courses of treatment were introduced, each carrying a set number of Units of Dental Activity (UDAs). Patient charges were based on the band of treatment delivered. From a dentist point of view, there was a general feeling that certain items were going to be difficult to provide without considerable financial loss e.g. complex

treatments involving crowns, bridges, certain types of dentures, high needs patients which sometimes demanded a considerable number of visits to complete a course of treatment, other complex treatment such as surgical removal of teeth, complex molar endodontics and advanced periodontal therapy treatment. The contract incentivises simple treatments (e.g. extractions) over the provision of more complex treatments (e.g. molar endodontics) which require more time and visits for the same fee. Furthermore, the same fee was payable for the provision of one crown and for three crowns, yet the laboratory bill for the three crowns was three times that for one crown: also, the surgery time is considerably more. In addition to this, increasing costs of practice management because of continually increasing regulation were not factored into a fixed price contract at its inception and had to be absorbed by the dental practice. As with the previous contract there was little reward for prevention and again the contract rewarded intervention. The regulations also removed practices' ability to charge for frequent missed appointments by patients, thereby increasing the likelihood of not being able to hit contract targets and thus increasing the risk to the practice of clawback which is unable to be compensated for.

c. The method of calculating contract value and number of UDAs required to meet the target was unclear at the outset and the method used to calculate all this and ultimately the UDA value left different UDA values for each practice, varying from less than £20 to almost £40. This meant that some practices would be paid £20 for a Band 1 treatment whilst others were paid £40 with other practices any amount in between, Band 2 treatments varied between £60 and £120 and Band 3 treatments between £240 and £480. This caused considerable discontent in and amongst the practices as can be imagined. It also affected ability to pay associate dentists, the higher paid practices having a distinct advantage over their lower paid colleagues

d. The idea of reform of this contract was welcomed by the profession provided it was to be piloted over a suitable period of time and be properly evaluated. Welsh Government has been developing a new dental contract since 2010 following a report of a Task and Finish Group. In 2011 eight practices in Wales took part in the initial pilots, and then in early 2016 2 practices in ABMU moved to trial a more advanced prototype. There was a shift in emphasis from treatment to prevention, using the whole practice skill mix in delivering care and giving patients more responsibility for improving and maintaining their oral health. One of the worries of LHBs with implementing these reforms was the potential loss of patient charge revenue (PCR), and although initially there were reductions in theoretical UDA claims, on which patient charges are based, latterly one of the practices reports that it is now up to 70% of the theoretical measurable outcomes. The other is similar although the prototype is more child based and therefore much less PCR is expected.

e. The Chief Dental Officer (CDO) has subsequently introduced a piloted reform programme in line with one of the three priorities contained in the framework of priorities published by WG in March 2017, Taking Oral Health Improvement and Dental Services forward in Wales. In this, practices experience a 10% reduction in their contracted UDAs for the same contract value in order that they submit clinical profiles on all patients assessed and treated. If the percentage is gradually increased then there would be more scope for practices to treat the patients and items mentioned previously that practices find difficult to provide because of financial restrictions, high needs patients, more expensive (time consuming) treatments such as molar endodontics and minor oral surgery.

f. Morgannwg LDC fully supports the further development of this project, and the development of a preventive based rather than intervention-based model of dental care in general dental practice. It is clear that some part of contracts will remain UDA based and consideration needs to be given for further Bands of treatment to be introduced which will encourage colleagues to see the high needs patients, difficult minor oral surgery, molar endodontics and multiple provisions of laboratory products. It will require some thinking outside the box in terms of contract monitoring but this must be achievable with close collaboration between the profession and the Health

Boards and WG. Colleagues would also find it useful if an agreed document on 'claiming regulations' could be introduced as long as UDAs are retained, this would help to eliminate the many 'grey areas' of the claiming regulations.

2. How 'Clawback Money' from the Health Boards is being used.

a. Morgannwg LDC is only able to speak with any authority on clawback money in ABMUHB.

b. Since 2016/2017 ABMUHB has fully collaborated with Morgannwg LDC on the use of ring fenced dental funds and developed a three-year plan ending in the investment of the whole of the dental allocation being invested in oral health care by 2020/21.

c. Prior to this it was agreed that all commissioning of dental activity should be made through a formal procurement process with LDC involvement. This involvement is in line with the document WSI 2010 No. 2846 (W.234) previously mentioned.

d. In September 2017 a plan was agreed which included a range of service and financial initiatives to achieve a series of formal strategic objectives:

- Improve the Oral Health of vulnerable groups, e.g. children, adults in care homes,
- Improve equity of access to general dentistry
- Reduce variation in dental pathways
- Improve access to special care dentistry
- Reduce Referral to Treatment times in restorative dentistry
- Improve governance and leadership
- Improve compliance with key legislation

e. Through a mixture of schemes, the service made significant progress to make a range of improvements against objectives that had been prioritised for years 1 and 2:

- Increased UDA value to £25 for those practices (43) who agreed to a range of quality initiatives, including taking on new patients, including direct referrals from Health Visitors and Designed to Smile, participation in contract reform programme, computerization.
- Commissioned additional GDS activity in 7 practices in high need areas (30,000 UDAs) including re-opened, expanded practice in Afan Valley and new practice in Port Talbot in 2018/19
- Halved children-only contracts, rewarding practitioners who 'converted' to full range of patients with a higher UDA rate
- Introduced Referral Management Centre [RMC] and new paediatric pathway to support referrals for treatment under a General Anaesthetic [GA]; savings from GA contract being reinvested in building alternative pathway, including RMC administrative and clinical staff in Community Dental Service
- Transferred resources to the Community Dental Service recognizing its contribution to providing domiciliary dental services in Bridgend county (only) and to support the new paediatric pathway
- Enhanced Clinical leadership and management at Port Talbot Resource Centre, investing in additional Dental Practitioner sessions, Clinical Leadership roles in Community and Restorative Dentistry and primary care management support.
- Supported practices to comply with the Equality Act through award of improvement grants to introduce hearing loops, disabled access, commissioned bariatric waiting and toilet facilities to support Dental Training Unit and CDS patients in Port Talbot Resource Centre.

f. The LDC is happy that it is now being fully consulted on use of GDS ring fenced funds, including the use of clawback monies. It will of course, continually monitor the situation.

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

a. One of the reasons that the Dental School in Cardiff was set up was to increase the Welsh dental workforce, which it appeared to have done successfully in the initial graduate years from 1967 onwards. The 2012 workforce survey says that *'Welsh trained dentists account for 41% of the dentists currently working in Wales'*. Surely it is not beyond the realms of possibility for some preference to be given to Welsh domiciled students because of the likelihood that they will stay in Wales to work following graduation, but it is a politician's call.

b. In the 2012 workforce review it stated that '*On average during the period 2007-2010, 58% of Welsh-trained dental graduates entered the Welsh workforce after completing DF1.* ***Undertaking DF1 training in Wales is a significant factor in the decision to continue working in Wales****. Of these, 90% undertook DF1 training in Wales and 10% undertook it elsewhere before returning to work in Wales'.*

c. The Welsh Government funds DF training in Wales on a matched basis, but Wales is now part of a national (England and Wales) recruitment programme. It is difficult to obtain figures for the recent proportion of Cardiff trained graduates doing DFT in Wales. Anecdotal evidence suggests that English trained undergraduates come to Wales to do their DFT and then return to England to further their careers.

d. The Dental Training Unit at Port Talbot Resource Centre has trained 35 dentists since 2010. Only 9 (28%) are still working in the ABMU area, 2 of these in the CDS.

e. There are 13 other training practices in ABMU. Many of these would want to keep on trainees as associates but the contract does not allow this, additional UDAs being needed to employ an associate. There is also the surgery cost and extra staff costs. We are trying to establish figures for these issues at the moment and will continue to do so. Not all practices have the facilities to retain a DFT as an associate, without giving up their status as a training practice.

f. Morgannwg LDC believes that consideration should be given to giving priority for Welsh domiciled potential dental undergraduates (including Welsh speakers) to train in Wales, and once qualified to pursue their DFT in Wales. We do not suggest solutions to this at this stage, nor how this should be achieved, but will be willing to contribute to any discussions relating to this. Perhaps discussions of a new dental school in North Wales might be appropriate,

4. The provision of Orthodontic Services

a. ABMU commissions 7 PDS primary care orthodontic contracts from specialists on the GDC specialist register, 3 primary care GDS orthodontic contracts (with an orthodontic element attached for a Dentist with Enhanced Skills (DES)). It also provides secondary care consultant services from Morriston Hospital. The DESs work from treatment plans provided from the consultant service at Morriston Hospital.

b. The Local Orthodontic Committee (LOC) represents orthodontic providers on the LDC and has a representative, together with the LDC on the Orthodontic Managed Clinical Network (OMNC) which advises the HB on orthodontic services in both ABMU and Hywel Dda and helps to develop policies to improve the quality of orthodontic care by:
   - Identifying patterns of referrals which are considered inappropriate (further discussed later).
   - Plan and deliver suitable targeted interventions.
   - Improve waiting times.
   - Identify robust waiting times monitoring arrangements.

c. The LDC dislikes the term 'inappropriate' referrals. The GDC guidance on Standards for the Dental Team and WG Prudent Healthcare guidance speak of patients being treated by the most appropriate clinician, and if a primary care dentist feels that an opinion of, or treatment by a specialist is required then there is a duty to refer. We are aware that in the past colleagues have referred earlier and earlier, and often to multiple providers in the hope that a patient will be seen at the correct time, and we agree and are aware that this has the effect of increasing waiting times. E-referrals will benefit this and should help identify outliers, although the reasons for outlying the norm must be taken into consideration, e.g. high proportions of child patients. We believe GDPs should have specific training in IOTN funded by and organised by LHBs or centrally.

d. There have been orthodontic waiting list initiatives in the past and these have proved unsuccessful in reducing waiting lists in the long term. The proportion of child dental health spend on orthodontics is 40% and the LDC feels that resources for waiting list initiatives should come from central funds not from ring fenced dental budgets and that any such initiatives should have clearly defined aims and outcomes established.

e. The LDC believes that there should however be a review of all orthodontic provision in terms of efficiency and value for money. PDS and GDS services are scrutinised closely, but the same cannot be said for the HDS and CDS. Prof Stephen Richmond appears to make this point in his Review of Orthodontic Services in Wales 2015-16 where one of his recommendations is that a comprehensive review of the Community and Hospital Services should be undertaken incorporating numbers and types of orthodontic treatment provided per year and the contribution of the services to overall orthodontic care in Wales. The LDC believes that a comparison of the cost per case and cost per patient visit of hospital care, CDS care and GDS/PDS care might be useful but it needs to be borne in mind that HDS treats severe, multidisciplinary cases that are unable to be treated in primary care.

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

a. Morgannwg LDC fully supports the CDS run Designed to Smile (D2S) programme and has a representative on its local forum.

b. The scheme has enjoyed successes such as a tooth decay prevalence falling by 12% among five-year olds. D2S has had a recent refocus to include children 0 to 3 years old, as it is extremely important to include this age group. However, this refocus of D2S now excludes children just as their permanent teeth are erupting. Therefore, it is a gamble to remove 5-6-year olds from the remit of D2S as it could greatly impact their future oral health.

c. The success of the D2S programme is well documented and we will not comment on the statistics further, just confirm Morgannwg LDC commitment to supporting the programme.

Morgannwg LDC offers this submission to the Committee's enquiry. In the interests of readability and brevity, it has deliberately not included statistics which are widely available, but refers to them when necessary. Any evidence that it is unable to source in the literature it offers and defines as anecdotal evidence.

The Welsh Assembly's Health, Social Care and Sport Committee's Inquiry into Dentistry in Wales 2018

Response by the BDA Wales

"More than Words"

The BDA

We are the voice of dentists and dental students in the UK. We bring dentists together, support our members through advice and education, and represent their interests. As the trade union and professional body, we represent all fields of dentistry including general practice, community dental services, the armed forces, hospitals, academia, public health and research.

Contents

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- Mr Roger Pratley, Vice Chair Welsh Council
- Mr Tom Bysouth, Chair, Welsh General Dental Practitioners Committee
- Ms Lauren Harrhy, Vice Chair, Welsh General Dental Practitioners Committee
- Dr David Johnson, Chair, Welsh Committee for Community Dentists
- Dr Kenneth Hughes, Vice Chair, Welsh Committee for Community Dentists

The Welsh Assembly's Health, Social Care and Sport Committee's Inquiry into Dentistry in Wales 2018

Response by the BDA Wales
"More than Words"

Introduction

1 The BDA Wales greatly welcomes this inquiry into dentistry and the opportunity to present our views, which have been carefully crafted by gathering and analyzing various data, many of which are not normally in the public domain, and by consulting widely with our craft committees and our membership who are daily facing the challenges of delivering dentistry in Wales. We undertook a survey of our members in Wales especially for this inquiry and the results are in *Appendix 1*.
We have representatives from the Local Dental Committees (LDCs) on our committees and expect the LDCs to make their own submissions. We look forward to making our oral presentation to the committee on 27 September 2018. The focus of the inquiry, and therefore our response, is general dentistry, orthodontic dentistry and certain aspects of community dentistry. However, we acknowledge the important contributions to patient care by all the dental crafts.

2 The BDA Wales wishes to highlight the very important part that good oral health plays in the overall health of the person. When oral health suffers it can have detrimental effects on a person's mental health as well as physical health. We have long-held the view that "the mouth needs to be put back in the body". The Royal College of Paediatrics and Child Health's report, *State of Child Health 2017*[1] asserts that **good oral health is essential for children's overall health and well-being**. Furthermore, when considering services for health and social care there needs to be "proper joined-up thinking". This philosophy is captured in the tenets of *Healthier Wales 2018*[2], which is warmly welcomed. Such tenets, however, need to be translated into action and system change.

3 We also wish to emphasize that the various challenges surrounding general dental practice - including the 2006 General Dental Services (GDS) contract & Units of Dental Activity (UDAs), clawback, contract reduction, poor recruitment/retention and practice closures - are tightly inter-linked and that the combination is leading to a substantial problem with patient access to NHS dentistry. We trust this response helps to explain these complex inter-dependencies. In the current term of the Assembly, BDA Wales has strenuously engaged with stakeholders including Assembly Members to convey the evidence that NHS dentistry in Wales is at a tipping point.

4 A major challenge in presenting this report has been the difficulty in accessing relevant data - much of them were derived by Freedom of Information (FOI) requests. There are other data that are simply not available. Assembly members may think that all is well with dentistry in Wales. However, "*absence of evidence is not evidence of absence*". We believe the Government and Health Boards have a crucial role to play in ensuring this evidence is comprehensively gathered, fully analysed and made publically available.

Dentistry services - NHS and private - are highly regulated and quality assured, as are dental professionals. The Government website is out of date so a summary of these regulations from 2006 onwards (including those for patient charges) is given in *Appendix 2.*
A glossary is provided in *Appendix 9.*

Dental Contract Reform

5 The 2006 England and Wales General Dental Service Contract and Welsh pilots for contract reform are discussed in detail in *Appendix 3.*

6 The 2006 GDS contract was flawed from its inception and has caused untold havoc ever since. Many practice owners in the intervening decade have struggled to make it work and then given up, either by handing back their NHS contract and only practising privately, or by selling their practice - often to a corporate (see pg 18 and *Appendix 9*) - and then working (often reduced hours) as an associate in that practice. The other option favoured by increasing numbers of practice owners is to simply retire early, as the reduction in the lifetime pension allowance might tip the balance. (See the *training and recruitment* section.)

7 Because of the nature of the 2006 dental contract, dentists can be reluctant to take on patients with higher needs as they are effectively penalised for doing so. This is because the NHS funding system operates blind to the extra costs of these patients and furthermore dentists need to achieve 95% of their targeted units of dental activity (UDAs) to avoid clawback of funding from the local Health Board. As a result, there is a systemic disincentive for dentists to take on the patients who need their services the most. We refer to this as the *inverse care law*. (See *Appendix 3* for further explanation.)

8 To test alternative systems of payment to dentists and new approaches to the delivery of NHS dental services in Wales, The Welsh Dental Pilot programme[3] was developed. It ran from 2011 to 2015 and focused on widening access; improving quality; and incentivising prevention. Two of the eight pilots moved on to a trial of a more advanced 'prototype' of the new contract in 2016 based on 85% capitation/15% quality. However, following the announced contract reform[4] by the new CDO in 2017, the 'prototype' contract was not rolled out, with the two 'prototype practices' remaining as such and not returning to UDAs. Instead, in September 2017 a new pilot scheme began, now with 21 practices taking part. This pilot scheme works with a modest 10% of UDAs given over to oral health needs assessment data collection.

9 The BDA Wales supports any reform of the contract that allows for prevention and the oral health needs assessment element. We are pleased to be part of the contract reform project board and a source of expertise and guidance. However, we have yet to be convinced that, without root and branch reform of the GDS contract, these goals of prevention can be achieved. We support a direction of travel that results in UDAs and clawback eventually being outmoded.

Clawback and Handback in General Dentistry

10 The BDA Wales has conducted several FOI Requests looking into the amount of monies clawed or handed back by each of the Health Boards in Wales and also the contract reductions resulting from clawback. In May 2017 we published our findings in BDJ in Practice[5] and have added to the data since then. We have submitted our findings to the BDJ (August 2018)[6.] Clawback is explained thoroughly in *Appendix 3.*

11 In three years, from 2014/15 to 2016/17, a total of **£16,322,445** was clawed or handed back to the Health Boards in Wales. See table 3 in *Appendix 3* for a breakdown. Table 4 in *Appendix 3* shows the number of practices affected by clawback in the last three years. It is evident that many practices, (indeed in some health boards the majority of practices), have experienced clawback in this period. In Wales overall, 31% of practices experienced clawback in 2017 which compares with 41% in 2016. These findings chime with the sample of 20 practices in the BDA telephone survey in 2017 which

showed that 60% of practices experienced clawback. In those telephone conversations it was apparent that practice managers and practice owners felt a strong sense of failure, and were hesitant to discuss their own clawback circumstances until it was explained that clawback is actually wide-spread, affecting around one third of practices.

12 The fact that fewer practices had clawback in the last year but the total clawback remained the same means that those practices affected will have suffered higher rates of clawback. This is however, not the full picture.

13 After two years of clawback such practices are then at risk of permanent contract reductions.

14 The BDA discovered that all Health Boards were applying permanent contract reductions to a greater or lesser extent. Table 5 in *Appendix 3* shows contract reduction over the three-year period between 2014/2015 to 2016/2017. Our research shows that over **a quarter** (26.5%) of all NHS practices in Wales have experienced **contract reduction** in the last 3 years. This amounts to approximately **£4,323,078**. Hywel Dda Health Board alone effected more than half of this contract reduction.

The sums of clawback, handback and contract reductions combined add up to
£20,645,987
of the dental budget removed in just three years from general dentistry
away from direct patient care.

(The breakdown is shown in Appendix 3.)

15 Health Boards have not yet disclosed what happens to the monies clawed back, handed back or reduced from GDS contracts: Replies to our FOI requests are overdue from six Health Boards. We know unofficially that some use it to "balance the books" i.e. the money has been used for areas other than NHS dentistry. One Health Board is proactive in seeking to reinvest a portion of the clawback into practices' infrastructure.

16 It is vital that Health Boards are transparent in their accounting practices, and that they are held accountable by the Welsh Government. Given the amounts of money clawed back every year, there are ample yet unrealised opportunities for greater investment in existing oral health programmes, including Designed to Smile. (*See section on oral health programmes.)*

17 It seems perverse that the Welsh Government has put up patient charges twice in the last two years, obtaining an estimated extra £2.6 million in the process, and yet in that **two-year period** alone there has been a total **clawback of circa £13 million**. It is well-understood that patient charges were originally introduced to cause rationing of dental care. Remarkably, there has been *a sharp increase in the proportion of patients paying charges relative to the increase in patient numbers in Wales in the last six years*, according to the Government's own data, as shown in *Appendix 4.* This is inexplicable. Whilst we acknowledge that charges are lower than in England, we challenge this creeping escalation and the impact it will have on lower income families who are not exempt.

Training, Recruitment and Retention

18 Government data show that NHS general dentistry in Wales is at a time of significant change. The number of providers who are also NHS performers (providing-performers) across Wales has more than halved in the 6 years from 2010 to 2016, from 418 to 201. The fall in providing-performers is unexplained because no systematic Wales-wide survey has looked at this issue. However, if numbers

continue to decline at current rates, there will be near zero providing-performers left in NHS dentistry in five years' time. NHS Digital this month[7] said: "*Nearly two-thirds of Principal dentists and over half of all Associate dentists across the UK often think of leaving dentistry."*

19 Many practices in rural Wales are struggling to see all their patients, let alone new patients, as they are having trouble recruiting and retaining associates. The BDA Wales telephone survey in 2017 covered all the Health Boards and showed that of those 20 practices surveyed, 50% of them believed their problems with recruitment and retention had led to clawback, thus affecting patient access.

20 Problems with recruitment and retention of associates, together with a vast reduction in providing-performers, has inevitably resulted in NHS dental contracts being reduced or returned altogether and large numbers of patients being left without access to NHS dental care. Such matters have been made clear to Welsh Government including in the last DDRB evidence. Yet in last year's evidence the Government held down the number of training places for dentists, despite continuing and predicted population growth as shown by the public health observatory (2016)[8]. They instead proposed increased numbers of training places for Dental Care Professionals (DCPs). This however masks the fundamental issue that we need more 'home-grown' dentists in Wales. (Please refer to *Appendix 5* for a fuller picture.)

21 The depressed environment of NHS dental practice has contributed to some of the lowest scores for motivation and morale across dentists in Great Britain. This is discouraging young dentists from undertaking a career within NHS dentistry and compelling experienced dentists to leave the NHS or the entire profession. NHS Digital this month[7] said: "*The more time dentists spend on NHS/Health Service work, the lower their levels of motivation."* The recent announcement from the DDRB of a 2% pay uplift (yet to be confirmed in Wales - but in England will not be backdated so is in effect 1% for the 12-month period to March 2019) again represents another pay cut in real terms and will only exacerbate the present situation.

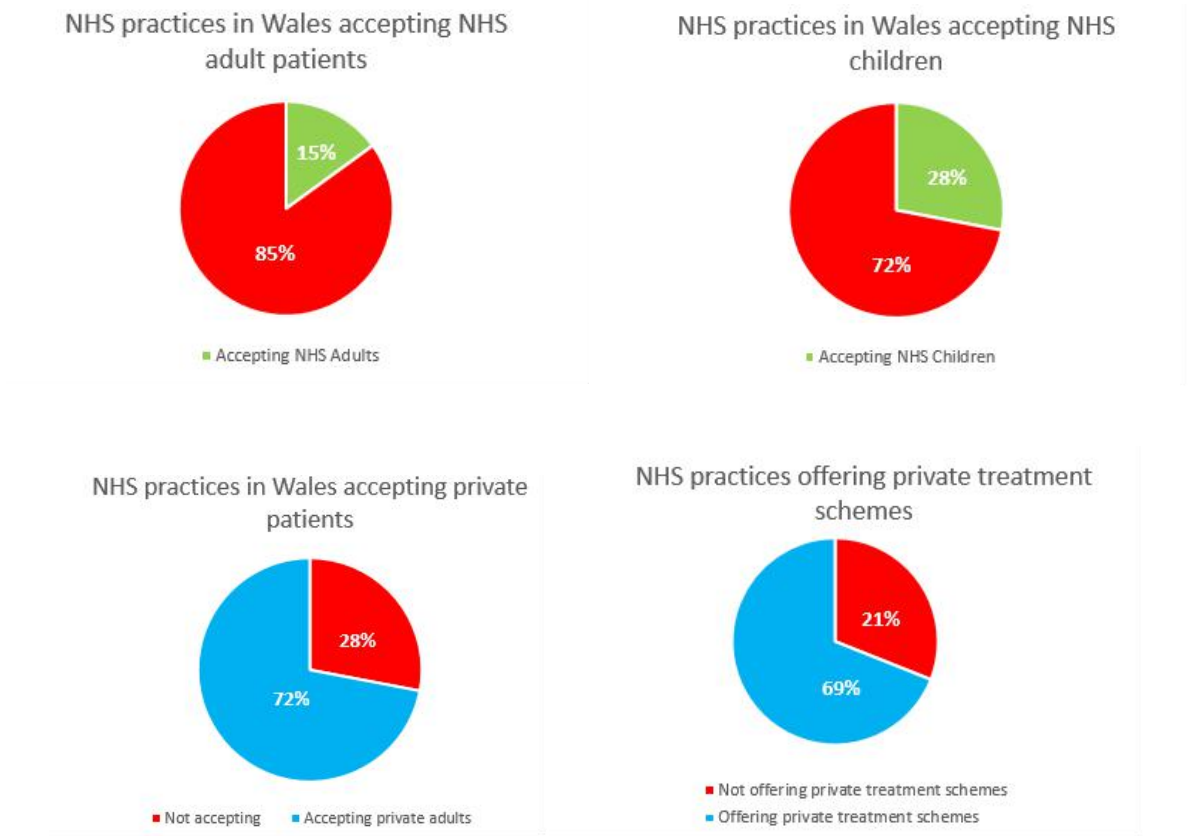
Access to NHS general dentistry

22 The BDA Wales wishes to draw particular attention to the impacts that the GDS contract, UDAs, clawback, under-recruitment of dentists, dental practice closures and under-spend of the GDS budget are having on access to dentistry in Wales. In 2017 BDA Wales undertook research into levels of patient access, and we submitted our findings in a paper to the British Dental Journal (BDJ) in August 2018[6]. This research shows that access for new NHS patients to primary care dentistry has plummeted in the last few years to an all-time low. Figure 1 below summarizes key findings.

23 In 2017 we found that only **15%** on average of all NHS practices were accepting **new adult NHS patients** and only **28%** of all practices were accepting **new child NHS patients**. In many cases this was with a waiting list. Therefore, based on current levels, nearly three quarters of children being born in Wales today will struggle to access an NHS dentist. This is down to the contract cap put on each dental practice by the Health Boards, which in turn are constrained by the Government's dental budget allocations. The Royal College of Paediatrics and Child Health's report *State of Child Health 2017*[1] lists ***access to timely primary dental care*** as a key health objective. The reality is that this objective is currently not possible. If children cannot easily access NHS dentistry, then good oral health cannot be achieved and maintained.

24 This problem of access is not peculiar to Wales. In January 2018, Healthwatch England, the patient watchdog, published six priorities for NHS England including *Tackling access issues in NHS dentistry*[9]. Healthwatch England and their 52 branches have published extensively about problems with access to dentistry in the last few years. Wales needs a strong voice for patients. The Community Health Councils are being wound down and in any case have lacked patient experience of dentistry data.

Figure 1 showing percentages of dental practices accepting new patients (including via waiting lists).



25 The newly reconfigured National Survey for Wales[10,11] asks 11,000 people every year about their health and lifestyle and access to services. We are disappointed that the only question asked currently is how many natural teeth the person has. No questions are asked about access to dentistry.

26 The population of Wales is projected[8] to increase by almost 9%, from around 3.1 million in 2011 to over 3.3 million in 2036. The 65-to-84 and 85+ age groups are projected to have the largest increase by 2036, when an estimated 1 in 4 people in Wales will be aged 65 and over. This changing demography will require additional resources to meet the increased need for restoration. Yet the latest Government figures[12] show an actual fall of 0.4% in courses of treatment in the last year 2016-2017.

Orthodontic Services

27 The number of orthodontic performers in Wales has reduced by 38% from 133 to 82 between 2008-09 and 2015-16. There is evidence of significant reductions in performers in Betsi Cadwaladr and Hywel Dda. The budget for Personal Dental Services (PDS) has reduced in the last three years. (See *Appendix 6*.) Not surprisingly this has had a severe effect on waiting times. Dentists working in various Health Boards in Wales have been known to refer patients more than 3 years in advance of their needing treatment as this is the only way for dentists to ensure that patients are treated at the time they would need orthodontic services. In 2014, an FOI request[13] discovered that Cardiff and Vale had the second largest waiting list in Wales. (See *Appendix 6* for further information.)

28 In 2017, there was a target to reduce waiting times to 6 months for Hywel Dda Health Board. There was no plan included in this target. Now, Hywel Dda has a 5-year waiting list. This year, the commissioning of UOAs (Unit of Orthodontic Activity) has a reduced unit value.

29 We appreciate the work being done by the Welsh Government on the new electronic referrals system which should markedly improve data quality by ensuring robust systems for **data recording** and transparent reporting on all aspects of orthodontic provision in all provider settings.

The effectiveness of oral health improvement programmes

30 Tooth decay is an entirely preventable disease and using schemes to educate children on oral health can have a significant positive impact on oral health. Wales has had some success in recent years with Oral Health improvement programmes, but there is much more to be done.

31 The Well Being in Wales (2017)[14] report claims that oral health in children is improving. However, this presents a partial picture and is based on comparisons with old data from 2007/8. We would suggest that the Well-being of Future Generations (Wales) Act 2015 is forward looking legislation and that a true picture of oral health improvement is more nuanced, including the adverse effects of deprivation. (See *Appendix 8* for further information)

32 Of those BDA members who took part in our survey, 90% would like to see new oral health programmes for older primary school children. There is plenty of evidence showing that many older children and young teenagers in Wales still have poor oral health. In 2016-2017 on average 29.6% (37.5% most deprived quartile) of 12-year old children had dental decay[15]. In 2013 66% of 15 year-old children had obvious dental decay experience[16]. NICE Guidance[17] recommends raising awareness of the importance of oral health, as part of a 'whole-school' approach in all primary schools and secondary schools too. Considering only a quarter of GDS practices across Wales are accepting new child patients then the Government needs to substantially invest clawback money in preventative schemes aimed at all children and also their parents.

Recommendations

See *Appendix 1* for the full list of responses from BDA members

GDS Contract

1) The Welsh Government must make the pledge that everyone should be able to access good quality NHS dental services - and then provide the resources to fulfil it, including establishing minimum UDA values and an uplift of UDA values in areas of deprivation.

2) The contract must move away from UDAs and towards meaningful performance measures and capitation for effective preventative dentistry and the provision of care needed for patients with poor oral health.

Clawback

3) It is vital that Health Boards are transparent in their accounting practices, and that they are held accountable by the Welsh Government for any underspend of the GDS budget.

4) Welsh Government should enforce Health Board KPIs for delivery of the GDS contract. Health Boards should account for how the clawback will be fully reinvested, including in oral health programmes for children of all ages. No clawback money should be reabsorbed into the general budget.

Patient experience

5) Systematic research should be conducted showing the experience of patients and would-be patients, including access to dentistry and the impacts of this on the population as a whole.

6) The National Survey for Wales must include patient experience of dentistry and access to dental services. The latter could be addressed by a simple question – W*hen did you last visit a dentist?*

Workforce

7) The Government should take fully into account the changing demography of Wales and the future requirements of the population in planning the dental workforce of the future.

8) Welsh Government must conduct an evidence-based review of the dentist workforce ensuring the requirements for the future for all dentistry crafts, including community dentists, will be fully met. The Government must not rely on skills-mix as the alternative to training more dentists in Wales.

9) The Welsh Government must ensure dentists' pay does not continue to be eroded as it has been in the last decade, and from now on should ensure annual uplift keeps pace with real inflation.

Orthodontics

10) As advised in 2016, the Welsh Government and the Orthodontic Strategic Advisory Forum should lay out a clear **strategy** for orthodontics in Wales for the next 5 years.

11) Health Boards must produce clear plans on how they intend to reduce waiting lists for orthodontic services, as well as updates on the effectiveness by showing outcomes data.

Oral Health Programmes

12) The Government should fund the D2S programme sufficiently that the 5 and 6 year-old children can receive the same benefits of inclusion as they did previously, including fluoride varnish.

13) The Government should ensure that age-appropriate oral health programmes for up to 12 year olds are delivered through schools in all Health Boards in order to address high prevalence of decay in that age group. There are more than enough funds from clawback to provide this.

14) The Government should do much more in promoting oral health messages and restricting access to sugar and sugary drinks in schools, hospitals and other public-funded organisations.

Data Analysis and Reporting

15) Official data about dentistry and oral health need normalisation against population numbers to allow for proper intra- and inter-Health Board comparisons on performance.

16) Many elements of data collection and reporting across the Health Boards need a major overhaul. Comprehensive data on dentistry budgets need to be systematically collected and transparently and routinely reported by these procuring authorities for public access.

Conclusion

This inquiry must produce **more than words** to make a real difference to dentistry in Wales.

Appendix 1: Summary of results from BDA Wales membership survey

The BDA conducted a survey of its members in Wales in August 2018 to help inform our response to the inquiry. Those who responded were GDPs (68%), community dentists (19%) and 12% working in hospital or other dentistry roles. We are very grateful to the 79 dentists who took part.

We received responses from across all the Health Boards. The largest response came from dentists in the Betsi Cadwaladr University Health Board (24.36% of respondents), closely followed by Cardiff & Vale University Health Board (20.51%).

Table 1. Recommendations from the BDA Wales membership to the Welsh Government:

Recommendation	Strongly Agree or Agree	Disagree or Strongly Disagree
Invest more in dentistry in Wales, to improve access and address oral health inequalities	96%	1%
Freeze patient charges, and provide additional investment from general taxation	38%	30%
Provide a prevention-based NHS dental contract that makes a decisive break from targets	87%	1%
Limit the marketing and promotion of sugary foods and drinks to young children	94%	1%
Ensure Clawback from NHS dental contracts should be reinvested back into NHS dentistry	97%	0%
Do more to encourage younger dentists to work in Wales	86%	0%
Raise awareness of the fact that NHS dentistry is free for under-18s, and exempted groups	78%	3%
Do more to inform parents of young children about the dangers of sugary food and drinks for good oral health	96%	0%
Extend the Designed to Smile programme to children aged 5-12, to address the concerning levels of tooth decay in these age groups	90%	5%

There were five response options:
strongly agree, agree, neither agree nor disagree, disagree, strongly disagree

Table 2. Members' reports on dental caries and oral health status of young children and oral health promotion activities

Question	Yes	No	?
Q3 Practices who saw more than 40% of younger child patients with visible signs of tooth decay?	**36%**	**61%**	**3%**
Q5 Do you do any unfunded oral health promotion from your practice or work place, e.g, putting up posters in your practice highlighting the dangers of sugar, or whilst carrying out school visits, etc.	**86%**	**11%**	**3%**
Q4: What other preventable oral health problems are you seeing in young child patients?	*Tooth loss, erosion (including acid erosion caused by fizzy drinks, or perceived 'healthy' fruit juice drinks), gingivitis and abscesses, poor oral hygiene and poor diets, dummy usage up to school age*		

Appendix 2: Regulations governing NHS and private dentistry in Wales

The government web page is out of date so the up-to-date list is provided here:

2018
The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2018

2017

a) Private Dentistry (Wales) Regulations 2017

b) The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2017

2015
The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2015

2014
The National Health Service (General Dental Services Contracts and Personal Dental Services Agreements) (Wales) (Amendment) Regulations 2014

2013
The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2013

2012
The National Health Service (Primary Dental Services) (Amendments related to Units of Dental Activity) (Wales) Regulations 2012

2010
The Local Health Boards (Consultation with Local Dental Committees) (Wales) Regulations 2010

2006

a) The National Health Service (General Dental Services Contracts and Personal Dental Services Agreements) (Amendment) (Wales) Regulations 2006

b) The National Health Service (Performers Lists) (Wales) (Amendment) Regulations 2006

c) The Functions of Local Health Boards and the NHS Business Services Authority (Primary Dental Services) (Wales) Regulations 2006

d) The National Health Service (Dental Charges) (Wales) Regulations 2006

e) The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006

f) The National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006

g) The Functions of Local Health Boards (Dental Public Health) (Wales) Regulations 2006

h) The Health and Social Care (Community Health and Standards) Act 2003 Commencement (Wales) (No. 4) Order 2006

i) The General Dental Council (Professions Complementary to Dentistry) (Dental Hygienists and Dental Therapists) Regulations Order of Council 2006

Appendix 3: The 2006 NHS GDS contract, UDAs, clawback, contract reform and members' views

A) The NHS Dental Contract explained

1. The NHS General Dental Services Contract was developed by the Department of Health and came into force on the 1st April 2006 in England and Wales. (Scotland and Northern Ireland operate different types of GDS contracts.)

2. Dental practices are constructed to run as independent businesses; having to cover all running costs, capital expenditure and overheads as well as salaries. Practices contract with the commissioner, (in Wales this is the Health Board), for an NHS dental contract. The practice performance is scrutinised and closely managed against targets. (See section on clawback.)

3. The contract's system consists of three bands that determine how much the patient is charged for their treatment and how much the dental practice is remunerated by the Health Board.

    i. Band 1 includes diagnosis, treatment planning and maintenance, for example a clinical examination, assessment and report and an x-ray.

    ii. Band 2 includes all necessary treatment covered by band 1 plus additional treatment such as fillings, root canal therapy and extractions.

    iii. Band 3 includes all necessary treatment covered by band 1 and band 2 plus more complex procedures and provision of appliances, for example, bridges, crown and dentures.

4. The patient charge costs in Wales have been increased by Welsh Government twice in the last two years: Band 1 costs £14; Band 2 costs £44; Band 3 costs £195. Patients on benefits are exempt from paying dental charges and all patients are exempt from paying drug prescriptions. http://www.healthcosts.wales.nhs.uk/proof-of-entitlement

5. The 2006 contract changed the way that dentists are contracted, through the introduction of UDAs (Unit of Dental Activity). Dental practices are evaluated on the UDAs they achieve against the contracted allowance of UDAs allocated by the health Boards. These UDAs are linked to the three-band system.

    i. Band 1 is classed as 1 UDA, Band 2 is 3 UDAs and Band 3 is 12 UDAs.

    ii. UDA values vary considerably between practices and between Health Boards. Average Health Board values vary between £23.38 and £29.96, but there is considerable variation and many UDA values are too low to be workable.

6. The contract does not take into account the extent of the work required within a band. For example, in Band 2 a dentist will receive 3 UDAs whether they perform one filling on a patient, or three fillings and an extraction on a patient. This is considered to be one single course of treatment – regardless of the dentist's time taken and the cost of materials required. (Dentists' activities are highly scrutinised by NHS Business Services and HIW and

outliers are individually inspected and fined for any separation of activities within a course of treatment.)

7. It is worth considering that the dental budget spent in the last three years (£133,005,780 per annum) equates to £42.72 per capita per annum.That compares with the whole Health budget of £2,300 per capita per annum, or 1.9%. Given that 54% of the population were treated in 2017 (1,710,254) that equates to approx £78 per patient, or roughly 3 UDAs.

8. The real costs of treating high needs patients are therefore not accounted for within the contract and can often represent a loss to the dental practice business. Where there may be high needs patients not currently registered with a practice their potential treatment costs would not be covered by the UDA value, so there is no incentive for practices to alter their patient lists to include them.

9. The contract therefore acts as a strong disincentive for dentists to treat high needs patients owing to the broken business model. It is a misnomer to talk about units of dental activity when they are clearly expected to be infinitely elastic and not a unit in any normal business sense. The UDAs do not work for high needs patients and are consequently not fit for purpose.

10. Not only do dentists not receive remuneration commensurate with the work done for high needs patients, but in areas where good oral health predominates dentists are not remunerated should they attempt to treat more patients than their contract allows because of the cap imposed by the contract. This creates a barrier to improving patient access generally.

11. Over 90% of dentists say the 2006 contract has limited their capacity to treat patients with high needs.

B) What is Clawback?

1. If a dental practice fails to achieve 95% of their UDA target they will face clawback.

2. These Health Boards have a variety of different ways of handling clawback. Some clawback everything owing, others allow the dentist to carry 5% over to next year and only claw back the excess, some deal with dentists on an individual basis.

3. Setting targets can be helpful to productivity in many circumstances, but it does not work with UDAs. A dentist facing clawback could have worked longer hours and helped more patients with more challenging ailments than a dentist who has completed their UDA targets. This is in part due to the banded systems relation to UDAs. (See previous section.)

C) What is Handback?

1. If a dentist is struggling to achieve their UDA target for that financial year they may choose to give back a percentage of their UDAs to the Health Board. Handback may also occur if a dentist chooses to close their practice or if they retire for example.

2. These UDAs can then be auctioned back to dental practices within the Health Board, although this reinvestment does not always occur. In Betsi Cadwaladr for example there has been a net closure of 8 practices in the last three years with a knock-on effect on patient access.

Table 3: Clawback handback and contract reductions in all Health Boards over three-year period and resulting underspend.

Health Board	GDS Budget from 2014/2015-2016/2017 TOTAL	Clawback and handback from 2014/2015-2016/2017 TOTAL	Contract reduction from 2014/2015-2016/2017 TOTAL	GDS Spent from 2014/2015-2016/2017 TOTAL	Percent of budget unspent	Percent of equivalent budget (with contract reductions included) unspent
Betsi Cadwaladr	£83,507,000	£3,937,222	£318,382	£79,251,396	5.1%	5.5%
Cwm Taf	£49,375,173	£1,402,929	£252,305	£47,719,939	2.8%	3.3%
Cardiff and Vale	£76,747,000	£1,520,000	£216,827	£75,010,173	2.3%	2.5%
Powys Teaching	£15,426,215	£1,818,656	£616,952 (approx.)	£12,990,606	15.8%	19.0%
ABMU	£88,712,738	£2,724,903	£488,537	£85,499,297	3.6%	4.2%
Aneurin Bevan	£68,902,203	£1,704,983	£196,672	£67,000,548	2.8%	3.0%
Hywel Dda	£36,993,000	£3,213,770	£2,233,391	£31,545,383	14.7%	19.6%
Wales Total	**£419,663,329**	**£16,322,463**	**£4,323,066**	**£399,017,342**	**4.9%**	**5.9%**

Table 4: Number of practices which experienced clawback over a three-year period

Health Board	Number of Practices facing Clawback 2014-2015	Number of Practices facing Clawback 2015-2016	Number of Practices facing Clawback 2016-2017
Betsi Cadwaladr	35 (50%)	36 (51%)	35 (50%)
Powys Teaching	11 (55%)	12 (60%)	11 (50%)
Hywel Dda	7 (16%)	10 (23%)	8 (19%)
ABMU	32 (50%)	31 (48%)	17 (27%)
Cwm Taf	8 (28%)	13 (45%)	6 (21%)
Aneurin Bevan	16 (26%)	16 (26%)	21 (34%)
Cardiff and Vale	17 (21%)	26 (39%)	12 (18%)
All Wales	**126 (36%)**	**144 (41%)**	**110 (31%)**

Table 5: GDS contract reductions in each Health Board

Health Board	Number of Practices	Total Amount
Betsi Cadwaladr	18	£318,382
Powys Teaching	11	22884 UDAs (approx. £616,952)
Hywel Dda	20 (11 temporary)	£2,233,391 (£1,336,214 temporary)
ABMU	11	£488,537
Cwm Taf	7	£252,305
Aneurin Bevan	15	£196,672
Cardiff and Vale	12	£216,837

D) How are Clawback and Handback affecting Dentistry?

1. Clawback and Handback mean that the patient access issues being faced in Wales will only worsen, especially when two years of clawback in a practice results in permanent contract reduction.

2. Clawback and handback have resulted in millions of pounds that should be used for dentistry not being reinvested. **In the last three years alone £20 million has been taken out of NHS general dentistry in Wales due to clawback and contracts reductions**, but only a small fraction of this has been reinvested into dental practice facilities by one or two Health Boards.

3. To illustrate the loss of patient treatment resulting from clawback in 2015-2016:
   - The money clawed and handed back in Hywel Dda was equal to 51,348 Band one treatments; that is 37% of the Band 1 work Hywel Dda did that year.
   - In Cwm Taf 9,752 more Band two treatments could have been performed with the funds they clawed back.
   - A shocking 50% more Band 3 treatments could have been performed with the clawback in Hywel Dda if the funds had been reinvested.

4. The current system of clawback and handback only exacerbates the growing patient access problem because taking on new patients is a risk to dentists trying to achieve such tightly managed targets. Dentists are disincentivised in the current contract to treat high needs patients because there would be a significant financial loss to the practice.

5. Scaled up, a large proportion of high needs patients can result in a practice failing to reach its targets and facing clawback, handback or contract reduction despite the increased expense to the practice. This is a double negative impact – the loss of revenue and the higher costs of treatment.

6. Clawback is prevalent in all Health Boards, meaning that patients with poor oral health are disproportionately affected. *Inverse care law* is felt acutely in general dentistry.

7. Many overheads such as running a chair and employing staff are fixed commitments. Therefore, clawback and contract reduction have a direct impact on staff employment, particularly ancillary staff. Such a model will always work against the interests of high needs patients. This requires to be fundamentally changed.

8. There needs to be new thinking 'outside the box'. Clawback is pernicious, counter-productive and operates with a bureaucratic machinery. We welcome any advances within contract reform that help to use this money directly for the benefit of patients and the support of practices.

9. The cost of materials has been rising above inflation for many years, and now with the new environmental regulations concerning the use of mercury, amalgam use is being sharply reduced and the more expensive restoration materials used in its place. This will further strain an already broken business model.

10. There is a growing trend for practices to bought by corporates rather than early career dentists taking on their first practice ownership, because this is becoming prohibitively expensive for the majority. Yet corporate practices are finding that NHS contracts are unworkable and, after suffering clawback and contract reduction, are as a result closing in ever larger numbers. In one area alone there have been closures in Knighton, Machynlleth, Dolgellau and just recently Builth Wells. The latter is the corporate, 'MyDentist'. This matter of practice closures has been made clear to Welsh Government by dentists' representatives on several occasions, and yet in their most recent evidence to the DDRB the Welsh Government does not acknowledge there is a problem with provision of NHS dentistry services.

11. One dentist wrote to their AM and MP in 2017 to seek support for their practice situation as such pleas had fallen on deaf ears in the Health Board. This is a rural, single-handed dentist who could not recruit an associate in two years and had to give back their NHS contract in 2017. This extract sums up succinctly the very real problems that many dentists are facing throughout the country, and especially but not exclusively in the more rural areas.

> **"The NHS contract is a disgrace - it promises patients comprehensive care, but in reality, is so poorly resourced and constructed, that care takes place despite it. The current environment is simply not fit for purpose. On the ground, officials do care, and they do their best, but the system and available resources are grossly inadequate. Someone, somewhere, should be held accountable for the current situation. In the longer term, there has to be some integrity and honesty about what the state is prepared to provide through the NHS."**

12. There are similar comments from members who took part in our August survey:

> **"Everybody seems to agree that we should focus on prevention yet prevention is simply not 'recognized' in the UDA system as an 'activity' and therefore it is not remunerated. We are expected to deliver prevention to each and every one of our patients for free while trying to meet UDA targets in order to keep our practices afloat, and indeed, most of us are doing it because we care about our jobs and our patients, and the Government is taking this for granted.**
>
> **When are we going to look at the elephant in the room and see it for what it is: there hasn't been any new money going into NHS dentistry in the past 10 years, money is being taken away from us (through claw backs) and used to patch up holes in other NHS departments.**
> **NHS dental practices are struggling to survive, some are closing down and others are just about managing to break even, there is a huge recruitment crisis all over the country because the value of our work is not being recognized and the highly skilled work that we do is not fairly remunerated.**
>
> **I am not a pessimistic person and I love my job, but after 11 years working under the current NHS contract I fear for the future and frankly I'm expecting the worst."**

"The system needs to change. We are penalised when we see patients with high need. This is a disincentive to opening the books to new patients. It's also a ticking time bomb for the older generation with heavily restored mouths. The system will not recompense sufficiently to treat this considerable group, many of whom had the original treatment at different practices (and countries) years ago. So despite what the CDO may say I think oral health and dental care for the majority is on the slide unless we move away from a targeted based system and concentrate on patients need; which will vary between areas."

E) What is Contract Reform (and will it help)?

1. Contract reform has taken place in several different Government pilots in Wales since 2011 and the BDA Wales has endeavoured to be the Government's critical friend and a support to practices undertaking such pilots. Eight practices took part in the original scheme. Those taking part in the pilots favoured this new way of working and argued that whilst the UDA system focused on numbers, the pilot focused on people (capitation). This ethos of prevention was strengthened in the 2016 prototype contract run in two practices in Swansea which had no UDAs. However, although those two practices remain on that contract until today, the new CDO introduced a different type of pilot in 2017[4], based on the current contract of UDAs.

2. The new pilot in Wales has been running since September 2017 and operates based on 10% of UDAs used for data gathering of oral health needs assessments, which is the first small step to improving a patient's oral health. However, the BDA would like to see a much greater percentage of UDAs (at least 30%) being used for prevention to make it a workable prospect.

3. In an ideal world the BDA Wales would prefer all practices to be given the type of contract that the two prototype practices in Swansea are operating, which is 85% capitation and 15% quality measures. With such a contract no clawback is imposed, and preventative dentistry is at the front and centre of its operations. The 'prototype practices' saw an initial reduction in patient numbers at the early stages because preventative treatment is more resource intensive initially until the high needs patients are stabilized, but two years on and the most recent data show that patient access has returned to the required levels.

4. One of the key aspects of contract reform propounded by the Welsh Government is the use of skills-mix[18,19], which essentially is employing dental hygienists and therapists to take on some of the work usually done by dentists. (These DCPs might also be upskilled to optimise this arrangement.) The proposed theory is that in turn dentists would be freed to upskill to more specialist dentistry, thereby maximizing the use of their expertise and skills outside of the practice on an intermittent basis, making room for the DCP to work in their stead. This arrangement, together with extended recall times for patients with good oral health, would in theory allow capacity for increased access of patients. Whilst this appears to be a rational approach, we wonder if it is practicable. The BDA has requested from Welsh Government the business model that demonstrates how this skills-mix would work, particularly for single-chair dental practices.

5. There are many fixed overheads in running a dental surgery chair and apart from the salary differential (which is not a great saving) there are no other obvious savings to the practice. DCPs have a limited repertoire, even with the upskilling, and tend to be slower. Should the model

needs an extra dental surgery chair for the DCPs it is unclear a) how this can be afforded by the practice, b) how the return on investment (ROI) makes good business sense, and c) whether patients would be comfortable being seen by several different practitioners rather than just their dentist. In fact, the patient view is currently missing altogether from this model, although we trust the pilots will include this in the data collection. The BDA reports anecdotally that only a minority of dentists would be interested in upskilling and we would ask where the money for such training and the backfill would come from.

6. We were involved in the discussions that form the response[20] by the CDO to the Government's policy *A Healthier Wales*. However, we would like to see this fleshed out to include the critical financial, operational and cross-service reform considerations.

Appendix 4: Data showing dental activity over the last six years

Government data when computed as shown in table 6 demonstrate that the percentage of patients who are paying charges is rising much more steeply than the population increase.

Table 6: Comparison of courses of treatment, number of patients treated, patients charged and the total population between 2010-11 and 2016-17 (Data from Stats Wales)

Period	total courses of treatment	number of patients treated	Patients who paid charges	Population of Wales
2010-11	2,316,330	1,653,797	932,917	3, 050, 000
2016-17	2,383,391	1,710,254	1,071,298	3, 113, 000
Increase in six years (N)	67,000	56,457	138,381	63,000
Increase in six years (%)	2.9%	3.4%	**14.8%**	2.1%
Average yearly increase (%)	0.48%	0.57%	2.47%	0.35%

Appendix 5: Recruitment and Retention of Dentists

1 Substantial evidence of recruitment and retention problems was provided by the BDA to the last DDRB review, which included sections from Wales describing the knock-on effects of clawback on patient access - some of that clawback was a result of practices not being able to recruit associates. Nevertheless, the DDRB chose to ignore the collective UK BDA evidence describing it in July 2018 as anecdotal[21], and instead favoured the Governments' figures[19] that suggested that all was well with NHS dentistry. The official Welsh Government statistics, in their evidence to the DDRB, failed however to account for population growth which means that NHS dental activity as a percent of the Welsh population has remained stubbornly at 54% for the last 6 years. (*See Appendix 4*.)

2 The BDA Wales will be presenting new evidence to this year's DDRB suggesting that this percentage is likely to decrease in the near future with access now being very low for new patients, and with many practices now experiencing clawback and contract reductions, problems recruiting associates and more practices closing, including corporate practices such as MyDentist.

3 There have been several closures of MyDentist practices in England and Wales in the last few years, in many cases because of not being able to attract enough associates and because they operate a different business model to practitioner-owned practices and have not found dentistry profitable enough. Peter Ward, the CEO of the BDA, in 2017 pointed out, 'dentistry isn't the only area where the corporate "consolidators" have entered the fray.' This has happened in both pharmacy and optical services, but for them 'the clinical component of the income streams for both businesses is relatively small and the merchandising activity is vast.' Dentistry is different, in that 'the biggest part of what patients pay for is the dentistry itself – the actions of the clinically trained professionals.'

4 The BDA produced an extensive report on The State of General Dental Practice in 2013[22]. Section 16.2 states: "*Recruitment seems particularly difficult in Wales. Welsh associates have the highest pay of any region which probably reflects their difficulty in recruiting. Practice owner pay in Wales is much lower than that in the other countries. Welsh practice owners seem to be paying themselves less in order to engage associates to help meet their UDA targets*."

5 NHS Digital this month[7] said: "*Whilst the results for Associate dentists are quite similar when comparing England & Wales to Wales only, there are larger differences for Providing-Performer dentists where dentists in Wales tend to work longer hours, take fewer weeks' annual leave and perform more NHS work."*

6 NHS Digital[23] also reported that in 2016/17 Providing-Performer dentists' average taxable income from NHS and private dentistry decreased by 7.3%. Associate dentists have also seen a decrease in taxable income by 2.1%

7 The BDA Practice Owners Survey 2016 has shown that morale is low for Welsh dentists who perform mostly NHS dentistry, only 26% of whom feel they are fairly remunerated. [NHS Digital this month[7] said: "*The most common contributory factors to low morale are increasing expenses and/or declining income and the risk of litigation and the cost of indemnity fees. Regulations are also cited as a major cause of low morale amongst Principal dentists."]* Yet despite this long-running narrative from the BDA, the UK Governments appear impervious to these messages.

8 In the most recent statistics (August 2017) published by the Welsh Government it appears there has been little change in the number of dentists per 10,000 of the population. However, this figure does not consider the full-time equivalents (FTEs) providing NHS treatment and is merely a headcount. NHS Digital this month[7] said: *"During the last decade there has been a notable drop in the amount of time dentists spend on clinical work across the UK."* The FTEs will be therefore lower. Also, the figure 1,475 includes Dental Foundation Year 1 posts. We therefore believe this latest report does not paint the whole picture.

9 The last time the Welsh Government systematically considered workforce issues was the survey[24] of 2012. The review states that 'On average during the period 2007-2010, 58% of Welsh-trained dental graduates entered the Welsh workforce after completing DF1. Undertaking DF1 training in Wales is a significant factor in the decision to continue working in Wales. Of these (58%), 90% undertook DF1 training in Wales and 10% undertook it elsewhere before returning to work in Wales'.

10 The Dental School in Cardiff was set up in the main to increase the Welsh dental workforce, which it appeared to have done successfully in the initial graduate years from 1967. The 2012 workforce survey says that 'Welsh trained dentists account for 41% of the dentists currently working in Wales'. However, since then the picture of Foundation Training has been changing with the recent introduction of the centralised Foundation Training Application Process[24] which is UK-wide, and which means that trainees cannot be guaranteed which country, let alone which county, they will be assigned to. This has a high risk of creating a highly volatile post-training workforce and with no guarantee that Welsh-born dentists will feel a strong imperative to return to Wales.

Appendix 6: Orthodontic services

Table 7 shows the most recent data available from FOIs[13] in 2014 as well as a comparison to each Health Boards population. Cardiff and Vale, Betsi Cadwaladr and Powys were handling orthodontic waiting lists 3-5 times better than Hywel Dda. Moreover, ABMU and Aneurin Bevan were handling orthodontic waiting lists 20 to 40 times better. It should be noted that while this figure may show ABMU to be coping well, we are aware that there are difficulties within the orthodontic services in ABMU. The Review[26] of the orthodontic services in Wales 2008-09 to 2015-16 stated that a strategy needed to be developed for the future of Orthodontic services. The Strategic Advisory Forum on Orthodontics reports[27] periodically to the CDO on progress.

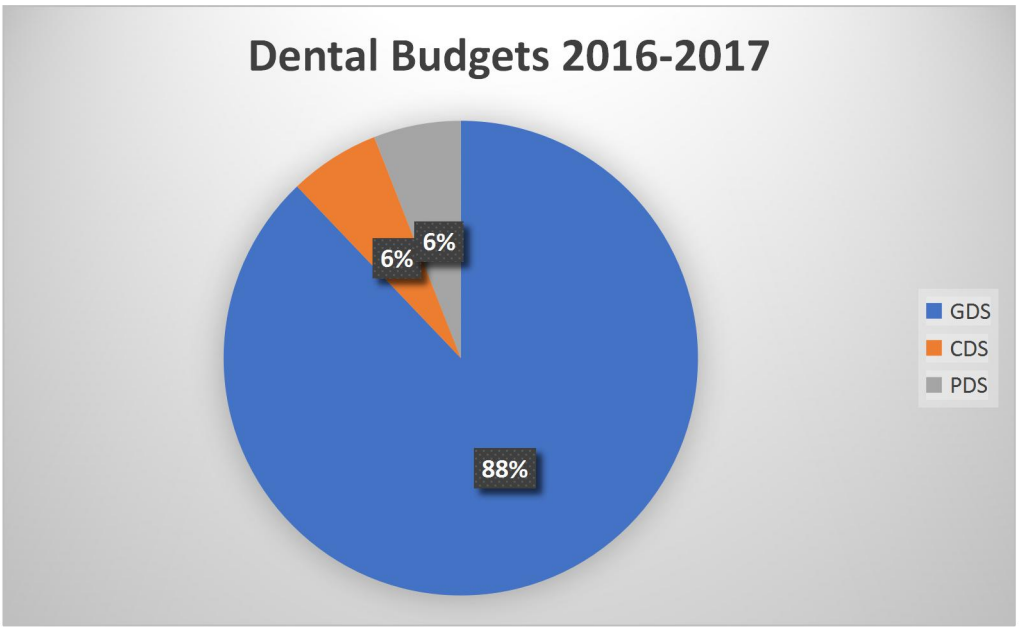
Table 7: Waiting list numbers for orthodontic services in 2014 for each Health Board

Health Board	Waiting list in 2014	Population aged 0-15 in 2014	Percentage of 0-15 Population
Hywel Dda	1584	65,236	2.40%
Cardiff and Vale & Cwm Taf	1019	144,193	0.70%
Betsi Cadwaladr	769	123,699	0.62%
Powys	100	21,919	0.45%
ABMU	83	91,439	0.09%
Aneurin Bevan	73	108,355	0.06%

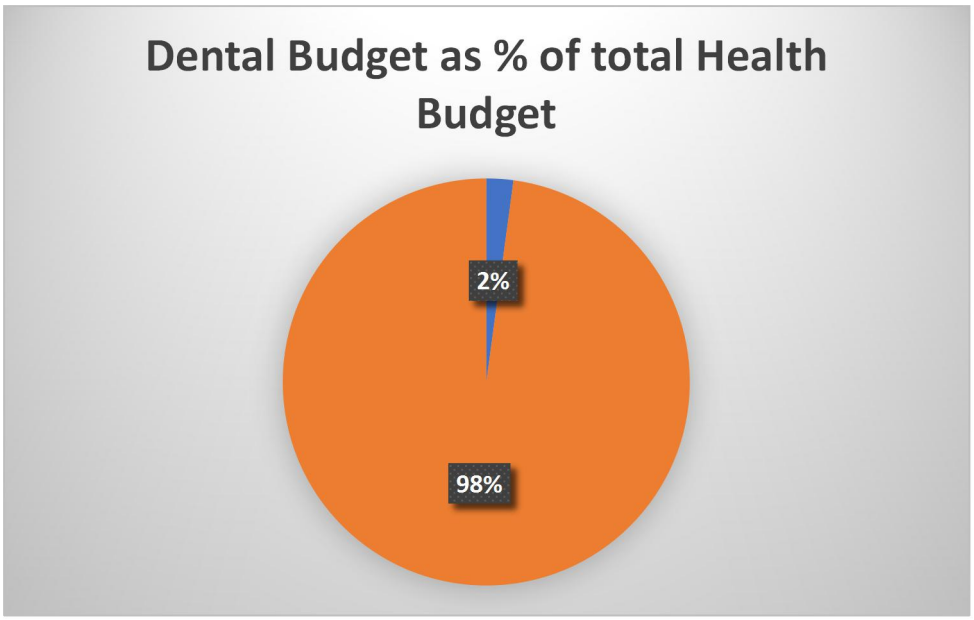
Table 8: PDS Budgets for 2014-15 to 2016-17

PDS Budgets	2014/2015	2015/2016	2016/2017
Betsi Cadwaladr	Not separate from GDS		
Powys Teaching	£521,611	£747,219	£966,115
Hywel Dda	£1,516,289	£1,550,786	£1,606,696
Cwm Taf	£168,804	£171,066	£172,948
Aneurin Bevan	£4,543,509	£2,484,571	£2,657,592
ABMU	Does not hold this information		
Cardiff and Vale	Have not responded		
4 HBs total	**£6,750,213**	**£4,953,642**	**£5,403,351**
Estimated Total	**£11,812,872**	**£8,668,873**	**£9,455,864**

Appendix 7: Comparison of GDS, CDS and PDS budgets 2016-2017



*The figure for PDS required estimation



Total Health, Well-being and Sport Budget £7,291,241,000 (2018-2019 figures)

Appendix 8: Oral health programmes in Wales

1. Cwm Taf Health Board[28] runs the scheme *Baby Teeth Do Matter* which works with GP practices and other health care professionals to promote the oral health of children, particularly those age 0-2 and 3-5. This scheme has seen an increase of 42% of children attending dental appointments in the Merthyr locality. There has also been a significant 70% increase of children aged 0-2 visiting the dentist. Cwm Taf also runs its own tooth brushing scheme. This scheme employs oral health educators to visit 38 schools in Cwm Taf. Now, only 15 schools in Cwm Taf don't participate in a tooth brushing scheme.

2. The CDS-run *Designed to Smile* (D2S) scheme has enjoyed some successes such as a tooth decay prevalence falling by 12% among five-year olds[29]. The scheme costs approx £4m per annum to run[30]. D2S has had a recent refocus[31] to include children 0 to 3 yrs old, as it is extremely important to include this age group. However, this refocus of D2S now excludes children from fluoride varnish treatment just as their permanent teeth arrive and offers over 5's only tooth brushing. These children are expected to receive fluoride varnish in the GDS instead. Currently 66% of children visit a NHS dentist, leaving 34% who do not. Given the very low access for new children in many parts of Wales, the number of children treated in future is likely to go down not up. Therefore, this refocus is a gamble as it could greatly impact their future oral health. The BDA has previously called for additional funding of approximately £2m per annum to maintain their inclusion. One third of the GDS clawback would cover this.

3. Since the National Assembly for Wales Children and Young People Committee Inquiry[32] into children's oral health in 2012 there has been some notable progress against the various recommendations put by the committee. However, without a modest increase in investment (from GDS clawback money) this programme will not reap all the rewards that are potentially there for children's oral health improvements.

Appendix 9: Glossary of Terms

Name/Acronym	Explanation
Amalgam	Dental amalgam is a liquid mercury and metal alloy mixture used in dentistry to fill cavities caused by tooth decay.
Associate	Dentists who contract with dental practices to provide general dentistry services
CDO	Chief Dental Officer
Clawback	Money deducted from the practice by the Health Board when fewer than 95% target UDAs are achieved
Corporate Dental Practice	Corporate bodies are a relatively new phenomenon in dentistry; it is only 12 years since the GDC removed restrictions on the number of 'Bodies Corporate' who could operate. Cynically, there is an argument for the NHS to commission NHS dental contracts from a handful of large corporates rather than thousands of small independent practices. However, the impact of large dental corporates has not been a positive one. The largest group is currently "MyDentist", the second largest is BUPA/Oasis. Both of these large players have struggled to grow smoothly and profitably and have found it hard to recruit dentists to work for them, particularly in rural areas. This and other problems led to MyDentist bringing its acquisition campaign to a halt, and then to start selling off some practices.
D2S	The CDS-run Designed to Smile Oral Health Programme in Wales
DCP	Dental Care Professional - includes dental therapists, hygienists, dental nurses, oral health educators
DDRB	Doctors and Dentists Pay Review Body
LDC	Local Dental Committees were set up in 1948, at the inception of the NHS. In England and Wales, provision in statute has been made for them to be recognised and consulted since the NHS Act 1977. Local NHS representatives may consult with LDCs on any matters of local dental interest.
National Survey for Wales	Each year the National Survey for Wales involves over 11,000 people across Wales. From 2016-17 the National Survey replaced the 2012-15 National Survey, the Welsh Health Survey, Active Adults Survey, Arts in Wales Survey, and Welsh Outdoor Recreation Survey, as agreed by Cabinet in 2014.
PCR	Patient charge revenue. Contrary to public perception the dental practice does not keep this money. It is returned to the Health Board. The BDA Wales would like to see patient charges frozen or restructured as they are a tax that involves a lot of bureaucracy and which acts as a deterrent to patients who are not eligible for benefits but are on lower incomes.
Pilot	A variant of the 2006 contract being trialed for a set period of time in selected dental practices. Different pilots have been running since 2011. Variation can be as little as 10% UDA for preventative work up to 85% of UDAs. The current Welsh pilot is 10% UDAs for oral health needs assessment data recording only.
Poor Oral Health Impact	The Global Burden of Disease study[33] (2010) found that most disability amongst 5 to 9 year olds in the UK was caused by poor oral health. An average of 2.24 hours of children's healthy lives was lost for every child aged 5 to 9 years because of poor oral health. This exceeded the level of disability associated with vision loss (1.64 hours), hearing loss (1.77 hours) and type 2 diabetes (1.54 hours).
Providing-performers	NHS Contract holders who also perform NHS dentistry
UDA	Unit of Dental Activity
UOA	Unit of Orthodontic Activity

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The Welsh Assembly's Health, Social Care and Sport Committee
Inquiry into Dentistry in Wales 2018

Response by the BDA Wales
"More than Words"

Report submitted on 30 August 2018

Dr Caroline Seddon
National Director BDA Wales
Report Editor

BDA Wales has a policy of publishing key documents in Welsh and English (see our website)
https://www.bda.org/bdawales

Due to the time constraints of this consultation, it was not possible to translate this response into Welsh.

British Orthodontic Society (BOS) Submission to the National Assembly for Wales Health, Social Care and Sport Committee's Inquiry into Dentistry in Wales.

Author: Mr. Benjamin R.K. Lewis, Consultant Orthodontist.

Background

The British Orthodontic Society (BOS) is a charity that aims to promote the study and practice of orthodontics, maintain and improve professional standards in orthodontics, and encourage research and education in orthodontics.

The BOS is also a representative body of all branches of general dentists and specialist orthodontists in the UK who provide orthodontic care. The Groups within the Society are the Orthodontic Specialists Group, Practitioner Group, Community Group, Consultant Orthodontist Group, University Teachers Group and the Training Grades Group.

Orthodontics is the dental specialty concerned with facial growth; the development of the dentition and occlusion; and the assessment, diagnosis and treatment of malocclusions and facial irregularities.

Orthodontic treatment provided by the National Health Service (NHS) is undertaken according to clinical need as determined by the Index of Orthodontic Treatment Need (IOTN).

Orthodontic treatment is recognised to have a range of health benefits including the reducing the risk of dental trauma from prominent teeth; reducing the risk of root resorption of adjacent teeth from impacted teeth; recreation of space for the replacement of missing teeth or eliminating the space completely to reduce the restorative burden in the future; improving the ability to clean the teeth and reducing the risk of dental caries; improving dental function; and correcting dento-facial deformity .

One must consider the definition of health in its entirety as promoted by the World Health Organisation: "Health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity."

With this in mind, in addition to the dental health benefits highlighted above, there is also an improvement in the appearance, self-esteem and psychological well being, which can be especially important during the formative years of adolescence.

Orthodontic provision in Wales is undertaken by a range of professionals: Orthodontic Therapists (under supervision), Dentists with Enhanced Skills (DES)/Dentists with Special Interest (DwSI) in Orthodontics; and Orthodontic Specialists; in a range of clinical environments: General Dental Practice; Specialist Orthodontic Practice; Community Dental

Clinics; District General Hospitals; and Cardiff University Dental Hospital. Who undertakes an individual's orthodontic treatment is determined by the complexity of the malocclusion and the treatment required; any additional dental, medical and social needs of the individual; and the availability of the required expertise within the geographical area.

To date there have been three major documents produced with regards to orthodontic provision by the National Assembly for Wales:

- National Assembly for Wales Health, Wellbeing and Local Government Committee – Orthodontic Services in Wales, February 2011
- National Assembly for Wales Health and Social Care Committee – Orthodontic Services in Wales, July 2014
- "Review of the Orthodontic Services in Wales 2008-09 to 2015-16." (Professor Richmond 14/12/16). This document supersedes the Professor Richmond's previous "Review of the Orthodontic Services in Wales 2013-14." (Professor Richmond 06/02/15)

With regards to the current Inquiry, the BOS have been asked to comment of the following areas:

1) Progress made to improve the efficiency of orthodontic services delivered in Wales, with reference to the recommendations of the previous reports.
2) Training, recruitment and retention of the orthodontic workforce
3) Waiting times for appointments and treatment.

1. Progress made to improve the efficiency of orthodontic services delivered in Wales, with reference to the recommendations of the previous reports.

The recommendations from the previous reports are detailed below with the subsequent action, as far as the Society is aware, that has been undertaken detailed in bold.

<u>National Assembly for Wales Health, Wellbeing and Local Government Committee Report on Orthodontic Services in Wales (February 2011) made the following recommendations:</u>

Recommendation 1. We recommend that the Welsh Government commissions further research to assess the orthodontic treatment need, ensuring that contracts for orthodontic treatment are adequate to meet demand.

Action: We are not aware of any Research in this area commissioned by Welsh Government. It is, however, established best practice, that before any procurement procedure, a Needs Assessment is undertaken within that area, with input from all professional stakeholders and representative bodies, to fully assess the local requirements.

Recommendation 2. We recommend that Local Health Boards improve the efficiency and effectiveness of orthodontic services delivery through effective procurement processes. This should include ensuring that contracts contain details about the number of treatment starts and treatment completes per year in each contract.

Action: Key Performance Indicators (KPI) form part of the Contracts issued to Orthodontic Providers. The exact nature and wording of the KPIs will be determined by the LHBs, who will take into consideration the steer of Welsh Government via the following document:

"Updated guidance: Delivery of orthodontics in primary care – November 2015".

Recommendation 3. We recommend that the Welsh Government produces guidance for Local Health Boards on the effective and efficient procurement of orthodontic services. This should include guidance on developing agreements based on the number of treatments provided per year, quality of services, orthodontic treatment outcomes and value for money.

Action: Welsh Government issued the following documents:

"Guidance on Management of NHS Orthodontic Contracts in Primary Dental Care – July 2013"

"Updated guidance: Delivery of orthodontics in primary care – November 2015"

Recommendation 4. We recommend that the Welsh Government discusses with the Welsh Consultant Orthodontic Group how to introduce standardised UOA rate to address the disparity in UOA value and volume of treatment provided.

Action: Not undertaken.

Recommendation 5. We recommend that Local Health Boards review contracts identified as delivering orthodontic assessments only or mainly assessments and very few treatments.

Action: We believe that the LHBs have identified and eliminated Providers who were delivering assessment only contracts.

Recommendation 6. We recommend that Local Health Boards introduce specific contractual changes to take account of treatment provided rather than just delivery of UOAs. This should include consideration of whether practitioners should be allowed to claim for a repeat assessment within a short period of time unless it is clinically justified.

Action: We believe that the LHBs have introduced variations to the KPIs which have stipulated the recommended ratios between different types of claim in accordance with the Guidance documents issued by Welsh Government. Any variations from the average

by individual providers is automatically highlighted to the LHBs and these will be discussed as the routine contract review or at an earlier meeting if necessary.

Recommendation 7. We recommend that the Welsh Government facilitates the development of an electronic referral system in line with Recommendation 6 of the Government's national review, which will allow records to be monitored centrally.

Action: The Electronic Referral Management System (eRMS) for all Dental Referrals has been commissioned following an open tendering process by Welsh Government. The eRMS is currently under construction with expected phased roll out to the LHBs toward the end of 2018 and into 2019.

Recommendation 8. We recommend that Local Health Boards support the establishment of local Managed Clinical Networks (MCNs) in orthodontics with the view of improving patient care. MCNs should take lead responsibility for reducing early, multiple and inappropriate referrals in line with Recommendation 12 of the Government's national review.

Action: Orthodontic MCNs have been established in North Wales & Powys, South East Wales and South West Wales. The MCNs input into their local Oral Health Strategy Groups as well as having representation on the Welsh Government's Strategic Advisory Forum in Orthodontics. All MCNs have established local referral proformas and criteria to improve the quality of referrals as well as leading the way with regards to quality and safety within their regions.

For MCNs to operate efficiently, it is essential that they have full engagement from all the relevant stakeholders within the Profession and the HB. This is never more important when considering policy introduction that will have a profound effect on local service provision such as appeals processes and retendering of services.

The three Welsh MCNs have also liaised to produce a National Orthodontic Referral Form which has formed the basis for the orthodontic section of the forthcoming All Wales Electronic Referral Management System and a number of orthodontic electronic referral systems in England.

Recommendation 9. We recommend that the Welsh Government funds a one off waiting list initiative to clear the backlog of patients waiting for orthodontic treatment.

Action: Not undertaken.

Recommendation 10. We recommend that the Welsh Government discusses with the General Dental Council how to ensure that the issue of inappropriate referrals is addressed and whether IOTN training should be mandatory for all GDPs.

Action: No information available as to whether this has been undertaken.

Recommendation 11. We recommend that the Welsh Government amends Regulations to include a contract penalty for practitioners who persistently refer patients early or making a high volume of inappropriate referrals in order to encourage them to change practice.

Action: Not undertaken

Recommendation 12. We recommend that Local Health Boards set out clear contractual arrangements with DwSIs including close monitoring of treatment outcomes, with a view to the development of specific orthodontic Personal Dental Services agreements.

Action: DwSIs should be monitored to the same level with the same expectations of the outcome as orthodontic specialists (although the range and complexity of cases they have undertaken will be inevitably reduced). It would be anticipated that DwSi, who are only treating patients from their own Practice, should be using a higher proportion of their allocated UOAs, if not all their allocated UOAs for treatment, as any reviews before treatment is commenced would be undertaken with their General Dental Practitioner "hat" on.

Recommendation 13. We recommend that Local Health Boards work with local MCNs to introduce a local accreditation scheme and continuing professional development for DwSIs.

Action: Accreditation schemes have been undertaken by all three MCNs, each with variations to accommodate local circumstances, but underpinned by a tripartite agreement that all orthodontic treatment plans should be undertaken by an orthodontic specialist.

Recommendation 14. We recommend that the Welsh Government facilitates the development of the skills base of the orthodontic workforce.

Action: No information available as to whether this has been undertaken.

Recommendation 15. We recommend that the Welsh Government strengthens the current General Dental Council guidance to ensure orthodontic therapists must be supervised by an orthodontist on the specialist register as opposed to a general practitioner at all times.

Action: No information available as to whether this has been undertaken at a Welsh Government level, however modifications to the required level of supervision of orthodontic therapists have been included in Contracts issued in North Wales following the PDS Specialist Orthodontic Contract re-tendering process. In addition, it has been agreed by the Strategic Advisory Forum in Orthodontics that the BOS Guidelines on supervision of Qualified Orthodontic Therapists 2017 should act as the <u>minimum</u> standard as this document also uses the term "dentist" as many areas of the UK do not have Accreditation Schemes for DESs/DwSIs.

Recommendation 16. We recommend that the Welsh Government amends Regulations to include a contract penalty for poor quality treatment (based on PAR and excluding those cases where the patient was not compliant with the treatment).

Action: No information available as to whether this has been undertaken.

Recommendation 17. We recommend that the Welsh Government develops an implementation process to facilitate close monitoring of treatment outcomes through PAR and establish a system where PAR score reductions are monitored independently on annual basis for all providers.

Action: No information available as to whether this has been undertaken at a Welsh Government level, however within each MCN area, Peer Assessment Rating (PAR) score monitoring is undertaken instigated by either the Local Orthodontic Committee (LOC), MCN or HB.

National Assembly for Wales Health and Social Care Committee Report on Orthodontic Services in Wales (July 2014) made the following recommendations:

Recommendation 1. The Committee recommends that the Minister for Health and Social Services works with local health boards and managed clinical networks to develop robust monitoring arrangements to ensure consistent compliance with treatment outcome requirements.

Action: PAR score audits are undertaken within all MCN areas. These are conducted by either the LOC, MCN or HB. It is essential that all practitioners with responsibility for the treatment outcome are included and judged to the same standards, accepting that PAR is not designed to assess the outcome of certain malocclusion types.

Recommendation 2. The Committee recommends that the Minister for Health and Social Services confirms when the electronic referral system will be introduced, and sets out the actions local health boards and managed clinical networks can take to identify patterns of inappropriate referrals, and plan and deliver suitable targeted interventions.

Action: The Electronic Referral Management System for all Dental Referrals is currently under construction and is due to be rolled out 2018/2019.

Recommendation 3. The Committee recommends that the Minister for Health and Social Services sets out the actions local health boards and managed clinical networks can take, with associated timescales, to improve waiting times in each local health board area, and identifies the monitoring arrangements he will put in place.

Action: No information available as to whether this has been undertaken.

Recommendation 4. The Committee recommends that, to ensure that the service received by patients is of a sufficient standard, the guidance issued to local health boards by the Chief Dental Officer in relation to commissioning orthodontic services includes best practice for the establishment and monitoring of such services.

Action: This is included within the Welsh Government's document: "Updated guidance: Delivery of orthodontics in primary care – November 2015"

Recommendation 5. The Committee recommends that the Minister for Health and Social Services takes steps to reform payment arrangements for orthodontic services to address the concerns raised by the Committee.

Action: This has not been undertaken. Retendering of Specialist Primary Care Contracts within Wales is currently ongoing. However, different approaches have been taken by the different Health Boards. It was highlighted in this report how important it was that

Practices have the "confidence to invest" with longer term contracts. However, it is also essential that any new contractual arrangements are viable, as there is concern that new UOA rates that do not take into account local circumstances and National requirements will pose a risk to the long term sustainability of Specialist Practice and the associated service provision.

Recommendation 6. The Committee recommends that the Minister for Health and Social Services reviews the guidance available to support local health boards in entering into contracts for the provision of orthodontic services which take local needs into account. Such guidance should cover, as a minimum, determination of contract length, robust performance and quality monitoring arrangements, protections against the selling on of contracts, and contract exit arrangements.

Action: See concerns raised above.

Review of the Orthodontic Services in Wales 2008-09 to 2015-16. (Professor Richmond 14/12/16)

Recommendations:

Welsh Government

• The Welsh Government in association with the various dental authorities and the Orthodontic Strategic Advisory Forum should lay out a clear strategy for orthodontics in Wales for the next 5 years. This should incorporate:

i. The personnel (skill mix) who should deliver care (GDP, Practitioners with a special interest in orthodontics, Specialist practitioners, Specialist/Orthodontic therapists
ii. The setting of the delivery (PDS, Hospital, Community, Private) and treatment thresholds with defined numbers requiring multiple dental/medical specialty treatments.
iii. Pragmatic patient access and coverage of orthodontic provision across Wales
iv. The type and quantity of orthodontic cases treated in the various settings.
v. Encourage contracts that are purely treatment driven to ensure equity and fairness for all Performers across Wales.

Action: It is believed that this work is ongoing, but yet at a relatively early stage in the process.

• Promote improved communication in Health Board decisions and local implementations of any local orthodontic decision/strategy.

Action: This can be achieved by a fully functioning MCN, however, as has previously been mentioned, for an MCN to operate efficiently it requires full engagement of all the

relevant stakeholders from within the Profession and the HB working together in an environment of mutual respect and cooperation.

• Facilitate improvement of data sharing and ensure robust systems for data recording/reporting with regard to all aspects of orthodontic provision in all provider settings.

Action: We are unaware as to how much progress has been made within this area.

Health Boards

• Orthodontic contracts should be based on "Assess and accept" only.

Action: Orthodontic provision includes both advice and treatment. To alter the renumeration system to cover only treatment would be unfair to the practitioners and a retrograde step.

• The practice of "Assess and review" should cease unless there is a clear indication.

Action: There are clinical circumstances where a further review, prior to commencing treatment, following an initial assessment, is entirely appropriate. To prevent inappropriate levels of "Assess and Review" the HB Contracting Teams have put into place expected ratios, outside which further investigations will be triggered.

• Ensure that there are contracts that reflect population provision in each Unitary authority and cross border flows are fully accounted for with robust pre-determined contracts.

Action: This should be established by a local "Needs Assessment". However, there is concern that the calculations of need based on a third of 12 year olds within an area can underestimate the actual local demand in practice. It is also essential that cross border activity, both between HBs and between Wales and England are full appreciated by those undertaking any "Needs Assessment" and are taken into account fully when considering any changes in policy.

• The Health Boards should monitor the performers according to key performance indicators, specifically the number of patient receiving active orthodontic treatment and whether these patients fulfil the orthodontic entry requirements as well as assess the outcome of treatments assessed by the PAR Index.

Action: We believe that these processes are in place within each HB. However, there are anecdotal reports that the level of monitoring by the HB can vary between different Providers within a HB.

• The number of Performers in each Health Board should match the likely need of the local population (as close as possible to expected numbers) and/or needs of the population in nearby Unitary authorities in other Health Boards.

Action: It must be recognised that it is the "whole time equivalent" number of performers that is most important to match rather than the actual number of performers. This will then be more able to reflect variations in working patterns and professional demographics. It is also essential that any cross border activity, and appropriate supervision of non-specialist orthodontic performers, is taken into account when calculating the "ideal" numbers.

• The data obtained relating to orthodontic treatment in the GDS/PDS is improving. More resources should be allocated to document orthodontic provision in other settings.

Action: We are not aware that this has occurred.

Orthodontic providers/performers

• Performers should routinely accept patients above the orthodontic treatment threshold and deliver average treatment outcomes consistent with 70% reduction in PAR scores

Action: All practitioners should only accept patients for treatment who qualify for NHS Orthodontic treatment according to the current threshold of IOTN. All completed treatment should be competed to a satisfactory standard as stipulated within the PAR guidance.

• Waiting list data (specifically date of birth, post code and date placed on waiting list) should be routinely collected and reported annually to the Health Boards.

Action: This should be available following the introduction of the Electronic Referral Management System.

• Re-treatments should be undertaken through the private sector.

Action: It is accepted that only one course of definitive treatment should be provided by the NHS to an individual patient, unless there were exceptional extenuating circumstances which the HB felt justified a second course of NHS funded treatment.

2. Training, recruitment and retention of the orthodontic workforce

The Orthodontic workforce undergo a variety of training pathways. These are summarised below:

Orthodontic Therapist – Dental Nurses who undertake a 12 month course cumulating in an exit examination by one of the Royal College of Surgeons.

Dentists with Extended Skills (DESs) / Dentists with Special Interest in Orthodontics (DwSI) – Dentally qualified practitioners who have experience in orthodontic management, often

having training in posts which are not monitored or approved by the Specialist Advisory Committee (SAC). In Wales, these individuals will then have been formally assessed by the DwSI Accreditation Process established by each MCN.

Orthodontic Specialist Practitioner – Dentally qualified practitioner who has undertaken a number of years training in related specialties such as Paediatric dentistry, oral and maxillofacial surgery, before embarking, via competitive entry, on a 3 year Orthodontic Specialty Training Pathway (StR 1-3) recognised by the SAC which also includes undertaking a taught postgraduate qualification such as a Masters or Doctorate. This cumulates in an exit examination by one of the Royal Colleges.

Consultant Orthodontist – Dentally qualified practitioner who has undertaken the Specialty training detailed above to become a Orthodontic Specialist Practitioner and then embarks, via competitive entry, on a SAC approved higher training pathway lasting from 2 to 2 ½ years (StR 4-5). This additional training focuses on the multi-disciplinary care that is the mainstay of secondary care orthodontic provision, but also provides training in the wider remit of an orthodontic consultant. This cumulates in an exit intercollegiate examination by the Royal Colleges.

It is recognised that throughout the UK, the more rural the environment, the harder it is to recruit suitably trained professionals. This is due to a number of factors, with two of the most important being where an individual's family/social connections are based, and secondly, that professionals tend to "settle down" near to where they trained due to the personal and professional links they established during their training period. The Welsh Orthodontic Training Programme is provided by Cardiff University which introduces logistical challenges to undertaken orthodontic training posts within North Wales. The Welsh Deanery have been very supportive of orthodontic training in North Wales, recognising its importance in recruitment and retention locally. A pragmatic solution has been agreed between the Welsh Deanery and Liverpool Orthodontic Training Programme to allow orthodontic trainees in North Wales to obtain their education element as well as some clinical training within Liverpool University Dental Hospital and Alder Hey Children's Hospital.

The main Orthodontic Training Programme in Wales is run via Cardiff University. All trainees undergo competitive entry via National Recruitment. The potential trainee ranks each available post and they are matched depending on their performance during the National Recruitment Process. Unfortunately, this system has resulted in some unintended consequences as it has been reported that trainees, who have a local connection to Wales and a desire to remain in the region in the long term, have not secured training places in these areas. This has lead to increased challenges in recruitment of specialists in Wales following completion of their training. Discussions have been held about the regional benefits of undertaking a recruitment process outside National Recruitment. In an attempt to improved Consultant recruitment, run through training has been established where a

trainee undertakes both the Specialist Orthodontic Practitioner and Consultant Orthodontist training in succession within the same Region over a 5 year period. There are currently 4 "run through" trainees in post and it is hoped that they will continue through to the completion of the Consultant training. Unfortunately, in other regions with "run through" training pathway, some trainees have stopped their training after the end of the Specialist Orthodontic Practitioner training period rather than completing their Consultant training, so it will need to be seen if the new policy increases the prospects of successful Consultant Orthodontic recruitment in due course.

For 2018 intake there have been two Orthodontic Specialist Trainees recruited (StR 1-3), one in South Wales and one in North Wales. Only one higher trainee (StR 4-5) was appointed out of 3 posts which were advertised. There is currently no Orthodontic Therapist Course being run in South Wales.

Another issue which has been raised as a potential barrier for trainees to accept orthodontic training posts within Wales is the differential payscales between England and Wales and the varying costs of the University fees to undertake the Orthodontic academic postgraduate qualification as Cardiff University reportedly has one of the highest course fees. This can lead to an income differential of £23,000 per annum between a trainee in England and Wales.

The issues with training along with the topography and rural nature of Wales has resulting in significant problems in recruitment and retention of certain sections of the orthodontic workforce. Within Primary Care Specialist Orthodontic Practice, some issues with regards the recruitment of Specialist orthodontists has been reported. There is a tendency for this to more common with Corporate Bodies as they can have a higher turnover of staff as well as the orthodontic performers not having a financial investment within the Practice. Within secondary care, the problem is more acute. This is due to numerous factors including issues of supply and demand, with at least 48 unfilled consultant posts within the UK, the tendency of newly appointed consultants to work part time, decreased uptake of Consultant training positions, and the inability of some posts to offer the prospect of a fully integrated Multi-Disciplinary Team and teaching opportunities, due to vacancies in other areas.

Table 1 Current Vacancies by Health Board

Health Board	Vacant Post(s)
ABMU (including Hywel Dda)	1wte Consultant 2 x post CCST (x3 attempts to recruit)
BCUHB	0.5 wte Consultant (YGC) 0.6 wte SAS (YMW & YG)
Cardiff and Vale	1.4 wte Consultant

Table 2 Further additional Vacancies from retirements in the next 5 years by Health Board

Health Board	Vacant Post(s)
ABMU (including Hywel Dda)	1 wte Consultant
Aneurin Bevan	None envisaged
BCUHB	1.2 wte Consultant (YG)
Cwm Taf	1.1 wte Consultant 1 wte CDS Post
Cardiff and Vale	None Envisaged

3. Waiting times for appointments and treatment

Waiting times within an area will be determined by a number of factors including the following:

I. Treatment Need
II. Treatment Demand
III. Commissioned Activity
IV. Availability of suitably trained professionals
V. Geographical influences
VI. Overall dental health
VII. Levels of deprivation

I. Treatment Need

An estimate of the treatment need can be calculated using a recognised traditional formula of a third of 12 year olds. However, as has been eluded to above, there is some evidence that this frequently used ratio can underestimate the actual treatment need in practice. The 2003 Child Dental Health Survey revealed that 8% of 12 year old and 14% of 15 years were undergoing orthodontic treatment and that a **further** 35% of 12 year olds and 21% of 15 year olds were assessed as having a treatment need. This equated to a recognised treatment need in 43% of 12 year olds and 35% of 15 years old. In addition, even this data is likely to underestimate the true treatment need as the "need" in the Survey was qualified as IOTN Dental Health Component of Grades 4 and 5 or an Aesthetic Component of 8-10, which is higher that the threshold currently in use for the allocation of NHS resources.

II. Treatment Demand

The perception of body and dental image has radically changed over the last 20 years and along with it the acceptance of undergoing orthodontic treatment. This has led to a substantial increase in the demand for orthodontic treatment. Fortunately, the strict adherence to only providing NHS orthodontic treatment to those to qualify according to the IOTN criteria, means that precious NHS resources are only used on those individuals with the greatest clinical need.

III. Commissioned Activity

The majority of current orthodontic activity is based on the historical distribution that was in place when the "New Contract" was introduced in 2006. The level of activity was determined by the orthodontic activity that had been carried out previously rather than what was required by the needs of the local populous. A number of HBs have commissioned "Needs Assessments" along with additional activity to address any discrepancies identified, however, the accumulated "back log" of individuals waiting for an orthodontic assessment and possible treatment has never been addressed.

IV. Availability of suitably trained professionals

It is recognised that throughout the UK, the more rural the environment, the harder it is to recruit suitably trained professionals. This is due to a number of factors, with two of the most important being where an individual's family/social connections are based, and secondly, that professionals tend to "settle down" near to where they trained due to the personal and professional links they established during their training period (See section 3). Wales has additional challenges due to its topography and ignorance and misperception surrounding potential linguistic challenges.

V. Geographical influences

The topography of Wales with the associate transport infrastructure have a substantial influence on accessing Specialist care for those individuals who reside in the most rural areas. As most Specialist provision is based in areas of high population density, the provision of Orthodontic Treatment by outreach programmes such as the Community Dental Service or within the General Dental Service by DwSI/DESs is an important component of overall service provision in remote areas.

VI. Overall dental health

Orthodontic treatment can only be undertaken on individuals who have a stable dental health. In fact, the desire to undertaken orthodontic treatment can often be a very compelling motivator for individuals to change their behaviour to establish a good level of dental health. As this change is often permanent, it reduces general dental treatment needs for those individuals in the future resulting in a cost saving for the NHS over the long term. As the general dental health of the population improves following improved dental education and excellent interventions, such as "Design to Smile", then the proportion of children with a recognised need for orthodontic intervention, as identified by IOTN, who now demonstrate a level of dental health sufficient to support a course of orthodontic treatment increases. This subsequently increase demand.

VII. Levels of deprivation

Deprivation levels will have a bearing on accessing orthodontic provision in a number of ways including suitability, due to poor levels of dental health, and transport limitations. As general dental interventions targeted at this demographic have a positive effect then access to treatment is improved.

Within Wales there are substantial waiting times for orthodontic assessments and treatment. Not every individual who has an orthodontic assessment will go on to have NHS orthodontic treatment. This can be for a number of reasons including general dental health, patient motivation/compliance to undertaking a prescribed treatment, personal circumstances, and not reaching the qualifying criteria according to IOTN.

The processes of managing referrals varies between providers. In general, in primary care, when a patient is referred, they are placed on a “waiting list” for assessment and possible treatment and are then taken off this list when a “treatment slot” becomes available. This results in a long referral to assessment time, but a short assessment to treatment time.

In secondary care settings, the patients are usually seen within 26 weeks from initial referral for a New Patient Assessment, as the Referral To Treatment (RTT) is only applicable for that initial assessment and then the patients are either discharged with advice, referred to another discipline/primary care specialist as appropriate, added to a treatment waiting list or reviewed depending on the clinical circumstances. This results in a relatively short referral to assessment time, but a much longer assessment to treatment time.

There is a concern about the identification of individuals who would benefit from “priority” orthodontic assessment and intervention, such as impacted teeth causing damage to adjacent teeth. This will be improved by the introduction of the eRMS as this will help identify these individuals, although it is recognised that any identification process is only as good as the referral information provided. Consideration has been given to altering the referral management process in Primary care to the secondary care model with patients experiencing a shorter Referral to Assessment time and if appropriate then being added to a longer assessment to treatment time, however, due to the current back log of patients waiting for the initial assessment, this would have implications on orthodontic treatment activity.

The current waiting times within both Primary and secondary care sectors is a result of historic and current discrepancy between referrals/need for treatment and actual treatment capacity.

The current orthodontic waiting times within Wales are reported as follows:

Table 3 Waiting times in primary care by Health Board

Local Health Board	New Patient Waiting Times (RTT)	Treatment Waiting Times after NP Assessment
ABMU (including Hywel Dda)	3-48 months	2 months
Aneurin Bevan	3-30 months	2-24months
BCUHB	8-10 weeks 16-24 months	18 months 2 months
Cardiff and Vale	6-30 months	2-6 months
Cwm Taf	17 weeks 6-22 months	6-15 months 2 months
Powys	4-12 weeks	2 months

Table 4 Waiting times in secondary care by Health Board

Local Health Board	New Patient Waiting Times (RTT)	Treatment Waiting Times after NP Assessment
ABMU (including Hywel Dda)	4-13 weeks according to urgency	In excess of 48 months
Aneurin Bevan	Up to 26 weeks (2 units)	54 months
BCUHB	20-26 weeks (3 units)	18-37 months
Cardiff and Vale	26 weeks	Longest wait 43 months
Cwm Taf	19-26 weeks	9-36 months
Powys	Up to 20 weeks	30 months

The current waiting times are a result of a discrepancy between need/demand for orthodontic treatment and commissioned orthodontic activity as well as issues with the recruitment and retention of appropriately trained clinicians. Previous Reports have recommended a one off initiative to clear the treatment backlog, however, this would need

to be carefully thought through with regards the overall service provision and there may be greater merits in distributing any additional initiative funding over a longer period to allow a sustainable approach to be adopted, as this would allow for a managed recruitment process to be undertaken with diversification of the workforce as appropriate.

4. Summary & Recommendations

a. There is a wide variation in the waiting times within individual Health Boards and Wales as a whole. This is evident in both primary and secondary care settings. It is suspected that this is primarily due to an intrinsic discrepancy between the treatment need and the commissioned activity, however, the reasons for this need to be fully established and options investigated to address these discrepancies in sustainable way which allows services to adapt.
b. The introduction the Orthodontic MCNs has been greatly beneficial. It is essential that all stakeholders remain fully committed and engaged and that the recommendations of the MCNs are incorporated into HB policy via their Oral Health Strategy Groups and their Oral Health Plans.
c. Continue the collective work of the Strategic Advisory Forum in Orthodontics to obtain a All Wales approach within Orthodontic Provision.
d. Continue with the introduction of the eRMS to produce a universal referral pathway and help identify individuals who require priority assessment and intervention as well as allowing more robust data collection. Although the introduction of the eRMS will streamline the referral process and it is anticipated that there will be an initial reduction in referrals while the referral base adapts to the new system, it is unlikely to have a significant downward effect on treatment need in the long term.
e. The awarding of short term contracts results in a limitation in the flexibility of the Practices to invest and modify their current practices. It is prudent to commission longer term contracts with appropriate quality safeguards incorporated within the KPIs to ensure qualify and productivity. It is essential that any reduction in UOA value is sustainable and that any cost savings achieved due to a reduction in UOA value are reinvested within the orthodontic provision to help address discrepancies between need and capacity.
f. Orthodontics is the most monitored speciality within dentistry. We would advise the continue monitoring of treatment outcomes to ensure quality and value for money is achieved within the framework of Prudent Health Care. The exact monitoring mechanisms will be determined at a HB level under advice from MCN and SAFO.
g. Training, recruitment and retention of the orthodontic workforce within Wales is problematic. This area needs to be investigated and options devised to address it. This needs to be done expediently as upcoming retirements are going to compound the problem leading to further disruptions to service delivery, and an exacerbation of the excessive waiting times currently experiences within all sectors.

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D16
Ymchwiliad i Ddeintyddiaeth yng Nghymru / Inquiry into Dentistry in Wales
Ymateb gan Fwrdd Iechyd Prifysgol Abertawe Bro Morgannwg
Response from Abertawe Bro Morgannwg University Health Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

	Abertawe Bro Morgannwg University Health Board [ABMU] response to the Health, Social Care and Sport Committee's inquiry into dentistry in Wales
Contact	[redacted] Head of Primary Care, ABMU [redacted]
Date created	30 August 2018

Introduction

1. Abertawe Bro Morgannwg University Health Board [ABMU] welcomes the opportunity to respond to the Health, Social Care and Sport Committee's enquiry into dentistry in Wales. The information and views set out below have already informed inform the Wales-wide report from the Welsh NHS Confederation but are provided in full to reflect a perspective on oral health care services provided and commissioned in the Swansea, Neath Port Talbot and Bridgend county areas. The submission comprises responses on the specific issues the Committee requested in 39, numbered paragraphs across 9 pages.

Welsh Government's Dental Contract Reform

2. In 2017 four of 95 general dental contractors in the ABMU area volunteered and met the locally developed criteria to test out a Wales-revised version of the 2005 General Dental contract which aims to reduce the disincentives to providing holistic, preventive care that are inherent in the original. The problems associated with the 2005 contract are described in other submissions to the Committee. They were so significant that pilots of three alternative models were being piloted across Wales within three years of its inception. By 2011 only ABMU was content to pursue a more effective alternative and continued to support two practices operating without an 'activity' target with very positive results in terms of treatment and access. These two 'Prototype' practices are now providing both a helpful foundation and in-built control test for the dental contract reform programme introduced from September 2017. The six reforming practices (four Contract Reform and the two Prototypes) have, for the past year, formed a ABMU Contract Reform group, supported by the Health Board, Public Health Wales and Chief Dental Officer to share learning, and views on the proposed programme, its benefits, potential pitfalls and how it can be taken forward. ABMU is represented on the Chief Dental Officer's national contract reform group through the Dental Director and Primary Care Manager who has driven and supported much of this work locally.

3. The ABMU pre-2017 legacy is that, from 2011 onwards the two Prototype practices had their standard Unit of Dental Activity [UDA] target removed from their contract and were instead paid on a Capitation and Quality Payment which focused on patient numbers and promoting prevention. Recording of activity on a UDA basis continued as a background check. The practices introduced a new Dental Care Assessment service, increased the focus on prevention, recalled patients based on NICE clinical guidance (rather than fixed 6 month periods) and scored

patients' oral health cards as Red/Amber/Green to give clear indicators of the patients' journey and facilitate a genuinely co-produced plan. Five stages of treatment were identified following assessment and planning: Urgent care, Risk Reduction, Stabilisation, Restoration of Function and Advanced Care. This allowed Practice teams to review the patient's progress with them before committing to providing advanced care, e.g.crowns, implants. The Prototypes also tested a more equitable system for patient charge revenue and allayed fears associated with that aspect of the pilot. By 2017 it had been demonstrated successfully that removing the UDA as a driver from these practices gave clinicians more freedom to make decisions, using their own clinical judgement about what was in the best interests of their patients. Once established, it became evident that more new patients were being seen and the proportion of patients provided with advanced treatment had reduced.

4. The national dental contract reform programme launched in 2017 built upon the Prototypes as well as experience introduced from elsewhere in the UK. They were joined by four other practices in ABMU (14 across Wales) to test a 'blended' contract methodology which comprises a compromise between the GDS contract and the prototype described above. Phase 1 of the contract reform programme (September 2017 – March 2018) reduced, but did not eliminate, the UDA target by 10%, easing the time/financial pressures on practices to enable them to complete and submit clinical profiles on all patients assessed and treated.

5. The six, very different, practices who comprise the Phase 1 Contract Reform group hold a total contract value of approximately £2.2 million to deliver almost 87,000 UDAs or equivalent. The UDA rates per practice varied from £23.13 - £38 (average £26) for contracts ranging from 5,800 to 34,500 UDAs. Between them, they can provide a true test of what might be deliverable with contract restrictions lifted to varying degrees.

6. In June 2018 Public Health Wales colleagues produced and shared the initial draft of the practice-based patient and practice profiles drawn from the data collected by the practices. Further, more detailed profile information that will support decision making, factoring in practice size, contract value etc., is awaited from year-end returns. However that available to date indicates that the Health Board and Practices can be confident in reducing further UDA targets in return for specific quality initiatives to secure greater, more appropriate, patient access to General Dental Services with improved health outcomes.

7. The reform programme has, as an aim, that 10% of Wales' practices will be testing the blended contract by 31 March 2019. The current thinking within ABMU is that the next phase of the reform project, from October 2018, will seek to reduce the contract targets by 10% in at least two more practices* and drop further the UDA target in the phase 1 practices in return for specific quality initiatives, some of which are already being explored. Some examples discussed within the Primary Care team and/or contract reform group to date include initiatives that could:

    - improve practice sustainability and retain Dental Foundation trainees in struggling practices
    - improve patient access to general dental services with demonstrable increases in unique patient numbers (in contrast to current high levels of repeat attenders) and/or
    - support enhanced skills training of General Dentists to help reduce what are currently secondary care waiting times for treatment which could be delivered out of hospital.

    *NB 10% of contractors in Swansea and Neath Port Talbot = 8. There are currently no contract reforming practices in Bridgend county.

8. ABMU is aware that not all practices are in a position to embrace the multi-disciplinary approach upon which a holistic model of service depends. This is particularly the case in those who are single-handed and/or operating in small premises that cannot accommodate additional staff, e.g. hygienists, therapists, dental nurses. As an integral part of its service planning and development in 2018/19 ABMU will undertake a survey, jointly with the Local Dental Committee, of practice staffing and facilities to help gauge the extent to which practices are in a position to remodel the services they provide.

9. It is the view in this Health Board, based on experience to date with the Prototype Practices and the wider contract reform, that the changes have resulted in improved access, especially for the most vulnerable, and the nature of the care provided has been driven more by individual need than a contract target. However, as the programme is rolled out it is important that it is underpinned by robust governance and that changes for individual practices are based on the needs of the local population and not simply an 'all-Wales' framework. Experience from the Prototype practices should be shared nationally and these practices should continue to drive and test innovation. Local management teams will need to ensure they have the resources and the capabilities to support the changes and provide reassurance to Health Boards and Welsh Government.

How 'Claw back' money from Health Boards is being used

10. Since February 2017, investment of all ABMU's funding for primary and community dental services has been guided by a three-year oral health service and financial framework. Now known locally as the Oral Health Delivery plan, its broad plans and progress to invest an increasing amount of the ring-fenced budget up to the full allocation in 2020/1, including contractual recovery monies, referred to above as 'claw backs' - is summarized from 12. below. The reasons why a three-year approach to budget setting and management was both necessary and beneficial lie in the constraints imposed by the General Dental Services [GDS] Contract and local circumstances.

11. The GDS Contract requires Health Boards to pay practices 100% of their contract if they have delivered at least 95% of contractual activity, as expressed in Units of Dental Activity [UDAs]. It is also at Health Boards' discretion to pay contractors for over-performance of up to 105% against their contract. ABMU chose not to recognize over-performance in 2016, primarily because concerns had emerged in the preceding two years about inappropriate contracting practice by a significant number of dental contractors. However the removal of the potential reward for over-performance was a disincentive for many contractors to achieve more than 95%. Many achieved significantly less than this with consequent 'claw backs' required.

12. In 2016/17 ABMU's underspend of the Welsh Government [WG] ring-fenced general dental budget reached almost 7% for a variety of reasons *including* the recovery of monies from contractors who had delivered less than 95% of their contract at year end. A decision made in 2016 to commission all dental activity in ABMU HB via a formal procurement process to improve governance meant that it was not feasible to offer out the recovered funds to contractors willing to undertake additional activity in-year. The formal procurement process replaced an informal arrangement whereby the primary care management team wrote to dentists who met particular criteria (eg location, performance) to gauge interest in undertaking more activity on a non-recurring basis, then awarded it. Delivery of a formal procurement process requires significantly more investment of primary care and procurement management time. Consequently, the whole

of the 2016/17 underspend contributed to supporting the Health Board's overall financial position.

13. Action to prevent a recurrence of this situation was taken from early 2017 to prevent. The offer to pay over-performing contractors who met specific criteria was reinstated, and a three-year investment plan, informed by contract monitoring returns and trends, was developed and agreed within the Health Board in February 2017. This proposed increasing expenditure on dental services in three large steps to ensure the whole dental allocation was invested in oral health care by 2020/1. It was not feasible to achieve this sooner within the existing management resource.

14. The plan was revised in June 2017 when, as a consequence of ABMU's level of underspend, Welsh Government withheld contract uplift monies and increased the patient income target. This had the result of halving the additional monies available to invest in dental services. The revised plan demonstrated how the Health Board would succeed in spending the additional monies that remained and received approval within ABMU (June) and Welsh Government in September 2017. The plan includes a range of service and financial of initiatives to achieve the following broad objectives:

    1. Improve the Oral Health of vulnerable groups, e.g. children, adults in care homes,
    2. Improve equity of access to general dentistry
    3. Reduce variation in dental pathways
    4. Improve access to special care dentistry
    5. Reduce referral to treatment times in restorative dentistry
    6. Improve governance and leadership
    7. Improve compliance with key legislation

15. Through a mixture of schemes, ABMU made significant progress on a range of improvements against objectives that had been prioritized for years 1 and 2:

    - Increased UDA value to £25 for 43 practices who agreed to a range of quality initiatives
    - Commissioned additional activity (30,000 UDAs) in 7 practices in high need areas including new practice in Port Talbot from 2018/19
    - Halved children-only contracts, rewarding practitioners who 'converted' to full range of patients with a higher UDA rate
    - Introduced Referral Management Centre [RMC] and new paediatric pathway to support referrals for treatment under a General Anaesthetic, savings from reduction in latter being reinvested in building alternative pathway
    - Transferred resources to the Community Dental Service recognizing its contribution to providing domiciliary dental services in Bridgend county (only) and to support the new paediatric pathway
    - Enhanced Clinical leadership and management, investing in additional Dental Practitioner sessions, Clinical Leadership roles in Community and Restorative Dentistry and primary care management support.
    - Supported practices to comply with the Equality Act through award of improvement grants to introduce hearing loops, disabled access; commissioned bariatric waiting and toilet facilities in Port Talbot Resource Centre.

16. At 2017/18 year end, it was confirmed that the ring-fenced GDS budget had underspent by less than 2%. The Health Board's overall underspend on dental services (inclusive of General, Community and Restorative Dental services) was also less than 2% and demonstrated an

increase in expenditure towards full investment by 2020/21. ABMU had achieved the twin aim of investing in dental services, whilst also containing plans to ensure they were affordable to the Health Board.

17. In 2018/19, Welsh Government increased the dental allocation to restore the element withheld in 2017/18 on the basis of the demonstrable investment in dental services. However ABMU is not complacent: the advice received in July from Welsh Government colleagues that there needed to be an increase in expenditure in GDS from the level evident at the end of June is taken seriously. The Health Board is confident, and has provided assurance, that the further roll out of its Oral Health Delivery Plan will increase expenditure of the ring-fenced allocation and overall oral health service budget, as a consequence of the full year effect of the initiatives summarized above plus the following:

    - Introduction of an enhanced new dental service for HMP Swansea
    - Further development of new dental service to improve access by asylum seekers
    - Completion and introduction of a new, integrated, pathway and associated service specification for domiciliary care
    - Additional investment and reinvestment in paediatric pathways as consequence of changes made to date and impact of WHC(18)009
    - Remodeling of Restorative Dentistry service, creating intermediate care model with support of additional Dentists with Enhanced Skills

18. Additionally, the plans to invest the dental allocation in 2018/19 (inclusive of contractual recoveries) will include initiatives that did not feature in the original plan but which are considered appropriate to reflect emerging service issues. Notably, concerns about long-term primary care sustainability (referenced at 8. above and 22 below) have resulted in the development of General Dental Practice Fellowship to retain and train young dentists.

19. ABMU will be recovering more monies from contractors for 2017/18 than in the previous year, but this is as a direct result of significant underperformances in a few large contracts, reported by the providers as being the result of vacant dental posts. Proactive contract management, reducing the traditionally underperforming contracts for restricted groups (e.g. children only) if the contractor would not accept all groups of patients also had an impact. It is hoped that increasing intelligence around practice prescribing profiles, local population needs and regular engagement will reduce the need for 'claw back' will reduce in future years. It is also considered that the lines between General, Community and Hospital Dental Services will become less distinct than the historical position. ABMU is actively engaged in integrating the delivery of services and pathways across these areas. This is enhancing scope to deploy specialists to work alongside General Dental Practitioners in primary/community settings, and the development of intermediary services means that dental budgets will need to be considered as a whole rather than ring-fenced to service areas.

Issues with the Training, Recruitment and Retention of dentists in Wales

20. Although some corporate practices have reported that they experience problems recruiting dentists, recruitment is not yet felt to be a major problem in the majority of dental practices in ABMU. However, there is increasing awareness that this is changing in dentistry as in other areas of healthcare. Retention issues amongst the young is now seen as a problem, and the impact of likely retirements amongst senior dentists will need to be quantified and tackled. For example, the 14 training practices have all reported difficulties retaining their Dental Foundation trainees

and, particularly as this problem has been common to all types of practice, including the Prototypes last year, it is felt that this is a consequence of the disincentives associated with the UDA Target-driven GDS contract but also the UK-based allocation of training places. There is also a perception that many young dentists no longer aspire to take on the responsibilities of running a practice. ABMU's Post Graduate Training Unit at Port Talbot has trained 35 postgraduate dentists since completion of its first course in 2010, of which 9 are still working in the ABMU area (two within the Community Dental Service). Work is ongoing to confirm the retention rate for those trained in ABMU's 13 other training practices that would help gauge whether this should be considered a cause for concern, but it is understood that the retention rate generally is significantly less than at the Training Unit and is reducing.

21. ABMU was therefore keen to work with the Deanery to introduce, in September 2015, a 'longitudinal' training programme based around ABMU and Cwm Taf's Dental training units with rotations into practices that provided intermediate care (oral surgery) and the Community Dental Service. The hope was that a two-year training period would provide sufficient time and incentive to encourage trainees to establish roots in the area. However, this proved no more successful than the previous experience and, being as complex to undertake to deliver, the training programme reverted to one year's duration from September 2017.

22. As ABMU has concerns about this issue, it has developed and will pilot a three year General Dental Practitioner Fellowship from September 2018, linked with the Contract Reform programme. Expressions of interest were sought from individual practices and Dental Foundation Trainees themselves to receive funding which would support their placement and training as a Dentist with Enhanced Skills who could contribute to both the practice and the overall requirements of oral health services within ABMU. In 2018 the placement is being offered to train in the provision of Endodontic services (assessment and treatment of root canal disease) through the ABMU Restorative Dentistry-provided MSc course in endodontics and working alongside specialists in an intermediary setting. It is hoped that the chosen individual, as well as some of the annual cohort of six MSc-trained dentists, will be able to strengthen the skill-base of primary care dentistry and ensure that less patients need to be treated in hospital, with consequent reductions in waiting times. If successful, it is hoped that in subsequent years the scheme will attract dentists in other dental sub-specialties, e.g. oral surgery or oral medicine and allow a wider development of Dentists with Enhanced Skills.

23. The introduction of Dental Contract Reform and more use of a varied skill mix in dental practices requires the development of national and local workforce plans to ensure there is sufficient supply of these individuals to support dental practices. As indicated at 8. above, it is also important that practices also have the physical capacity in which they can work – hence the reference to review physical as well as staff capacity in general dental practices, lest it is a barrier to dentists wishing to adopt contract reform.

24. There continue to be difficulties in recruiting and retaining specialists and consultants in the recognized specialities – and some specialities do not exist outside the Dental Hospital in Cardiff. In ABMU it is considered that 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 and eventually provide such care from their own practices. At the heart of this must be a sustainable specialist workforce to drive standards, innovation and quality. Welsh Government is recommended to invest in services that can demonstrate a commitment to provide primary and community based services, including the smaller specialties such as paediatric, restorative and special care dentistry and oral surgery. Resources for specialty training posts should target population need, access and impact rather than

historical criteria. Health Boards should be encouraged to develop specialist training programmes which should help retention of the workforce as well as service provision.

Orthodontic Services

25. ABMU commissions 7 Personal Dental Service Primary Care Orthodontic contracts, three General Dental Service Primary Care Orthodontic contracts (with an orthodontic element attached for a Dentist with Enhanced Skills and provides Secondary Care Orthodontic services from the Morriston Hospital site. Six of the seven orthodontic contractors are based in Swansea, the seventh in Bridgend. The three General Dental contractors (in Neath Port Talbot and Swansea) provide orthodontic services to patients to a treatment plan submitted to and approved by the hospital-based specialists. The remaining contractors and the hospital service provide the whole assessment and treatment pathway.

26. Orthodontic and Specialist contracts are subject to similar contract monitoring processes as standard general or personal dental contracts, although some of reports may differ due to their speciality. Any concerns are raised with the Health Board's Specialist Dental Advisor who grades the level of concern using a 'traffic light' system and appropriate action is then taken. Exception reports are not applicable to specialist Contracts and Orthodontic services and currently Dental Assurance Framework [DAF] reports are not available in Wales. If and when these become available, ABMU will aim to align with guidance in England to include these as part of the monitoring process of orthodontic services.

27. ABMU's primary care management team, with the support of the Orthodontic Managed Clinical Network (ABMU and Hywel Dda) continues to develop policies to improve the quality of orthodontic care to predominately:
    - Identify patterns of inappropriate referrals
    - Plan and deliver suitable targeted interventions
    - Improve waiting times
    - Identify robust waiting times monitoring arrangements.

28. The 7 Primary Care Orthodontic contracts account for approximately 10% of the GDS expenditure budget. They were re-commissioned and awarded in December 2016 and will expire on 30 November 2021. The opportunity was taken to standardise the Unit of Orthodontic Activity rate at £63.15 (now £64.06 pending national uplift). That paid to the DES providers is at a similar level and has yet to be reviewed.

29. The Primary Care Team collates waiting time lists from all orthodontic providers on a quarterly basis and issues this information to all dental practitioners following discussion with the Orthodontic Managed Clinical Network [OMCN] which was re-established in 2017. The information is circulated with the aim of influencing referral practice, particularly to reduce the number of inappropriate referrals, notably of children under 11 years old and those whose orthodontic condition, measured against IOTN1 score, does not meet NHS criteria.

[1] Index of Treatment Need – dental health score indicates a developmental anomaly that would offer health gain from correction

30. Despite the above, waiting times are still unacceptably variable and long with over 3000 patients awaiting consultation across ABMU. The Health Board will continue to work with the support of the OMCN to secure a reduction in inappropriate referrals in line with the recommendations of the Welsh Government's most recent national review by Professor Steven Richmond. Access to an orthodontist across the Health Board ranges from one month (in one, General Dental practice only) to 36 months from referral to assessment. Waiting time remains at three years in Bridgend compared with 3 to 12 months between the Swansea providers. The team has been actively encouraging Bridgend dentists to send patients to Swansea, and requiring the orthodontists to tighten up on the application of their referral acceptance criteria. It is anticipated that significant improvement will follow the introduction of a new e-referral system across all dental specialties in Wales within the next 18 months; earlier in ABMU and Hywel Dda Health Boards who are designated 'early adoptors' .

31. It is considered that the resources are already in place to support the population needs but work is still necessary to ensure robust acceptance criteria are in place, especially for the under 12 year olds and cross boundary referrals. There is also a need to establish a national Dental Activity Review [DAR] for orthodontics and, as contracts are renewed, it will be essential to emphasise the need for a change in the model of delivering orthodontic specialist service.

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

32. A Public Health Wales' dental survey in 2016/17 revealed the lowest levels of dental decay across Wales in young school children since records began, with a consistent decline in the number of children with missing or decayed teeth. Public Health Wales subsequently reported, earlier in 2018, that the proportion of 12 year olds with decayed or missing teeth had reduced significantly over the past five years to 29.6% from 45.1% across Wales. The achievement in the ABMU area was even more significant, reducing from 47% to 28.9% over the same period.

33. The survey of young school children showed that dental disease levels continued to improve across all social groups with most deprived areas seeing the largest reduction in decay. It is considered that the continued increase in the activity of the Designed to Smile team, (an NHS Dental programme funded by the Welsh Government helping children to have healthier teeth) working in schools and nurseries in the Health Board's most deprived areas has made a major contribution to this

34. However it was also confirmed that 16% of three year old children in ABMU were reported as having decayed, missing or filled teeth. With 28,000 of children being cared for by the Health Board's Health Visiting Team, 2016/7 saw the establishment of a Public Health Wales-led "Lift the Lip" campaign with one of ABMU's Health Visiting teams. This has been continued and extended across ABMU. The excellent joint working with the Designed to Smile team to *make every contact count*, now includes closer working with dentists, the Speech and Language Department and school nursing team to prevent dental decay in pre-school and primary school settings.

35. The publication of WHC(17)23 cemented the need for Designed to Smile to focus on the youngest children and ceased the fissure sealant element of the programme. The team continues to provide fluoride varnishing in the 300+ schools and nurseries in which it educates and treats children but was required by the same Welsh Health Circular to cease the education programme for the year 7 age group. The evidence base for the programme change is respected but there is one element of the change in specification with which the local Designed to Smile

team is uncomfortable: removing the oral health presentation to the older age group. Local experience is that doing so has already weakened the bond with the school staff who are now required to deliver the message formerly conveyed by the D2S team and advise that they – D2S – remain in a good position to deliver that message immediately following the application of the fluoride varnish before the children are able to have their lunch.

36. The number of nursery and school settings in which Designed to Smile is delivered continues to rise (exceeds 300) and change, with an additional 18 identified by the Welsh Oral Health Information Unit in 2017. The challenge for the team is securing 100% engagement, e.g. four of the new cohort actively sought their input, three did not engage and five 'actively' refused. Although this position improved subsequently it was not without considerable effort and engagement directly with the schools, through the Healthy Schools teams and others and this will continue to require engagement at senior partnership level to achieve 100% engagement in target areas.

37. Additional work is also ongoing and required within ABMU to strengthen the links from the Health Visiting and Designed to Smile teams to general dental practices to enable them to secure immediate access for children who need dental care. In the past, there was a direct route to the Community Dental Service [CDS]. However, particularly since the publication of WHC(16)9 emphasised the pressing need to ensure the CDS focused on patients with special care dentistry needs rather than healthy children, that route has not been appropriate. Work is therefore ongoing to ensure access to General Dentistry is readily available for these children in deprived areas.

38. In the interim, Designed to Smile is, as required by WHC(17)23, engaging specifically with the 14 Teaching Dental Practices within the ABMU area to ensure Dental Foundation Trainees and senior colleagues are briefed on latest oral health education advice and training and provided, where appropriate, with the means to provide more fluoride varnish treatments within General Dental Practice. The impact of the change in emphasis in the programme will emerge within the next few years.

39. It is considered that Designed to Smile, although still in its infancy is beginning to deliver on its intended outcomes. However, there is also a need to expand oral health education and support to other vulnerable groups such as teenagers and the older population possibly in conjunction with other programmes such as the care homes project which was established with WHC(15)1, *Improving Oral Health in Care Homes*.

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.

North Wales Orthodontic Managed Clinical Network (OMCN) Submission to the National Assembly for Wales Health, Social Care and Sport Committee's Inquiry into Dentistry in Wales.

Author: David Plunkett, Vice Chair, North Wales OMCN.

Background

The Health, Social Care and Sport Committee is undertaking a one-day inquiry into Dentistry in Wales. One of the terms of references is to "Consider the provision of Orthodontic Services".

Evidence from stakeholders has been requested in relation to:

1) Progress made to improve the efficiency of orthodontic services delivered in Wales.
2) Training, recruitment and retention of the orthodontic workforce.
3) Waiting times for appointments and treatment.

I thank you for the opportunity to submit evidence on behalf of the North Wales Orthodontic Clinical Network.

1) Progress made to improve the efficiency of orthodontic services delivered in Wales.

Historically, North Wales had a functioning Local Orthodontic Committee with a membership composed of the orthodontic practitioners from across the region. In 2012 the North Wales Orthodontic Managed Clinical Network was established in accordance with Welsh Government and the Strategic Advisory Forum in orthodontics (SAFO) guidance. The OMCN has representation from all relevant stakeholders including Dental Public Health (DPH), Secondary Care Orthodontic Services, Primary care Orthodontic Services, Dentists with Special Interest (DwSI) in Orthodontics, Community Dental Services, Local Dental Committee (LDC), Local Orthodontic Committee (LOC), Health Board Primary Care Commissioners, Chair of the North Wales Oral Health Strategy Group (NWOHSG). The OMCN provides an advisory role to the LHB and reports to the NWOHSG and has representation on SAFO. The OMCN has been instrumental in the recommissioning of PDS Orthodontic contracts, accreditation of DwSI, introduction of a universal orthodontic referral form, protocols for the supervision of non-specialist members of the

orthodontic team, quality assurance programmes, andestablishing protocols to cover second opinions and appeal processes, and programmes. Some of these will be discussed in more detail below.

In 2013 the Besti Cadwaladr University Health Board (BCUHB) undertook the recommissioning of primary care Orthodontic PDS Specialist Contracts. This was undertaken with input from the OMCN to optimise the process. In accordance with best practice, a Dental Public Health Needs Assessment was undertaken to determine the required level of activity whilst also taking into consideration cross border activity, imminent retirements, cessation of assessment only contracts and the geographic challenges present within North Wales. A Primary Care Orthodontic Commissioning Group was established to undertake the process with representation from all the relevant stakeholders including the OMCN, LDC and DPH. Input was also obtained from an out of area primary care Orthodontic Specialist to provide advice on the appropriateness of any planned reduction in UOA rates and the sustainability of business models, as it was recognised that long term financial and clinical viability of the successful bidders was crucial to avoid significant disruption to patient care. In accordance with Welsh Government's Prudent Health Care agenda, maximisation of orthodontic activity was an important factor during the recommissioning process. It was anticipated that changes in working patterns and the orthodontic skill mix could offer the opportunity to achieve this aim.

After due tendering process, four orthodontic PDS contracts were awarded (geographically based in the 4 main population centres of North Wales). Key components of these new contracts were:

1. The overall level of activity (UOA) recurrently contracted by the Health Board with specialist orthodontic practices was increased by around 30%, (replacing varying levels of additional non-recurrent activity previously awarded on an annual basis) with a distribution between practices matching the anticipated demand set out in the Needs assessment.

2. The competitive tender process resulted in a reduction in UOA rate effectively limiting the increase in overall contract values to 13%

3. Key Performance Indicators (KPI) were introduced into the new contracts to improve monitoring and maximise the amount of orthodontic activity being used on treatment starts rather than orthodontic review activity (minimum number of treatment starts per year calculated by "contracted UOA ÷ 22.5" and only one review per patient in a 24 month period).

4. Stipulation was introduced on the appropriate supervision of the non-specialist dental team members (i.e. therapists and GDPs with or without DwSI accreditation).

5. Contract length was increased to 10 years, subject to satisfactory performance at review and with an optional break clause after the first 4 years. Locally this has resulted in training of orthodontic therapists and

employment of ancillary staff to facilitate this increased activity in the most efficient manner.

A review and extension of Primary Care Specialist Contracts was undertaken in September 2017. At this review, the providers were assessed against the KPIs which were included within the contract. The outcome of that assessment determined the degree of extension which was applied by the HB to the contract.

Due to the topography of North Wales and the transport infrastructure associated with it, accessing specialist services for those in the most rural communities can be difficult. It is within this environment that Dentists with a Special Interest (DwSI) in Orthodontics, based with Dental Practice setting, provide such a valuable role. However, it is essential that the patients, Health Boards and Welsh Government can have confidence in the quality of the service provided. It was on this basis that Welsh Government stipulated that all orthodontic treatment be undertaken by, or directly supervised by, an Orthodontic Specialist or accredited DwSI. It was agreed at a National Wales level that all orthodontic treatment plans should be provided by an orthodontic specialist. So the DwSI Accreditation process, undertaken by BCUHB with input from the OMCN, examined the ability of the DwSI to both assess the need for orthodontic intervention and carry out a treatment plan provided by an orthodontic specialist. This process was competed in 2015.

Historically, North Wales consisted of 6 separate Local Health Boards and 3 Trusts. Over time these merged, eventually forming Betsi Cadwaladr UHB in 2009. As such there was a legacy of various methods of referral to Specialist Orthodontic Providers (both in Primary and Secondary care) across North Wales. The OMCN wished to devise a regional referral form which would both standardise the information provided as well as helping to direct the referral to the most suitable provider. The referral form produced was then circulated to the other MCN Chairs to consultation and modification so that an agreed proforma could be produced which would act as a basis for the orthodontic pathway on the forthcoming electronic referral management system. This referral proforma with accompanying guidance document was introduced in September 2015 (see Appendix 1 & 2).

The electronic Referral Management System (eRMS) for all dental referrals has been commissioned by Welsh Government and is in the process of construction with a planned phased roll out from the end of 2018. It is essential that the local IT infrastructure is sufficient to support operation of this. The introduction of the eRMS will allow a streamlining of the referral pathway with better tracking and management of the referrals received. It should allow improved identification of individuals who require priority assessment and treatment as well as utilising internal algorithms to help to direct the referral to the most appropriate provider, thus improving the efficiency of the referral pathway and also improving the patient experience. Unfortunately, the introduction of the eRMS itself is not likely to reduce the treatment need within the region, so is unlikely to have any long term positive effect on waiting times.

North Wales LOC organises an annual Peer Assessment Rating (PAR) scoring audit. PAR is an internationally recognised method of assessing orthodontic treatment outcomes. It compares the occlusal features of the pre and post treatment study models to produce a PAR reduction score which will give an indication of the quality of the orthodontic treatment. The OMCN and LOC have designed the audit to be robust (as the cases examined are consecutively completed cases) and interactive, with each participant scoring other practitioners' cases randomly allocated to them. This has the added educational benefit of allowing clinicians to see the outcomes of treatment that others within the region are achieving and promotes the raising of standards.

2) Training, recruitment and retention of the orthodontic workforce.

In North Wales there are five categories of orthodontic clinician:

1) Orthodontic Therapist (supervised by an accredited DwSI or Orthodontic Specialist) – A dental nurse who has undergone a 1 year training period and examination.
2) Non-Accredited DwSI (supervised to the same level as an Orthodontic Therapist) – General Dental Practitioner with orthodontic experience.
3) Accredited DwSI (independent orthodontic practitioner working to the treatment plan of a specialist, treating a more limited case mix, as determined by their competence, than an orthodontic specialist) - General Dental Practitioner with orthodontic experience who has undertaken and passed the HB's Accreditation Process.
4) Primary care Orthodontic Specialist (on the General Dental Council's Specialist List) – Dentally qualified clinician who has undertaken 3 years Specialist Orthodontic training and Royal College examination.
5) Consultant Orthodontist (has undertaken additional training and qualifications beyond that of a primary care orthodontic specialist) - Dentally qualified clinician who has undertaken 3 years Specialist Orthodontic training and Royal College examination, plus a further 2-2.5 years of advanced training and a Royal College Examination.

North Wales, in conjunction with the Welsh Deanery and Liverpool Dental Hospital, provides training for a Primary Care Orthodontic Specialist (StR 1-3) and a Consultant Orthodontist (StR 4-5). There is evidence that clinicians are more likely take up a permanent post either around where they trained or where they have personal connections, it is therefore essential that North Wales continues to provide training opportunities to maximise the potential for future specialists to take up permanent posts within the region.

North Wales, like many rural areas, finds it challenging to attract and retain medical and dental professionals. This applies to the Specialty of Orthodontics especially within the secondary care sector as there are fewer appropriately trained clinicians and there is a discrepancy between supply and demand with currently at least 48 unfilled consultant positions within the UK. It is therefore essential that succession planning for anticipated retirements is planned well in advance. In addition, the posts themselves need to be attractive and enable the prospective candidates to enjoy the full remit of the orthodontic consultant. This will include educational opportunities, extended management roles and being able to foster good clinical relationships with the other specialties within the Multidisciplinary team. The HB needs to be proactive and adaptive in the recruitment process to ensure that suitable candidates are lost to other areas.

3) **Waiting times for appointments and treatment**.

NHS Orthodontic treatment is undertaken according to clinical need. This need is determined by the Index of Orthodontic Treatment Need [IOTN], which assesses features of the presenting malocclusion and allows its categorisation. The level of the IOTN above which treatment on the NHS is available is currently 4 & 5 or 3 with an aesthetic component of 6 (the aesthetic component is scored from 1-10, with 10 being the most severe). This threshold could be raised to only include categories 4 & 5 (great treatment need).

The introduction of the Regional referral form has helped guide the patient to the most appropriate provider in the first instance. However, to ensure that the service is equitable, it a patient is seen in one sector, but upon assessment it is felt to be more appropriately managed in another sector, then the time spent waiting for the initial assessment is taken into consideration by the subsequent provider.

The current waiting times within North Wales are:

Primary Care:

- Tameside: 18-20 months for initial assessment, then 1 month wait to commence treatment.
- Greenacres: 16 months for initial assessment, then 2-3 months wait to commence treatment.
- Total Orthodontics (Colwyn Bay): 18 months for initial assessment, then 1 month wait to commence treatment.
- Total Orthodontics (Wrexham): 18 months for initial assessment, then 1 month wait to commence treatment.
- CDS: Initial assessment dependant on waiting times to seek treatment plan from a Specialist (as per DwSI stipulation), with a 12 month wait to commence treatment

Secondary Care:

- Wrexham: Initial assessment within 26 weeks, then a 24 month wait to commence treatment.

- Glan Clwyd: Initial assessment within 26 weeks, then a 37 month wait to commence treatment.
- Bangor: Initial assessment within 26 weeks, then an 18 month wait to commence treatment.

The current waiting times within Powys are:

Primary Care – 4-12 weeks for an initial assessment, and then 2 months wait to commence treatment

Secondary Care (Brecon) – Initial assessment in 18-20 weeks, then a 30 month wait to commence treatment.

Following the retendering of primary care Specialist Practice PDS Contracts in BCUHB in 2014, the waiting times in Primary Care appear to have stabilised around 18 months. However, this regional "backlog" of 18 months is unlikely to reduce significantly within the current funding arrangements. In addition, the Needs Assessment took into consideration the historic cross border activity into England (this was present on the introduction of the 2006 Dental Contract) which equates to 400 cases per annum and is still utilised by referring GDPs in North East Wales. There is concern that the proposed recommissioning of primary care Orthodontic Contracts in Cheshire will prevent this ongoing cross border activity which will have a negative effect on the current waiting times within North Wales.

Waiting times in the secondary care sector have increased dramatically over the last 5 years. In line with Wales' Prudent Health Care agenda, only the cases that have the required complexity are treated in a secondary care setting. Unfortunately, departing colleagues, difficulties in attracting suitably qualified staff and significant delays in the recruiting process has resulted in missed opportunities to appoint suitable candidates both in the orthodontic and restorative specialties and this has led to increasing waiting time from assessment to commencement of treatment. In addition, prioritisation of achieving the Referral To Treatment target for new patient assessments of 26 weeks has meant additional patients being added to the validated treatment waiting list with the same or reduced treatment capacity. Vacancies and other clinical pressures in the related Multi-Disciplinary Team Specialties means that certain cohorts of orthodontic patients are not progressing with their treatment as efficiently as would be desirable.

4. Summary and Recommendations

The OMCN, with good support from BCUHB Commissioners and all local orthodontic providers have dramatically improved the provision of orthodontic treatment across the North Wales region. Our model has ensured 30% more treatment activity within the primary care setting, with activity directed to treatments rather than assessments.

The primary care waiting lists remain stable; whereas, anecdotally, they continue to rise in other parts of the U.K. The existing waiting lists reflect the historic situation and, although not ideal, reflect an accurate needs assessment and targeted commissioning to ensure activity has increased to met the demand.

In secondary care, waiting lists have risen. This is due to difficulties in attracting suitable staff members to the area, and efforts should be encouraged to improve the recruitment process and develop the job opportunities to attract new consultants into the region.

The core structure of these strategic changes has been the development of an effective Orthodontic Managed Clinical Network, and BCUHB commissioners positively engaged with this group to ensure the success of these large and positive changes.

As a result of the above measures, the BCUHB have been able to develop a unique model for providing Primary Care NHS Orthodontic Treatment. It has increased service capacity and improved access issues previously experienced by patients in geographically remote areas. At the same time, it has developed robust monitoring processes to ensure that these treatments are performed to the highest clinical standards. Importantly, this model has taken a long term view and has provided stability to the provision of care.

Recommendations

A) Great efforts have been undertaken locally to increase the standard and efficiency of orthodontic provision within the Region. Time now needs to be given to consolidate these improvements as well as allowing the other planned initiatives to be implemented and their effect assessed.

B) To continue to ensure that the OMCNs are fully functioning with the engagement of all stakeholders and that the OMCN are adequately supported by the HBs.

C) To continue to monitor the quality of outcomes for all orthodontic clinicians with responsibility for the outcome of treatment within the Region.

D) To ensure the continuity of the training posts within North Wales and to establish a pathway for DwSI training for future succession planning.

E) To establish the eRMS, ensuring local IT infrastructure is capable of supporting its use. Use the eRMS to monitor the quality and appropriateness of referrals.

F) To agree what would be an appropriate and acceptable time from routine referral to the commencement of treatment and to fund additional time limited activity to achieve this aim, and the additional ongoing resources to maintain it.

G) To ensure that, with Welsh Government support, the historic cross border activity into Cheshire remains following any recommissioning exercise to Primary Care Orthodontic Contract.

H) For Welsh Government and LHBs to recognise the importance of coordinated and timely management of retirements and other clinical vacancies to ensure minimal disruption to clinical services and patient care.

Appendix 1 - Referral Guidance

REGIONAL UNIVERSAL NHS ORTHODONTIC REFERRAL PROFORMA

Dear Colleague,

The Local Health Board in partnership with the North Wales Orthodontic Managed Clinical Network (MCN) have produced a regional universal NHS orthodontic referral proforma which is to be used by all practitioners when referring patients to access NHS Orthodontic services, whether this be in Primary or Secondary care. This referral form will cover North Wales & Powys (all areas where orthodontic treatment is funded by Betsi Cadwaladr University Health Board & Powys Teaching Health Board). It aims to provide a transitional step before the introduction of electronic referrals become mainstream (timeframe for electronic referrals introduction will be dependent on Welsh Assembly Government funding).

The referral form itself has been designed to help guide practitioners to the most appropriate service provider to whom to refer their patients on for an assessment. A simple "tick box" arrangement has been utilised with an additional free text space for any extra information the referring practitioner feels would be advantageous to be included.

Access to NHS Orthodontic treatment is via the application of the Index of Orthodontic Treatment Need (IOTN), with only categories 4 & 5 and some category 3 being eligible to receive treatment funded by the NHS. An explanation of the IOTN is provided below along with an overview of possible outcomes following a patient assessment by an orthodontic specialist.

Only patients who meet the IOTN threshold criteria and who are aged under 18 years old when they commence orthodontic treatment will usually be eligible for NHS funded treatment in Specialist Practice. In view of the current regional waiting times, patients should be referred for a Specialist assessment prior to their 17th birthday. If done so, the LHB will honour the commitment for funding orthodontic treatment for these patients (if they reach the threshold for treatment need) even if they turn 18 whilst waiting for an orthodontic assessment and commencement of treatment. No guarantee of orthodontic funding will be made by the LHB for patients who turn 18 whilst waiting for an assessment if they have been referred after they turn 17 years old. Patients over the age of 18 years old may be eligible for treatment in Hospital Orthodontic Departments if they are of a more complex nature often requiring multidisciplinary care.

This Universal Referral Form immediately replaces all other referral forms currently in circulation and as of the 1st September 2015. Only referrals using this Universal Orthodontic NHS Referral Proforma will be accepted by any orthodontic provider. Any referrals not received on this form after this date will be returned to the referring practitioner.

Yours sincerely,

Lynne Joannou
Assistant Director of
Primary Care Support
BCUHB

Warren Tolley
Clinic Dental Director
Powys Teaching LB

Benjamin Lewis
Chair of the North Wales
Orthodontic MCN

Dental Health Component of IOTN

Treatment Need From A Dental Health Perspective (5 Grades)

Dental Health Component of IOTN		
Grade 5 (Great Need For Treatment)	5i	Impeded eruption of teeth (except third molars) due to crowding, displacement, the presence of supernumerary teeth, retained deciduous teeth and any pathological cause
	5h	Extensive hypodontia (more than 1 tooth missing in any quadrant) requiring pre-restorative orthodontics
	5a	Increased overjet greater than 9mm
	5m	Reverse overjet greater than 3.5mm with reported masticatory & speech difficulties
	5p	Defects of cleft lip and palate and other craniofacial anomalies
	5s	Submerged deciduous teeth
Grade 4 (Need For Treatment)	4h	Less extensive hypodontia requiring prerestorative orthodontics or orthodontic space closure to obviate the need for a prosthesis
	4a	Increased overjet greater than 6mm but less than or equal to 9mm
	4b	Reverse overjet greater than 3.5mm with no masticatory or speech difficulties
	4m	Reverse overjet greater than 1mm but less than 3.5mm with recorded masticatory and speech difficulties
	4c	Anterior or posterior crossbites with greater than 2mm discrepancy between retruded contact position and intercuspal position
	4l	Posterior lingual crossbite with no functional occlusal contact in one or both buccal segments
	4d	Severe contact point displacements greater than 4mm
	4e	Extreme lateral or anterior open bites greater than 4mm
	4f	Increased and complete overbite with gingival or palatal trauma
	4t	Partially erupted teeth, tipped and impacted against adjacent teeth
	4x	Presence of supernumerary teeth
Grade 3 (Borderline Need For Treatment)	3a	Increased overjet greater than 3.5mm but less than or equal to 6mm with incompetent lips
	3b	Reverse overjet greater than 1mm but less than or equal to 3.5mm
	3c	Anterior or posterior crossbites with greater than 1mm but less than or equal to 2mm discrepancy between retruded contact position and intercuspal position
	3d	Contact point displacement greater than 2mm but less than or equal to 4mm
	3e	Lateral or anterior open bite greater than 2mm but less than or equal to 4mm
	3f	Deep overbite complete on gingival or palatal tissues, but no trauma

Grade 2 (Little Need For Treatment)	2a	Increased overjet greater than 3.5mm but less than or equal to 6mm with competent lips
	3b	Reverse overjet greater than 0mm but less than or equal to 1mm
	2c	Anterior or posterior crossbite with less than or equal to 1mm discrepancy between retruded contact position and intercuspal position
	2d	Contact point displacements greater than 1mm but less than or equal to 2mm
	2e	Anterior or posterior openbite greater than 1mm but less than or equal to 2mm
	2f	Increased overbite greater than or equal to 3.5mm without gingival contact
	2g	Pre-normal or post-normal occlusions with no other anomalies (includes up to half a unit discrepancy)
Grade 1 (No Need For Treatment)	1	Extremely minor malocclusions including contact point displacement less than 1mm

Scores in green are automatically eligible for NHS funding

Score in yellow *may* be eligible for NHS funding but requires an aesthetic score of 6 or above

Scores in red are not eligible for NHS funding

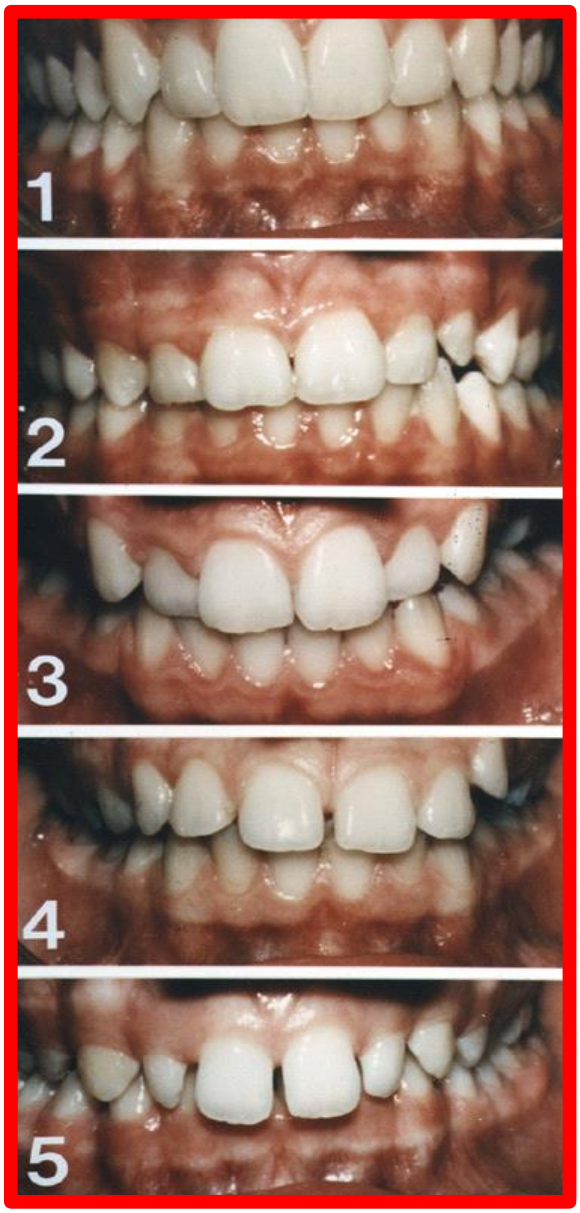
The second part of the IOTN is the Aesthetic Component (AC)

The NHS does recognise that some children need and benefit from orthodontic treatment on the basis of poor aesthetics. The Aesthetic Component of the IOTN is a scale of 10 colour photographs showing different levels of dental attractiveness. The grading is made by the orthodontist matching the patient to these photographs. The photographs were arranged in order by a panel of lay persons.

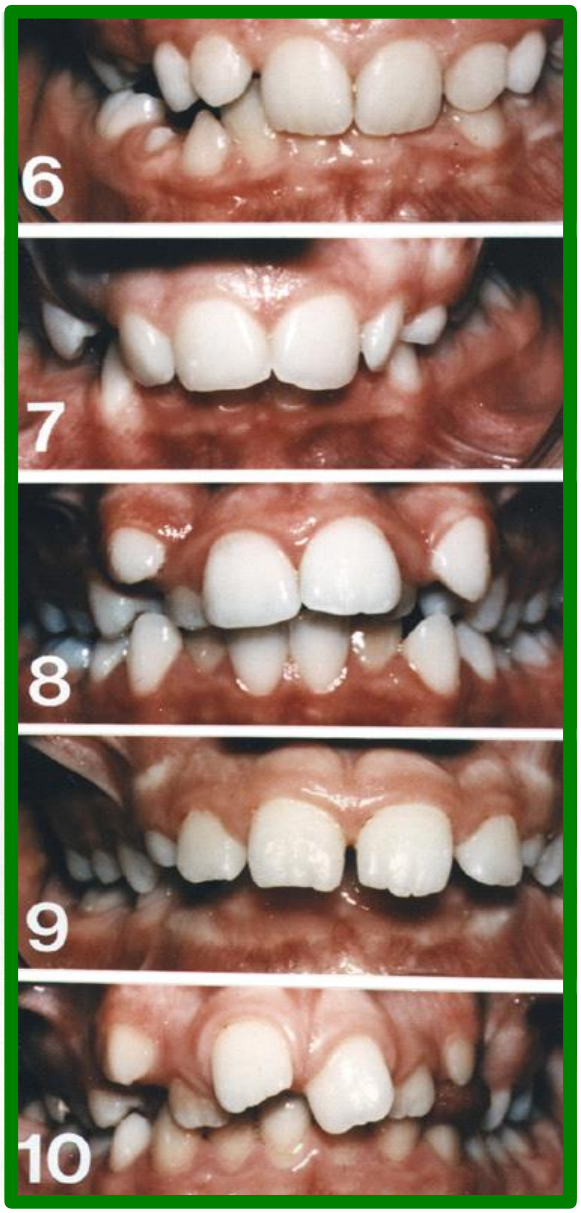
Within the NHS if a patient in Dental Health category 3 has an Aesthetic Component rating of 6 or more NHS treatment is permissible

Aesthetic Component of IOTN (AC) 10 Point Scale

No Treatment



Treatment



Steps orthodontic providers are likely to consider when reviewing a referral and possible outcomes following an orthodontic assessment

1. **Consultant Orthodontist**

   Does referral appear to meet criteria for hospital service?

   - No.

     Refer back to GDP to refer on to specialist practice as appropriate

   - Yes.

     Is the referral higher priority?

     - Yes – *Arrange appropriate priority appointment*
     - No – *Place on list for routine consultation*

   After consultation required action is:

   - treatment suitable for Dentist with Special Interest – *refer to DwSI with treatment plan*
   - treatment suitable for specialist practice – *refer tospecialist practice*
   - complex treatment needing hospital care:
     - Higher priority – list with appropriate priority for treatment or onward referral
     - Routine – place on treatment waiting list
   - orthognathic treatment – arrange joint clinic appointment
   - restorative treatment – arrange joint clinic consultation
   - not ready for treatment but needs to be kept under review – arrange review
   - unlikely to be ready for treatment within 12 months and review not needed – *refer back to GDP*
   - no treatment indicated – *refer back to GDP*

Specialist Practice

Does referral appear to meet criteria for specialist practice service?

- No.
  Refer back to GDP or *refer on to consultant* as appropriate

- Yes.
  Is the referral higher priority?
  - Yes – Arrange appropriatepriority appointment
  - No – Arrange routine appointment or place on waiting list.

After consultation action required is:

- treatment is within scope of specialist practice – book to treatment clinic or place on waiting list
- advice or treatment more suitable for hospital service – *refer to consultant*
- patient not ready for treatment:
  - likely to be ready within 12 months – review
  - unlikely to be ready within 12 months – *refer back to GDP*
- treatment not indicated – *refer back to GDP*

Appendix 2 –North Wales & Powys Orthodontic Referral proforma

GIG CYMRU NHS WALES

Date Rec'd (for internal use):

Universal Orthodontic Referral Form

Only referrals made on this form will be accepted for NHS orthodontic treatment in North Wales

PLEASE PRINT CLEARLY USING BLACK INK

Referral to:	**Referring Practitioner:**
Name: Address:	Name: Practice Stamp:
	GDP Details (if different):

Patient Details:	
Name: Address (including postcode):	Date of Birth: / / Age: Contact Telephone Numbers:

REFERRALS WILL BE SENT BACK TO THE REFERRING PRACTITIONER IF ALL THE RELEVANT INFORMATION ON THIS FORM IS NOT COMPLETED.

		Yes	No
a	Is the patient motivated to undergo orthodontic treatment (wear appliance)?		
b	Is the patient dentally fit at the time of referral?		
c	Is oral hygiene 'good' to 'excellent'?		
d	Have the patient and parents been advised that they may not be eligible for NHS treatment?		
e	Has the patient been referred for or received orthodontic treatment on the NHS previously?		

Reason for referral: Opinion ☐ Treatment ☐ Transfer ☐ Treatment Plan ☐

Radiographs Included: OPG ☐ Lat Ceph ☐ Periapical ☐ Occlusal ☐

Priority Referral	**Please Tick**
Decision on the management of recently (within 1-2 weeks) traumatised teeth	
Unerupted maxillary central incisor at age 7-8 years old **(IOPA Radiograph required)**	
Impacted permanent canines that are placing the incisor roots at risk **(Radiograph required)**	
Significant Class II skeletal discrepancies in patients approaching the pubertal growth spurt	
Patient below the age of 11 that have hypodontia, crowding or an increased overjet and require a GA for the extraction of an acutely symptomatic first permanent molar	
Significant medical or social history **(please provide details below)**	
Other reason (please give details)	

Please ensure all relevant radiographs are included

Welsh Universal Orthodontic Referral Form Version 4 (2015)

Presenting Problem	Please identify the ***main*** presenting problem only by ticking a column on the right. The clear spaces indicate the normal patient pathway to use for each problem. **NB** *Some cases suitable for specialist practice may also be accepted by hospital-based orthodontic units due their role as teaching institutions. Referrers are advised to liaise with their orthodontic providers if in doubt.*	Refer to hospital service	Refer to specialist practice	Keep under review at practice	Referral probably not indicated
Increased overjet	Overjet greater than 9mm *Age 10+yrs*				
	Overjet greater than 9mm *Age under 10yrs*				
	Overjet 6-9mm *Age 11+yrs*				
	Overjet 6-9mm *Age under 11yrs*				
	Overjet under 6mm *Any age*				
Incisor crossbite Early referral recommended	One or two incisor teeth in crossbite				
	Three or four incisor teeth in crossbite				
Crowding	*More than four deciduous molars still present*				
	Four or less deciduous molars present with:				
	- Marked crowding or irregularity				
	- Mild crowding, marked aesthetic detriment				
	- Mild crowding, little aesthetic detriment				
Upper canines not palpable buccally	*Age under 10yrs*				
	Age 10+yrs – take parallax radiographs				
	- Canines buccally placed or in line of the arch with sufficient space for eruption				
	- Canines buccally placed or in line of the arch with <4mm of space available for the canine				
	- Canines palatally placed				
Adults with severe malocclusions requiring multidisciplinary care					
Cleft lip and palate, syndromes, medical history complicating treatment					
Class II division 2 malocclusions – *late mixed dentition preferred*					
Hypodontia – more than one tooth absent per quadrant (ignore 8's)					
Hypodontia – *not* more than one tooth absent per quadrant (ignore 8's)					
Problems likely to need specialist surgical or restorative care					
Problems not covered above – *refer as most appropriate, add details below:*					

Other comments or complicating factors:

Referring Dental Practitioner's Signature:	**Date:**
Name:	**Performer Number:**

Please ensure all relevant radiographs are included

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.*

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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.
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[v] Welsh Government, July 2018. A Healthier Wales: our Plan for Health and Social Care
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[vi] The British Dental Association. Oral Health Inequalities Policy
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[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
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[xii] Betsi Cadwaladr University Health Board. Our Strategy for the Future, https://docs.wixstatic.com/ugd/a68b79_d5cfb8c42b2a4df69fad108a2c13c730.pdf

Consultation on Dentistry in Wales
Submission on behalf of Welsh Consultant Orthodontic Group

Author: Miss Joy Hickman, Chair

1. Background

1.1 Role of Welsh Consultant Orthodontic Group (Welsh COG)
See Appendix 1

1.2 Hospital Orthodontic Services
See Appendix 1

1.3 Terms of reference

1. Contract reform (progress made to improve efficiency and effectiveness of orthodontic services)
2. Training, recruitment and retention
3. Provision of orthodontic services including waiting times for appointments and treatment

In the context of reports:- Health and Social Care Committee Short Enquiry in to Orthodontic Services in Wales 2010/2011, Review of Orthodontic Services in Wales 2013-2014 (Professor S. Richmond), Review of Orthodontic Services in Wales 2008-2009 to 2015-2016 (Professor S Richmond), Together for Health: A National Oral Health Plan for Wales 2013-18, Taking Oral Health Improvement Forward in Wales, 2017

2. Service Delivery

2.1 Waiting times

The target waiting times to see new patients in secondary care are Referral to 'Treatment' (RTT) and have steadily been reduced to 26 weeks. All secondary care providers in the Health Boards appear to be delivering on this parameter. The time to commence actual treatment with appliances, after assessment, is not within RTT. Patients are now being seen for diagnosis and identification of the need for treatment in the hospital setting in a more timely fashion through direction of efforts and resources. However, this inevitably leads to more patient numbers added to treatment waiting lists with a substantial wait before appliance treatment can be offered to the majority of patients requiring hospital delivered care, where there is no over-riding clinical priority. Waiting times reported, through the Consultant body, are given in Table 1 by Health Board (H.B). The shortest treatment wait is 18 months in only one H.B. The other two units in the same H.B are 24 and 37 months which is the more typical picture of the long waits across the other six H.B.s where the treatment waiting times range from 26 months to 54 months.

Waiting lists in hospital departments are also potentially vulnerable to further increases from any pressures on contracts in primary care (see 4.1).

Table 1 Waiting times in secondary care by Health Board

Local Health Board	New Patient Waiting Times (RTT)	Treatment Waiting Times
ABMU (including Hywel Dda)	1-3 months according to urgency	In excess of 48 months
Aneurin Bevan (2 units)	Up to 26 weeks	54 months
BCUHB (3 units)	20-26 weeks	18-37 months
Cardiff and Vale	26 weeks	Longest wait 43 months
Cwm Taf	19 weeks	36 months
Powys	Up to 20 weeks	30 months

This rising trend in secondary care treatment waiting times, in comparison to earlier enquiries and reviews, is related to increased numbers added to the waiting list after assessment and diagnosis coupled with factors that impact on treatment capacity. Patients accepted for treatment in the hospital service have a high need for treatment and are the most severe cases involving the greatest technical treatment complexity and those requiring an interdisciplinary team approach. Factors impacting on treatment capacity include:-

- Longer treatment duration related to the complexity of treatments
- Vacancies
- Waiting times in other hospital disciplines (Oral Surgery, Restorative, Maxillofacial Surgery, Laboratory services).
- Ensuring safe clinical care of patients by accommodating treatments within existing case loads. These include patient transfers from specialist practice or out of area, priority cases or are related to career progression/other clinicians vacating posts, unplanned & planned longer term other clinician absences.

All contribute to reduce the number of new starts from the treatment waiting list. To effectively tackle these waiting times requires sustained treatment capacity because of the long term nature and multiple appointments over a 2-3 year course of treatment.

Other untargeted waits are also reported for access to joint clinic advice for complex multi-disciplinary cases. In some H.B.s this is a capacity issue and exacerbated by gaps in supporting services e.g. Maxillofacial and Restorative.

2.2 Referral Management

2.2.1 Referral Protocols

Following development of New Patient referral protocols, these have been introduced to allow General Dental Practitioners (GDPs) and Community Dental Officers throughout Wales to consider the appropriateness of the referral and to help them refer to the most appropriate provider in either primary or secondary care using the Universal Orthodontic Referral Proforma or specific referral forms and guidelines. Most referrals, particularly in primary care, are from GDPs which gives the best opportunity for the patients to be referred at the most appropriate time and with the appropriate level of dental health. These referral forms and protocols appear to be working well and the number of inappropriate referrals appears reduced and with more efficient referral of the patients to the most appropriate provider. However, management of new referrals has no effect on existing treatment waiting lists where the need for treatment has already been identified.

2.2.2 Electronic Referral System

The electronic referral system is in the process of development ready to be rolled out across Wales. Members of Welsh COG, in units where the new system is in the testing phase, have reported initial problems with communication and integration between the electronic referral platform and individual hospital IT systems. Assurances have been given that this can be resolved. Experience with other new initiatives suggest there is also likely to be a lag period before full uptake by referring practitioners.

The electronic referral system is a very positive step to harmonise and streamline the processes for new patient management across Wales. It is a welcome development but will not increase treatment capacity or impact on waiting times for treatment in hospital departments (or in primary care) where the treatment need has already been established.

2.3 Re-design of service delivery

With a 3 year training for Orthodontic Specialists and 5 year training for Consultants, an on-going long term view/strategy is required to support diversification in service delivery aimed at improving efficiency & effectiveness of orthodontic services.

Without the team leaders (Consultants in the Hospital Service & Orthodontists on the Specialist List-Orthodontic Specialists in primary care), other team members Dentists with Special Interests in Orthodontics (DwSIs) & Orthodontic Therapists cannot offer stand alone services as this is outside their clinical competence (General Dental Council Regulations).

There are currently no Orthodontic Therapy courses in Wales. Progress has been made with accreditation of DwSI and has been undertaken in some H.Bs.

Models of care, using other members of the dental team, with enhanced skills to deliver services, are also limited in some areas by estate management in existing hospital departments and premises.

3. Recruitment and Retention

3.1 Training and recruitment

All hospital orthodontic departments within Wales have clinical training posts and are involved in training. Education and clinical training for Specialty Trainees (StRs), Post CCST trainees, DwSIs, Orthodontic Therapists, other junior staff and trainee academics.

3.1.1 StR posts

Specialty Trainees (StRs) must successfully complete the 3-year Specialist Training programme before entering specialist practice and with the additional 2-year training (Post CCST) before eligibility to take up a Consultant post.

3.1.1.1 University fees and salaries

The StR posts are allocated through the Welsh Deanery and have an associated University component which attracts training/bench fees. The University of Wales fees are amongst the highest in the UK and coupled with a lower salary for Welsh trainees is potentially a disincentive to come to live and train in Wales.

3.1.1.2 National Recruitment and run through training

The Welsh StR posts are allocated through National Recruitment which is the recruitment/appointments process whereby all trainees applying for a StR post in the U.K are ranked, to ensure fairness. Some colleagues are aware of candidates who wished to train with a view to remaining in Wales long term but their preferred post was already allocated before they were eligible for their training offer.

Run through posts (the 3 year StR training plus the 2 year post CCST training in the same Deanery allocated through National Recruitment) is where candidates preference at the entry point of specialist training. In principal, the trainee remains in the same area for the full 5 years and following successful completion of training are eligible to apply for a Consultants post. This might be considered to subsequently improve the pool of candidates for a local post but does not, so far, appear to be the case. The next run through trainees complete their initial 3 year period of training in September 2019 and though not duty bound to stay will potentially complete the further 2 year post CCST period of training by the end of 2021.

3.2 Vacancies & Retirements

Many of the hospital departments in Wales are carrying vacancies (Table 2). This impacts on the waiting lists to offer treatment with appliances. There are a number of impending Consultant retirements in Wales in the next 1-5 years. Recruitment continues to be a big challenge with insufficient candidates to fill posts. Recent figures indicate there are 48 vacant Consultant posts across the U.K.

Table 2 Vacancies by Health Board

Health Board	Vacant Post(s)
ABMU (including Hywel Dda)	1wte Consultant (10 sessions) 2 x post CCST (x3 unsuccessful attempts to recruit)
Aneurin Bevan	0.4 SpR (appointment pending)
BCUHB	0.5 wte Consultant (5 sessions YGC) 0.2 wte SAS (YG) 0.4 wte SAS (WM)
Cardiff and Vale	1.4 wte (14 sessions)

4. Primary Care issues and potential impacts on hospital dental services

Through local clinical networks (Local Orthodontic Committee), engagement in MCNs and colleagues who also provide primary care services, there is an awareness of challenges in other care settings.

4.1 Tendering/Retendering

Already long waiting lists in hospital departments will potentially increase with any downward pressure on primary care contracts. There is an awareness that some specialists take on economically non-viable cases out of interest and because they have developed the skills. Realistically, they will review this practice if the UOA value is reduced too significantly and it is unlikely that corporate providers would agree to such activity.

Contract lengths in some Health Boards offer a lack of security for primary care practitioners and discourage investment and development of their practices. The retendering processes tends to favour the corporate provider.

4.2 Metrics

Greater clarity would also be welcomed with regard to the definitions and terminology used in relation to treatment quality and discontinued and incomplete treatments to ensure that reported metrics accurately depict the activity in clinical practice.

5 Summary of progress most relevant to secondary care services and with respect to previous reviews

There has been positive progress in a number of areas and in line with some of the past recommendations.

- Reduction in time to first assessment in hospital departments (Recommendation 3, 2014)
- MCNs established (Recommendation 8, 2011)
- Introduction of referral protocols and standard referral forms (Recommendation 8, 2011)
- E referral management system in progress (Recommendation 7, 2011 and Recommendation 2, 2014, Priority 3, 2017)
- DwSI accreditation schemes set up (Recommendation 13, 2011)
- Service re-design within existing estate and staff
- On-going StR recruitment and run through posts in conjunction with Welsh Deanery
- Development of processes for treatment outcome monitoring with engagement via MCNs (Recommendation 17, 2011 and Recommendation 1, 2014)

6. On-going challenges

One of the most dispiriting aspects for Consultant clinicians is explaining to patients, who have been assessed, that there will be a long delay before treatment can be offered. These patients have the greatest need, often requiring complex mainly multidisciplinary treatment which is undertaken in hospital departments. This is a capacity and treatment resource issue and top of the list in table 3 with the other on-going challenges also summarised.

Table 3 On-going challenges for Hospital Consultant services

Challenge	Potential Solution
Waiting times to access hospital treatment	Increased treatment capacity with associated resource (Identified as Recommendation 9, 2011 & Recommendation 3, 2014)
E-referral incompatibilities with existing hospital IT infra-structure	On-going development N.B. E-referrals will not affect existing treatment waiting lists
Vacancies in hospital departments	Workforce planning (Identified Recommendation 14, 2011)
University fee levels & StR salary scales	Outside Welsh COG influence
Limited administrative support for MCNs	Identification of staff/resource within Health Boards
Monitoring arrangements	Resourced independent fully inclusive

	monitoring processes by the Health Boards

7. Conclusions

The Welsh COG remains committed to assisting with a shared goal of promoting the development and efficiency of high quality orthodontic services. These are extremely challenging times for secondary care services. In particular, those patients with the most complex and greatest treatment need have the longest waits to access treatment further exacerbated by the difficulties recruiting to Consultant posts.

Joy Hickman (Consultant Orthodontist BCUHB)
Chair and on behalf of the Welsh Consultant Orthodontic Group

Appendix 1

1.1 Role of Welsh Consultant Orthodontic Group

The Welsh Orthodontic Consultants Group (Welsh COG) is a sub-Group of the Consultant Orthodontic Group and is a constituent group of the British Orthodontic Society. The Welsh Consultant Orthodontic Group's objective is to promote the development and efficiency of Orthodontic Services in Wales. Full membership is open to all persons holding a substantive or honorary contract as a Consultant Orthodontist, issued by a recognised NHS Health Board in Wales and Associate Membership is open to those holding a Post CCST Appointment within Wales. There are currently 17 full members & 2 Associate Members of the Group based in nine district general hospitals throughout Wales and in the University Dental Hospital who lead and deliver Hospital Orthodontic Services in addition to advisory roles and engagement with MCNs taking on leading roles where appropriate.

1.2 Hospital Orthodontic Services

1.2.1 Description

The Hospital Orthodontic Service is a Consultant-led service with Consultants having undergone a 3-year Specialist training programme with an additional 2 or 3 years further higher level training. Other members of the orthodontic team include Specialty Trainees undergoing the 3-year Specialist Training programme (StRs) or the additional 2-year training (Post CCST); Specialist Orthodontic Practitioners (Non-Consultant Career Grade); Dentists with Special Interests in Orthodontics (DwSIs) and Orthodontic Therapists.

1.2.2 Role

Consultants within the Hospital Service fulfil a unique role that includes:

-Treatments of patients with the highest need involving the greatest technical treatment complexity and those requiring an interdisciplinary team approach. Services are located within areas of greatest population.

-Education and clinical training for StRs, post CCST trainees, DwSIs, Orthodontic Therapists, other junior staff and trainee academics. All hospital orthodontic departments within Wales have clinical training posts and are involved in training.

-Advisory role to hospital colleagues, Specialist Practitioners, General Dental Practitioners (GDPs), Community Dental Officers and General Medical Practitioners (GMPs).

-Public health role and management advice by working with Consultants in Dental Public Health to determine the needs and demands of the local population with respect to orthodontic care

D21
Ymchwiliad i Ddeintyddiaeth yng Nghymru / Inquiry into Dentistry in Wales
Ymateb gan Ysgol Deintyddiaeth, Prifysgol Caerdydd
Response from the School of Dentistry, Cardiff University
Dentistry in Wales Consultation.

Written evidence
Professor Alastair Sloan, Head of School, School of Dentistry, Cardiff University

I am delighted, as Head of the School of Dentistry to contribute to this consultation. I will be focussing my views and thoughts to the areas on which I can comment with knowledge therefore not all areas within this consultation will be commented on.

Background to Education in the School of Dentistry

The School of Dentistry sits within the College of Biomedical and Life Sciences in Cardiff University. It was established in 1964. Students are taught primarily within the University Dental Hospital and the School has a strong relationship with Cardiff and the Vale Health Board to enable undergraduate dental education to take place. Students in Year 1 spend the majority of their time in the School of Biosciences where they are taught the underpinning physiology, anatomy and body systems biology. They spend 1 day each week in the School of Dentistry beginning their professionalism education, skills in communication and work with senior students on teaching clinics learning how to take medical histories and develop experience of working in a clinical environment.

In addition to clinical teaching in the Dental Hospital, our students spend significant time in 2 education outreach centres within the community dental service. Year 4 students will spend clinical time in the dental unit in St Davids, Cardiff and Year 5 students will undertake clinical work in the Mountain Ash unit. Student feedback consistently suggests students not only enjoy these placements, but also gain significant clinical experience during this time. IN addition to these outreach centres, students also undertake residential clinical placements in centres across Wales (e.g. Gwent, Wrexham, Morriston) and outside Wales (e.g Plymouth).

Since 2017, we have begun to teach early year BDS students alongside the 1st year Dental Therapy and Hygiene students (both in clinical skills laboratory and on clinic) to emphasize the connected working across the dental team.

At our last GDC visit the School was rated as ‘satisfactory’ (the highest standard you can be awarded) and the School will be visited again in early 2019 as part of the GDC’s new programme of visits. Our last National Student Survey (NSS) results in August 2018 reported that overall satisfaction with the BDS programme was at 95%, which was the 2nd highest in the College of Biomedical and Life Sciences and one of the highest across the University. All graduating students in 2018 were successful in obtaining a Dental Foundation Training (DFT) place.

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

1. The School of Dentistry has 70 undergraduate places each year for home students along with 4 places for overseas students to study dentistry. This number of places has been maintained since the last cut to our numbers (a cut which was seen across the UK). The School does not struggle to fill these places, and applications are in the region of between 6 and 7 applicants for every place available. Entry requirements are published clearly on the School and University website and is consistent with those from other UK Schools. The School has not entered clearing for the Bachelor of Dental Surgery (BDS) programme. Recruitment of dental students is thus strong and consistent.

2. We currently recruit across the entirety of the UK and work within Cardiff University's need to maintain high entry grades as the University is a high tariff institution. However, our entry grades are commensurate with those across the sector.

3. Students comment that their decision to accept offers at Cardiff is influenced by the early clinical contact they receive in Year 1, the environment and opportunities of and within the University and City of Cardiff (small size, manageable living costs and environment).

4. The School has, for many years, adopted admissions approaches to encourage and increase applications from Wales and Welsh applications. Over the past 5 years the percentage of Welsh domicile applications – to enrolment ratio has improved, despite a static or gentle fall in total dental applications. However, relatively few applications come from students in North and West Wales. The School is currently undergoing its 5-year Periodic Review and this area of recruitment is a key focus. The School, now having a dedicated communications and marketing officer, is working with the University Central Recruitment Team who in 2017-18 introduced a north Wales tour to represent Cardiff University programmes. We will have specific dental content in these tours. All degree programme material is bilingual and we have created promotional videos regarding Dentistry at Cardiff delivered by both English and Welsh speaking students.

5. The School is also in the process of identifying Clinical Academic Lead for Welsh Medium Provision and this individual will work with the central team to identify potential Welsh speaking Student Ambassadors for key careers fairs throughout Wales. As Head of School I am also in discussion with the Welsh Dental Society (Welsh speaking general dental practitioners) to explore the opportunity of their members acting as 'School Ambassadors' to assist the School promoting dental careers and the School's programmes in their local areas.

6. We also recognise that the first year of the undergraduate programme, when students are transitioning to University life, is when Welsh speaking students may benefit most from access to Welsh speaking personal tutor. The School does not have many Welsh speaking academic staff and we are exploring the option to provide such tutors both from within the School and from other Schools.

7. However, as a Russell Group Institution we should look to recruit as widely as possible. We thus need to ensure that the programme they undertake in Cardiff, and the clinical experiences they gain in the Dental Hospital from working with our part-time clinical tutors who are practitioners in South Wales and in Outreach encourages them to want to undertake their foundation training in Wales.

8. Adequate and protected funding is required to ensure undergraduate dental education can be maintained but more importantly can embrace a modern dental curriculum including inter-professional education.

9. Currently funding comes from 2 major streams. Student fees are paid to Cardiff University and this funding, along with other income streams (postgraduate programmes, PhD fees, research grants) form the annual expenditure budget the School of Dentistry receives. This covers University academic, part-time clinical tutor and professional service staff salaries and a non-pay budget to support education and research activity. The second major stream is the Dental Service Increment for Teaching (SIFT). This is funding from Welsh Government and provided to Cardiff and the Vale Health Board. This supports the dental hospital infrastructure, vital as it is a teaching hospital and 75% of all treatments in the hospital are delivered by our students. This funding is not protected from cost reduction programmes and in my view it needs to be to ensure we can deliver a proactive dental curriculum in a dedicated teaching hospital.

10. At present applications from 5th year students to enter DFT is managed by COPDEND (Committee of Postgraduate Deans and Directors) and is a joint England and Wales process. This is an issue for retention of graduate dentists within Wales as there is no Wales only system and over 65% of Cardiff graduates leave Wales to undertake DFT elsewhere. We need to develop a process or structure to encourage Cardiff students to undertake DFT within Wales. If we can retain a greater number of Cardiff graduates I undertaking DFT in Wales there is a chance to encourage them to stay longer term (hospital posts, further education, associate positions in practice) and thus retain students staying in Wales for DFT and beyond as practitioners. There needs to be some different thinking on if this is what is needed and if it can be developed alongside the Scottish and English systems. I have had initial conversations with the Chief Dental Officer and Postgraduate Dean around this subject.

11. It is important that moving forward we look at the issues as a whole and refrain from looking at the early stages of a dentist in isolation. Why do dentists leave once qualified or after initial practice? Are they returning back home to be nearer family, are there cost issues, is it an infrastructural problem?

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

1. The research from Professor Ivor Chestnutt, especially the Design to Smile programme, has been a significant success. In addition, a key strength in Wales is the work with the Oral Health Information Unit based in the School of Dentistry. Welsh Government currently funds a Senior Lecturer to lead this unit with Professor Chestnutt. This unit is vital to WG as it provides data and trends regarding oral heath (including children) in Wales. It is also vital to the School of Dentistry as the undertaken is ‘real-time’ research providing data which influences policy. The Senior Lecturer supported delivers teaching in Dental Public Health to our students and this places our students in a unique position compared to their peers in other schools as they are able to see how this research delivers for a community. This research also has Research Excellence Framework (REF) opportunities as the outcomes from this work has significant impact. It is vital however that Cardiff University see this as important research and why.

Welsh Government - Health, Social Care and Sport Committee Consultation: Dentistry in Wales

Response on behalf of North Wales Community Dental Service

North Wales Community Dental Service (CDS) welcomes the opportunity to contribute to this Consultation on Dentistry in Wales. The response highlights what has been already been achieved by the CDS in north Wales and identifies opportunities that could further enhance the contribution that the CDS could make towards achieving a healthier Wales.

The Welsh Government's dental contract reform

According to General Dental Service (GDS) data released 30th August 2018 access to dental services in BCUHB remains the second lowest in Wales; 49.5% of the resident population having been treated in the GDS in the 24 month period ending March 2018. This compares unfavourably with Wales (55%) and falls well short of that achieved by the best in Wales (ABMU 62.6%). The data that informs these access levels relates to GDS and although they include the salaried GDS (CDS/PDS) they exclude data relating to patients who are treated solely in CDS and those treated under private arrangements. Data is collected via FP17W forms which are submitted to the NHS Business Services Authority. From May 2019 it is intended that CDS activity will also be captured by submitting information in the same way. This will provide a more comprehensive picture of NHS primary care access. There is however, concern regarding the capacity of IT infrastructure support in Health Boards. Additionally, the requirement for dental software upgrades need to be ascertained as a priority**.**

A survey conducted by the British Dental Association in 2017 found that only 15% of practices in Wales were accepting new NHS adult patients and 28% accepting new child patients. Waiting lists were also operating at a number of these practices. In contrast, 72% of practices were willing to accept patients under private arrangements. Data is not available by Health Board.

The lack of access to GDS in north Wales disadvantages those people most in need of a service and results in a high volume of calls to NHS Direct and attendances at Emergency Dental Service clinics. It also impacts on the ability of the CDS to achieve its strategic objectives which are identified in the strategy document, *Services for Smiles* (2017-2022).

Welsh Government's vision for dentistry recognises the need for system change and to this end has introduced a programme of GDS Contract Reform. With the support of the Primary Care Resource Team, four pilot practices are already participating in this initiative in north Wales and additional practices are in the process of being recruited. The CDS has indicated its interest for a salaried GDS (CDS/PDS) practice to be included in the extended programme.

Units of Dental Activity has generally not been a popular system with the dental profession with the focus being on treatment and not promoting a preventative ethos. We welcome the proposed new way of working placing prevention at the core of all dental service provision and with personalised preventative advice being provided for all patients.

The introduction of the Assessment of Clinical Oral Risk and Need (ACORN) at least once a year for all patients attending NHS primary care dental services (GDS and CDS) will, in accordance with Prudent Healthcare principles, enable treatment provision to be focused on those most in need of care and for appropriate recall intervals to be applied. It is considered that a disproportionate amount of resource is being expended on the 'worried well'; a cohort of patients with low rates of oral disease who are attending at unnecessarily frequent intervals. Releasing time dedicated to seeing these patients will release appointments for patients with greater need who are currently unable to access care. Increasing GDS access in this way will benefit the CDS enabling it to concentrate on providing care to the most disadvantaged people in our society.

Contract Reform also promotes skill mix in the delivery of care and shifting the balance of some specialist treatment, traditionally provided in hospital, to the community setting.

The CDS is already contributing to providing primary care access as identified below:-

- The CDS organizes and coordinates the Out of Hours Emergency Dental Service (EDS) which is provided at CDS sites across North Wales utilising a workforce comprising GDS and CDS staff. Attempts have been made to improve access to rural areas by expanding the service to include sessions at Bethesda and Dolgellau. The CDS facilitates emergency/urgent care for those children and vulnerable adults who have been provided with a CDS code by NHS Direct.

- The CDS/PDS model, in essence a Salaried General Dental Service (GDS), was introduced by Welsh Government in 1996. Commencing in 1997 services were introduced utilising this model in geographically/socially disadvantaged areas or in areas where there was a dearth of primary care provision. Currently there are 3.5 WTE dental posts providing NHS primary care access under these arrangements in north Wales.

  One example is the service introduced to service Llangollen and Corwen utilising a mobile dental unit. When access improved in Llangollen the mobile was used as a fixed site providing a service to Corwen and environs. As part of the Corwen Health Centre Development the mobile is now being replaced with a two surgery dental facility which will open in October. It will provide both salaried GDS and CDS services utilising skill mix. This model has the advantage of facilitating care closer to home and the seamless transfer of patients between CDS and GDS in this geographically remote area.

- Direct access has been introduced with a cohort of dental therapists/hygienists trained to triage and treat children and older people living in care homes. They are able to carry out treatment for patients within their range of competencies with upward triage to a dentist as necessary. Some dental nurses have also been trained to apply fluoride varnish which they can deliver within preventative programmes and in surgeries. Cognisant of Prudent Healthcare principles these developments free up dentists' time to concentrate on procedures that only they can deliver.

- A new cadre of Dental Healthcare Assistant (DHA) was introduced into north Wales CDS in August 2010. The DHA is able to relieve the dental nurse of non-clinical

administrative tasks and assist with decontamination procedures. This development increased access to patients and was recognised by Welsh Government as an example of good practice. The Job Description has been shared with other HBs and the model has been adopted by ABUHB.

- In north Wales the shifting of the balance from the acute to community setting has already commenced.

  A Consultant in Paediatric Dentistry, based at Alder Hey Hospital, visits north Wales on a quarterly basis. Assisted by CDS dentists, she provides a service for north Wales' children at Holywell Community Hospital. Additionally, outreach cleft palate clinics from Alder Hey Hospital are supported by CDS dentists.

  Two dentists have been accredited as Dentists with Special Interest (DwSIs) in Orthodontics and a further two provide an Intermediate Tier Oral Surgery service. These developments with Consultant/Specialist oversight alleviate pressure on the hospital disciplines by reducing their waiting lists for the less complex treatments and take care closer to where patients live.

  Unfortunately, several attempts to recruit to the vacant Consultant in Restorative Dentistry post have so far proved unsuccessful. However, an expression of interest has recently been received. The CDS has therefore become increasingly involved in supporting the Head and Neck Cancer Multi Disciplinary Team with Specialists in Special Care Dentistry (SCD) arranging the provision of essential treatment and preventative advice before cancer therapy can commence. This development has been recognised as an example of good practice worthy of adoption by other units.

It is considered that the CDS has further contributions to make to Contract Reform as detailed below.

- Expansion of the Salaried GDS (CDS/PDS) model within a managed service has the potential to improve NHS access, especially in rural and socially deprived areas of north Wales. This model does not operate in a mixed economy and provides a purely NHS service. Those patients seeking aesthetic dentistry or complex restorative treatment (e.g. implants) are referred to colleagues in GDS.

- By creating a pathway for progression of the DHA model the post holder would be able to apply to become a trainee dental nurse and subsequently qualify as a dental nurse eligible to study for additional qualifications. The pathway opens up further opportunities for pursuing a career as a dental hygienist, therapist or dental health educator.

  An expansion of the DHA cadre in CDS has the potential to widen access to employment in areas of social or geographic deprivation in line with Welsh Government policy and to create a source of qualified nurses for all branches of dentistry. It is intended that a bid will be submitted to the Welsh Government Dental Innovation Fund to progress this development.

- There are also opportunities to build on the successful Direct Access initiatives for therapists and hygienists e.g. to prescribe radiographs as an extended duty**.**

- The service has a wealth of experience in delivering dental nurse training (commenced 1976). It has a history of achieving exemplary examination results exceeding the

national average with a number of students having gained national awards. North Wales CDS would welcome opportunities to be involved in the establishment of the National Training Faculty and the provision of training courses.

- The CDS strategy, *Services for Smiles,* identifies the need for the development of Consultant posts in Paediatric Dentistry and SCD. With Consultant supervision available locally, the introduction of further training posts in these disciplines could be facilitated. Discussions are ongoing regarding the possible options available to enhance the availability of consultant paediatric dentistry sessions in north Wales.

- In the absence of a dental hospital and difficulties in recruitment to some specialties the expansion of the intermediate care DwSI (DES) role is envisaged to support the HDS and GDS. In an attempt to make specialised services accessible to NHS patients the CDS has been proactive in identifying training opportunities and enabling CDS and Salaried GDS (CDS/PDS) dentists to pursue postgraduate qualifications in a number of specialised areas. This is addressed in more detail in the section on training.

How 'clawback money' from health boards is being used

There appear to be different approaches across Health Boards regarding the management of ring fenced primary care funding and 'clawback'.

In view of the access problems being encountered in north Wales it is clearly evident that the ring fenced dental funding provided by Welsh Government needs to be spent on NHS dentistry to ensure that the population has appropriate access to NHS care.

Along with low UDA values it has been asserted that recruitment difficulties have compounded problems experienced by some practices. It is suggested that, as is the case in medicine, salaried general dental practitioner posts may be more attractive to some dentists.

It needs to be noted that budgetary reductions have been applied to some CDSs. In north Wales CIP/CRES has amounted to £0.6m (approx 1% of budget) since 2014/15 with no uplift in funding for non-pay items since 1998. However, ring fenced funding for dedicated programmes has been received by the service in its entirety and never been subjected to CRES.

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

It has been noted that recruitment to the CDS in north Wales has greatly improved since the introduction of the new contract in 2008 with dentists living on the Welsh border favouring posts in north Wales rather than England. Many of the CDS dentists working in north Wales live in Chester, Wirral, Liverpool or Shropshire. Recruitment to posts in north east and central areas does not therefore appear to be problematic although vacancies in west Wales are sometimes difficult to fill.

The CDS already employs Specialists in SCD and Paediatric Dentistry. SCD links have been established with Liverpool and a Consultant in Paediatric Dentistry from Alder Hey Hospital provides a service for north Wales' children at Holywell Community Hospital. However, this latter service is only available on a quarterly basis. An StR post in Special Care Dentistry has been created from a dental officer post with the post holder benefitting

from an exchange arrangement with Liverpool. Although there are a number of Specialists in SCD available to provide supervision this arrangement fulfils the requirement for Consultant oversight of the post.

There continues to be a significant recruitment and retention issue in relation to some specialties (e.g. restorative dentistry) and the move towards community based specialist services is therefore supported. It is considered that the development of training opportunities (e.g. clinical attachments) for GDS and CDS dentists are required to complement and support services in secondary Care. This would reduce waiting list pressures in secondary care, enable career development and possibly encourage clinicians to stay in the area.

A Final Year Dental Students Outreach Scheme (Cardiff University) has been operational for many years with all final year dental students attending Wrexham Dental Centre in groups of six or seven for a two week period. The cohort has recently expanded from 75 to 80 students. Already subsidised by the CDS, the continuation of this programme is currently under threat due to a rise in accommodation fees. Discussions are on-going with Cardiff Dental School.

To date there have been three Dental Core Trainees (DCTs) accommodated at any one time in NWCDS. Unfortunately, with the understandable reduction of financial support from the Deanery, the CDS funded post will be withdrawn in 2019. It will be converted to much needed dental officer sessions in north-west Wales to improve access to vulnerable patients in that area.

As mentioned previously, a number of dentists have recently completed or are enrolled on MSc courses. Two salaried GDS dentists are on MSc courses - one is to complete her final year of training in Endodontics and the second is part way through a course in Restorative Dentistry. Both disciplines are difficult to access in north Wales under NHS arrangements. Additionally, two CDS dentists are studying for MScs in Paediatric Dentistry and one is in the final year of a Masters in Clinical Dentistry in Fixed and Removable Prosthodontics.

A North Wales Dental Bursary Scheme for dental students living in north Wales commenced in 1995/96. In the latter years a small number of therapists also received financial support. Due to financial constraints the scheme ceased to be offered in April 2014 with payments for the last cohort of students ending in the academic year 2017/18. The scheme successfully resulted in the majority of students returning to work in north Wales, including a number of Welsh speakers. Those who could not satisfy the terms and conditions were required to repay their bursaries.

Various surveys have reported that between 19 and 24 per cent of people living in Wales speak Welsh with the highest figures reported for North and West Wales. In north Wales a gradient is evident from east to west with Welsh language usage being highest in Gwynedd and Anglesey. In Gwynedd it is reported that 85% of the population speak Welsh on a daily basis and 31% attempt to use the language at all times when contacting public services.

The importance of encouraging Welsh speaking dental students to return to north Wales is implicit.

It is encouraging to note that Welsh Baccalaureate is now accepted as an A-level for entry to Cardiff School. It is considered that schemes that could encourage students from north Wales to return once qualified should be investigated. This would benefit recruitment to all branches of dentistry.

Although this section specifically addresses and seeks information in relation to dentists we consider it relevant to mention an issue that has emerged in relation to dental therapists

As mentioned previously, Direct Access training (children and older people) is provided by the CDS for dental therapists/hygienists and Inhalation Sedation Training is also provided for dental therapists.

Having seized training opportunities, some therapists in the CDS are understandably seeking financial recognition for their extended role. However, it has been noted that the gap between dental therapist and dentist pay is narrowing and this is likely to make the choice between employing a dentist, with a wider scope of practice, or a dental therapist more difficult. It has also been reported that therapists in GDS are seeking remuneration packages comparable to associates.

The provision of orthodontic services

The North Wales and Powys Orthodontic Managed Clinical Network (OMCN) has been instrumental in the recommissioning of PDS Orthodontic contracts and the Accreditation of Dentists with Special Interest (DwSIs).

Orthodontic DwSIs are of particular importance in north Wales in enabling children in geographically and/or socially disadvantaged areas to benefit from orthodontic treatment in the primary care setting. The service is provided by GDS and CDS dentists. Orthodontic DwSIs in the CDS also provide sessions in the HDS with this close liaison facilitating care being provided closer to home with shared care and transfer of patients between services operating as deemed appropriate. Other initiatives and achievements will have been highlighted in the OMCN response to the Inquiry.

The OMCN considers it essential that a DwSI training pathway is developed for succession planning to ensure that this service remains available for vulnerable patients and those living in geographically remote areas of north Wales.

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

The field work for Welsh National Epidemiological Surveys is conducted by CDSs led by local epidemiology coordinators. The national benchmark for the child dental heath surveys is a north Wales dentist with an MSc in Paediatric Dentistry.

Epidemiological surveys of 5 year old children have shown that the incidence and prevalence of dental disease in Wales continue to improve with children attending schools in the most deprived areas experiencing the greatest improvements. This has been attributed to the impact of the targeted Designed to Smile programme. However, a survey of 3 year old children (2013/14) revealed that one in five children in the most deprived areas of Wales had already experienced decay by age three (2015/16).

With the aim of keeping children decay free by the age of 5. Welsh Health Circular, *Refocusing of the Designed to Smile child oral health improvement programme* (2017) identifies the strategy for the future of D2S. It places greater emphasis on preventative measures for children aged 0-5 and the inclusion of GDS teams in the delivery of this targeted programme. The actions identified for the CDS in the circular have been implemented and D2S Dental Health Educators have already delivered the recommended input to Vocational Training Practices.

There do however remain some concerns regarding the dental health of older children. In 2013, the National Children's Health Survey reported that almost two thirds (63%) of fifteen year old children in Wales had obvious decay experience with 28% having active, untreated decay. These rates were higher for children living in socially deprived areas. It has been shown that GDS dental attendance is poor in the 18-25 age group. It is suggested that older children are rendered dentally fit before they leave school and that access to GDS is actively facilitated for this cohort.

The series of surveys of 12 year old children show that there have been statistically significant reductions across all health boards for DMFT (Decayed, Missing and Filled Teeth) between 2004/5 and 2016/17). However, the reduction in active, untreated decay levels in north Wales does not appear to demonstrate the reduction experienced by other Health Boards. In 2020/21 children who participated in D2S before their permanent teeth erupted will be surveyed and the longer term impact of D2S on caries in the permanent dentition of 11-12 year olds will be determined. These children are already aged 7-8 and may have received fissure sealant treatment before it was withdrawn but could already have experience of decay in their permanent teeth. North Wales CDS wish to make a research proposal in relation this cohort.

Local preventative programmes have been designed for a group of particularly vulnerable people and have been recognised as examples of good practice by Welsh Government. *Seren o Wên,* a programme for children with learning difficulties, complements D2S and *Gwên Wen*, a programme for adults with Learning Difficulties have been operational for a number of years. Unfortunately the roll out of these programmes has not been as rapid as planned due to reductions in CDS budget. Similarly, it is likely to be difficult to meet the Welsh Government target date of 2020 for rolling out the *Gwên am Byth* programme to all Care Homes in north Wales without further investment.

Welsh Government - Health, Social Care and Sport Committee Consultation: Dentistry in Wales

Response on behalf of the Community Dental Service Directors Group

The Group welcomes the opportunity to make a contribution to this Consultation.

The Welsh Government's dental contract reform

The Group is supportive of the philosophy underpinning contract reform with its emphasis on prevention and the reduction in inequalities in access to care. We welcome the proposed new way of working placing prevention at the core of all dental service provision and with personalised preventative advice being provided for all patients. The ethos is as relevant to Community Dental Service (CDS) as General Dental Service (GDS).

Access to GDS varies across Wales. Although the average for Wales is reported as 55%, it ranges from 45.6% in Hywel Dda to 62.6% in ABMU. Access data relates to the proportion of the resident population treated in the GDS in the 24 month period ending March 2018. The data that informs these access levels relates to GDS including Salaried GDS (CDS/PDS) but excludes information relating to patients who are treated solely in CDS and private patients who have not received any care under GDS arrangements. CDS data is currently collected separately and reported annually by Stats Wales. From May 2019 it is intended that CDS activity will be captured by submitting information in the same way as the GDS. Whilst this will provide a more comprehensive picture of NHS primary care access it will need to form a new access base line as it will not be possible to compare with past GDS access data. Whilst this development is supported there are concerns regarding the readiness of IT infrastructure support and the lack of non-clinical support (e.g. reception/dental healthcare assistant staff) in some Health Boards to be able to implement the changes required in the identified timeframe.

An E-Referral system is also to be introduced across Wales enabling General Dental Practitioners to refer to hospital specialties and CDS electronically. Whereas it is disappointing that some CDS suggested amendments to referral forms and medical histories have not been possible it is reassuring to learn that these will be considered once the system has been introduced. The early adopters are scheduled to commence in November, with the programme being rolled out across Wales in the subsequent months. A system will also be required to capture and report referrals to CDS from other sources e.g. Hospital departments, General Medical Practitioners, other healthcare professionals, Care Homes, Social Services. It is suggested that there would be benefits in designing a system adopting the 'Once for Wales' principles.

Salaried GDS practices have been successfully introduced in some Health Boards utilising the CDS/PDS model introduced by Welsh Government in 1996. Directly managed by the CDS it offers an alternative model of NHS dental healthcare provision. The results of a BDA survey conducted in 2017 suggested that 72% of practices in Wales were accepting private patients whereas a mere 15% of practices were

accepting new NHS adult patients. Unlike GDS the salaried GDS model cannot operate in a mixed economy and is required to conform to changes in Welsh Government policy. It provides a 'safety net' that can be utilised should practices close or opt out of providing an NHS service. This model is deemed ideally placed to participate in the Contact Reform programme and to pilot new ways of working.

The use of skill mix is well embedded in CDS with Direct Access having been introduced and expanded. However, there appears to be a range of pay scales being adopted across Wales and in some cases the gap between therapists and dentists is reduced to such an extent that it would be difficult to justify employing a therapist rather than a dentist with a much wider scope of practice. It has been reported that this is also the case in GDS where dental therapists are seeking remuneration packages approaching those received by associates. To reduce these inequalities and remove a possible threat to the development of skill mix it may be helpful if a decision on appropriate pay scales could be determined nationally.

With regards to the shifting of the balance from the acute to community setting, Intermediate Tier services have already been introduced by some CDSs. They support the Hospital Dental Service (HDS) specialties e.g. endodontics, oral surgery and take care closer to where patients live. It is expected that CDS dentists who have gained additional clinical qualifications and/or appropriate clinical experience will be seeking Dentist with Special Interest (DwSI) recognition as accreditation procedures develop.

How 'clawback money' from health boards is being used

It has been frustrating to hear of clawback and dental funding not being invested in dentistry when there is evidence of the most vulnerable in society being denied access to services. In some areas of Wales the investment in orthodontics is perceived to be disproportionate when people cannot access routine care.

Welsh Government funding for a number of initiatives granted to the CDS has been most welcome (e.g. Designed to Smile (D2S), Specialist sessions, Older Persons programme) and has enabled initiatives to progress. It was anticipated that Health Boards would also invest in these programmes but this has not happened in most areas. Additionally, some CDSs are experiencing significant budgetary reductions which is impacting on their ability to deliver their objectives.

Lack of access to GDS clearly impacts on the role of the CDS. Nevertheless, some Health Boards appear reluctant to invest in salaried GDS posts that could cost effectively resolve some of the difficulties being experienced.

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

Overall, recruitment to the CDS in Wales appears to have improved since the introduction of the new contract (2008) although some areas are still reporting difficulties. All branches of dentistry appear to experience difficulties in recruiting to the most western reaches of Wales.

Welsh is the first language for a significant proportion of the north and west Wales population; children and young people receiving all their primary and secondary

education through the medium of Welsh. It is suggested that ways of investing in the education of Welsh students, wishing to study dentistry, should be explored.
There appears to be a recruitment issue in relation to some specialties (e.g. Restorative Dentistry) and the move towards community based specialist services is therefore supported. It is considered that developing training opportunities (e.g. clinical attachments) for GDS and CDS dentists are required to complement and support services in secondary care. This would reduce waiting list pressures and enable career development and retention of primary care dentists.

The provision of orthodontic services

Orthodontic services continue to be provided by CDSs in some areas enabling vulnerable children or children living in geographically isolated areas to receive orthodontic treatment. The clinicians offering this service work closely with the HDS and it is considered that training opportunities for DwSIs in orthodontics will need to be available in some areas of Wales.

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

National Epidemiological Surveys are led by Public Health Wales with local epidemiology coordinators responsible for the local organisation of the fieldwork which is carried out by CDS staff.

Although the dental health of 5 year old children is improving a survey of 3 year old children (2013/14) revealed that one in five children in the most deprived areas of Wales had already experienced decay by age three (2015/16). With the aim of keeping children decay free by the age of 5. Welsh Health Circular, 'Refocussing of the Designed to Smile child oral health improvement programme' (2017) places greater emphasis on preventative measures for children aged 0-5 and the inclusion of GDS teams in the delivery of this targeted programme.

Although there have been improvements in the dental health of older children they are not as striking as those experienced by 5 year olds. The impact of D2S on the permanent dentition will not be realised until 2020/21.

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

Wales Deanery Dental section is confining written evidence to the specific terms of reference in the inquiry which deals with the- *consideration of issues with the training, recruitment and retention of dentists in Wales.*

1. Background

The Dental Postgraduate Section of the Wales Deanery supports postgraduate education and training for the whole dental workforce (Dentists and Dental Care Professionals) in Wales and is responsible for the recruitment, quality management and satisfactory delivery of postgraduate dental training. The Deanery works closely with colleagues from Cardiff University Dental School and liaises frequently with the Office of the Chief Dental Officer (Welsh Government). The dental section is responsible on an annual basis for approximately 170 trainees.

1.1 Dental Foundation Training (DFT)

Dental Foundation Training is the first phase of continuing postgraduate education after graduation and is recognised as a part of career pathways in all sections of the dental profession. The Dental Postgraduate section currently offers opportunities to complete 1 year of Dental Foundation Training (DFT). This equates to one year of training working in GDS/CDS in an approved training practice, with one day a week allocated to educational study. There are up to 74 Dental Foundation trainees (dentists in their first year after qualification- this year is a mandatory requirement for dentists who intend to work in the General Dental Services providing NHS dentistry).

1.2 Dental Core Training (DCT)

Dental Core Training offers the opportunity to broaden knowledge and experience within the dental profession and is a recognised career pathway following the completion of Dental Foundation Training (DFT). Wales has four Dental Core Training Year 1 (DCT1) Schemes that commence in September of each year. There is a 30-day educational element (study days) covering both hospital and community practice.

The main aims of the scheme are to allow participants to broaden their understanding of the inter-relationship between branches of the profession, enabling a more informed career choice and to further develop their dental expertise and skills, building on previous training received as undergraduates and dental foundation practitioners. In addition, there are further career development posts known as Dental Core Training Year 2/3 posts (DCT2 or DCT3). These posts are normally undertaken following completion of training at DFT and DCT1. Currently there are 74 Dental Core Trainees (30 at level 1, 39 at level 2, and 5 at level 3). It is important to note that all of these posts support service delivery in hospital and/or community dental services

1.3 Speciality Training

Over the past few years Dental Specialty Training has expanded considerably and the Dental Postgraduate Section of the Wales Deanery is proud to support a variety of Deanery approved training programmes across 7 of the 13 GDC approved Dental specialties with a total of 21 current specialty trainees.

Dentists who wish to train to be a dental specialist must complete at least two years of training post-graduation, covering a broad clinical experience. At least one year should be spent in hospital or community practice, and each post must be occupied for a minimum of three months. The exact length of specialty training will depend on the specialty in question. All specialty trainees must register with the Director of Dental Postgraduate Education in Wales, who is responsible for monitoring the trainee's progress and the quality of training received. On completion of training, the trainee will need to pass relevant examinations (depending on the specialty) provided by one of the Royal Colleges and will become eligible for recommendation, by the Director to the General Dental Council (GDC), for the award of a Certificate of Completion of Specialist Training (CCST) which in turn should lead to their name being entered on the GDC's relevant specialist list.

1.4 Dental Care Professionals (DCPs)

Dental Care Professionals (DCPs) is a collective term that includes the following roles: Clinical Dental Technician (CDT), Dental Technician, Orthodontic Therapist, Dental Hygienist (DH), Dental Therapist (DT), and Dental Nurse (DN). The greater use of 'skill-mix', where DCPs play a more pivotal front-line role in dental service provision in the NHS is a principle that aligns with the Prudent Healthcare agenda in Wales.

'Skill-mix' can be divided into role substitution and role supplementation. The former is where DCPs undertake clinical tasks instead of dentists, whereas the latter is where DCPs augment the activity of a dentist. Both are considered to be important in shifting the future provision from a 'cure' to a 'care' model, particularly in dentistry with an emphasis on prevention. Wales Deanery provides a wide range of postgraduate programmes for DCPs which facilitate this process and develops the workforce, extending the skill sets. In particular, a Foundation Training Scheme for Dental Therapists to work in NHS GDS is provided annually with limited subsidised places. DCPs are essential members of any dental team. The GDC registers and regulates all members of the dental team, dentists and DCPs.

2. Current and future issues affecting delivery and success of the training programmes

Over the last few years the team at the Deanery have become aware of a number of issues that could present challenges to the delivery of dental training programmes. These include:

- Policy issues
- National Recruitment processes
- Recruitment and retention issues

2.1 Policy issues

Workforce Intelligence

In 2012 the Chief Dental Officer (Wales) commissioned a review of the dental workforce in Wales (***Analysis of Dental Workforce: NLIAH 2012***). The aim of the review was to compare the anticipated future supply of dental staff against possible future demand, and make recommendations on planning for a sustainable dental workforce. The report highlighted a number of important issues. One of the key problems that was identified was the ability to track dentists' career patterns was constrained by the available data; sufficient data was

available to identify the number of dental graduates produced in Wales since 2007 who were in the Welsh workforce in late 2011/early 2012. The data also showed the number of dentists who completed DF1 in Wales during 2007-2011 and were in the Welsh workforce in 2011/12. On average during the period 2007-2010, 58% of Welsh-trained dental graduates entered the Welsh workforce after completing DF1. ***Undertaking DF1 training in Wales is a significant factor in the decision to continue working in Wales.*** Of these, 90% undertook DF1 training in Wales and 10% undertook it elsewhere before returning to work in Wales.

Whilst the forecasts reported in the Review provide useful information around the expected future direction of the demand for and supply of dentists it is important to recognise, the forecasts have limitations because they do not capture the complexity that affect the dental marketplace. Therefore, any decisions about the supply of dentists should be informed by both the forecasts and additional information

Briefly, at the time of compiling this paper some data on the destination of new graduates (2018) has been obtained. These data indicated that only 28% (23 out of 75) of Cardiff University graduates have taken a DFT position in Wales this year. Trend data on previous cohorts of graduates are currently being analysed. The introduction of Health Education Improvement Wales (HEIW) in October 2018 will bring a significant boost to the development of workforce intelligence and workforce planning for NHS Wales.

Government policy

Two recently published national strategic policy initiatives will have a bearing on DFT training in the future. ***Advancing Dental Care: Education and Training Review*** published by Health Education England (HEE) recently outlined a number of areas which will affect the dental workforce, particularly with regards to commissioning education and training. If all proposals are realised this could signify an important policy shift in the way that all dentists and DCPs are trained. The outcome of this review will not be known for some time. In addition, the Cabinet Secretary has released a written statement ***"A Healthier Wales: the oral health and dental services response"*** which details the contribution oral health and dental services will make in achieving the vision of a whole system change, focused on health and wellbeing. This policy document will have a major influence on how oral health services are organized and delivered in the future, and the workforce needed to support this.

2.2 National Recruitment processes

DFT

Since National DFT recruitment commenced in 2014/15, there has always been competition for DFT places from both UK, EU and overseas graduates. Over recent years a small minority of UK graduates have been unable to gain a place on the programme. This has put a strain on the system as these graduates need to be accommodated in an approved process of training/equivalence in order to obtain a place on a scheme to be able to work in the NHS General Dental Services.

DCT

A National recruitment process for DCTs has recently been introduced. This process has thrown up some different issues for dental services in Wales. Some providers have found it difficult to recruit suitable candidates for these positions. The reasons for this are multifactorial, however the pay differences between England and Wales and the specific geographical locations of these positions have been mentioned in feedback as problems from previous post holders

Specialty

Speciality training places are strictly limited due to the lack of specific funding and, all of the jobs that have been advertised over the last few years have attracted a large cohort of applicants. However, there are issues with the development of new (and the replacement of current) consultant led specialist services in some specialities (in particular – orthodontics and restorative dentistry). There are very many consultant orthodontist vacancies in all parts of the UK. The major issue appears to be the pay differences between a specialist and a consultant working in the field of orthodontics. A qualified specialist orthodontist (with 3 years training) can earn almost twice the salary of an NHS consultant (with 5 years training).

2.2 Recruitment and retention issues

The Dental Section are convinced that there are number of influences that need to be factored into the discussion that relate to the long-term retention of dentists in Wales. These factors include issues relating to the recruitment and delivery of undergraduate dentist (BDS) and DCP programmes at Cardiff University, pay differentials between England and Wales for training grade salaries (see appendix 1) and, the popularity and opportunity of work placements in primary dental care (in rural and remote areas) for those graduates who have completed their DFT programme.

Some rural areas in Wales (and in other parts of the UK) have found it harder than others to recruit and retain dentists. Training additional dentists does not guarantee that they will choose to apply for posts (or establish practices) in these particular areas. Social, cultural and professional opportunities afforded by life in a city have been shown to be important factors in the decision-making process of dental graduates about where they work. If these difficulties remain, government and health service planners will need to develop new and innovative solutions to meet the oral health needs of the local populations. Solutions developed in other parts of the UK; in particular, Scotland should be investigated. The dental workforce in Wales cannot be considered in isolation from the workforces in other parts of the UK and the wider EEA.

In summary the key issues that the dental section would propose to address these problems can be summarised as:

- **HEIW working with Cardiff University to develop a strategy to increase the numbers of Welsh domiciled applicants and entrants**
    - Collect and analyse further relevant demographic data and link to workforce planning
    - Analyse whether the use of cultural and social determinants could be incorporated into CU entry requirements
    - Develop a closer working relationship between undergraduate and postgraduate training processes (e.g. flexible use of outreach facilities)

- **HEIW must ensure that the recruitment and delivery of DFT programmes is improved**

    - Collect and analyse further relevant demographic data and link to workforce planning
    - Identify and use multi-surgery/trainers' dental practices in geographical areas where it is hard to recruit, and, award flexible long-term trainer contracts
    - Develop better training relationships with corporate providers who hold the majority of NHS contracts in North and West Wales
    - Work and publicise improving the undergraduate/postgraduate transition process

- **HEIW must work with LHBs to provide ongoing work/training experiences in the GDS**

    - Using/top slicing in-year LHB GDS NHS dental contract funds to fund and deliver additional DFT+ places in areas of dental access and disease need, in order to provide patients with some continuity of care and practice
    - Working with WG and LHBs to develop an incentives package to encourage working in less popular areas in Wales
    - Working with WG to develop cogent GDP career pathways
    - Work with Government contract reform programme to develop ongoing work opportunities for dentists/DCPs who have completed foundation training.

[redacted]
Wales Deanery
August 2018

Appendix 1
Dental Training Grade Pay scales in UK 2017/18

Annual Salary - £ Gross	England	Scotland	Wales	NI	Comment
DFT	31,356	30,468	31,044	31,176	Wales - Based upon 2017 figures NI – As per SDR 17-18
DCT 1	36,461	34,674	30,665	36,461	Wales - WG pay circular M&D(W)1_2017 dated 6th April 2017 NI – As per Pay and conditions Circular (M&D) 1/2017
DCT 2	36,461	35,121-37,041-38,960-40,880	32,548	36,461	Scotland – Scale Wales - WG pay circular M&D(W)1_2017 dated 6th April 2017 NI – As per Pay and conditions Circular (M&D) 1/2017
DCT 3	46,208	35,121-37,041-38,960-40,880	34,430	46,208	Scotland – Scale Wales - WG pay circular M&D(W)1_2017 dated 6th April 2017 NI – As per Pay and conditions Circular (M&D) 1/2017

Ymatebion i'r Ymgynghoriad yn y Gymraeg

Consultation Responses in the Welsh Language

Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon, Cynulliad Cenedlaethol Cymru

Cais am Dystiolaeth: Ymchwiliad Undydd ar Ddeintyddiaeth yng Nghymru

Mae Iechyd Cyhoeddus Cymru yn croesawu'r cyfle i gyfrannu at ymchwiliad y Pwyllgor ar Ddeintyddiaeth yng Nghymru. Mae iechyd y geg yn rhan bwysig o iechyd a lles cyffredinol. Er bod pydredd dannedd a 'chlefydau'r deintgig' (clefydau periodontol) yn gyffredin iawn, maent yn gyflyrau y gellir eu hatal. Dylid canolbwyntio'n ddiwyro ar waith atal drwy wasanaethau a rhaglenni iechyd cyhoeddus, yn ogystal â rhoi mwy o ffocws ar benderfynyddion ehangach iechyd fel bod modd lleihau baich afiechydon deintyddol yng Nghymru.

Er gwaethaf y gwelliannau cyson yn iechyd y geg i blant yng Nghymru, mae oddeutu 7,000 o blant yn dal i gael tynnu eu dannedd o dan anaesthesia cyffredinol bob blwyddyn o ganlyniad i bydredd dannedd. Mae'r sefyllfa'n dangos bod angen mwy o ymdrech ac ymdrech barhaus i leihau faint o siwgr sy'n cael ei fwyta, mwy o waith atal effeithiol yn y gymuned a gofal deintyddol sylfaenol er mwyn lleihau'r gwir alw am anaesthesia cyffredinol deintyddol. Amlygir hefyd bod angen datblygu llwybrau gofal priodol ac ystod ehangach o wasanaethau deintyddol, megis gwasanaethau tawelu ymwybodol, er mwyn lleihau'r defnydd diangen o anaesthesia cyffredinol mewn deintyddiaeth.

Rydym wedi strwythuro ein hymateb yn unol â Chlych Gorchwyl yr ymchwiliad.

1. Rhaglen Diwygio Gwasanaethau Deintyddol Cyffredinol (Gwasanaethau Deintyddol Cyffredinol) y GIG (a elwir hefyd yn Ddiwygio'r Contract Deintyddol)

1.1. Yn 2017 cyhoeddodd Llywodraeth Cymru *Symud ymlaen i wella iechyd y geg a gwasanaethau deintyddol yng Nghymru*. Roedd y ddogfen hon yn amlygu bod diwygio contract deintyddol Gwasanaethau Deintyddol Cyffredinol y GIG yn un o'r tair prif flaenoriaeth ar gyfer gofal deintyddol yng Nghymru. Yn fwy diweddar, cyhoeddwyd dogfen bolisi ar iechyd y geg, *Ymateb gwasanaethau deintyddol ac iechyd y geg, Cymru Iachach: ein cynllun iechyd a gofal cymdeithasol* a oedd yn atgyfnerthu ymrwymiad Llywodraeth Cymru i raglen ddiwygio Gwasanaethau Deintyddol Cyffredinol y GIG.

1.2. Pam mae angen diwygio Gwasanaethau Deintyddol Cyffredinol y GIG?

1.2.1. Mae cyfyngiadau a sialensau system Gwasanaethau Deintyddol Cyffredinol bresennol y GIG yng Nghymru yn dra hysbys. Mae'r contract presennol yn ei gwneud yn ofynnaol i Unedau o Weithgaredd Deintyddol gael eu cyflawni, fel procsi ar gyfer cyfrif triniaethau deintyddol. Nid yw'r system bresennol yn darparu unrhyw ysgogiad i dimau deintyddol gyflwyno gofal ataliol nac i dderbyn cleifion a chanddynt anghenion mawr. Yr un yw'r tâl am ddarparu deg neu fwy o lenwadau â'r tâl am un llenwad. Mae pydredd dannedd a 'chlefydau'r deintgig' (clefydau periodontol) yn gyffredin iawn, ond yn gyflyrau cronig y gellir eu hatal. Mae canolbwyntio ar drin y clefydau heb waith atal yn ddefnydd aneffeithiol o adnoddau'r GIG. Dylai'r gwasanaethau deintyddol fabwysiadu egwyddorion rheoli clefydau cronig gyda phwyslais ar ofal cydlynol sy'n canolbwyntio ar yr unigolion a dylid cefnogi hunanreolaeth y cleifion

drwy ddull cydgynhyrchiol. Mae angen i'r Byrddau Iechyd hefyd ddatblygu'r ffordd y maent yn monitro ac yn rheoli perfformiad contractau deintyddol, gan roi mwy o ffocws ar ofal deintyddol o ansawdd uchel (gan gynnwys gwaith atal) a chanlyniadau cleifion.

1.2.2. Dylid rhoi ystyriaeth hefyd i sut i ddyrannu adnoddau deintyddol er mwyn darparu gofal i'r unigolion a'r grwpiau sydd fwyaf angen gofal deintyddol. Caiff cyfran helaeth o adnoddau'r Gwasanaethau Deintyddol Cyffredinol eu gwario ar ddarparu archwiliadau rheolaidd bob 6-9 mis i gleifion y mae eu risg o gael clefyd deintyddol yn isel. Ar hyn o bryd, cynghorir y dylai cleifion sy'n ddeintyddol 'iach' gael archwiliad bob 6 mis, tra bod llawer o bobl sydd angen ac eisiau gofal deintyddol yn methu â'i gael. Mae hyn yn enghraifft o'r Ddeddf Gofal Gwrthgyfartal ar waith ac mae'n digwydd am nad yw trefniadau presennol Gwasanaethau Deintyddol Cyffredinol y GIG yn rhoi cymhelliant i ddarparu gofal deintyddol i gleifion a chanddytn anghenion mawr. Mae i hyn oblygiadau i bobl o bob oed gan gynnwys cenedlaethau'r dyfodol yng Nghymru. Yn 2016/17, roedd 15.5% o blant 12 oed yng Nghymru yn dioddef o bydredd dannedd. Heb waith atal a mynediad at driniaeth effeithiol, mae'r plant hyn mewn perygl o ddod yn genhedlaeth o bobl ifanc yr effeithir yn negyddol ar iechyd eu ceg, ansawdd eu bywydau ac, o bosibl, eu gweithgarwch economaidd gan glefyd deintyddol. Mae angen i'r newidiadau i'r Gwasanaethau Deintyddol Cyffredinol ganolbwyntio ar leihau yr annhegwch o ran 'mynediad at wasanaethau deintyddol' ar draws grwpiau economaidd-gymdeithasol a rhoi cymhelliant i ddarparwyr deintyddol roi mwy o flaenoriaeth a gofal o ansawdd uchel i gleifion a chanddynt anghenion mawr.

1.2.3. Mae'r defnydd doethaf o adnoddau gofal iechyd cyhoeddus yn galw am fanteisio i'r eithaf ar sgiliau pob aelod o'r tîm deintyddol, yn hytrach na dibynnu ar ddeintyddion i ddarparu'r holl ofal ataliol a'r driniaeth. Mae'n bwysig dysgu o brofiad rhyngwladol yn ogystal â mentrau cenedlaethol sydd wedi gwneud gwell defnydd o

'gymysgedd sgiliau'[1] wrth i ni ddiwygio'r Gwasanaethau Deintyddol Cyffredinol yng Nghymru. Mae nifer o wledydd wedi defnyddio sgiliau therapyddion deintyddol i roi gofal deintyddol i blant ac mae model gofal o'r fath wedi cael effaith gadarnhaol o ran cynyddu mynediad at nifer fawr o blant a lleihau nifer yr achosion o bydredd dannedd nad ydynt yn cael eu trin ymysg plant.[2]

1.3. Rhaglen Diwygio Gwasanaethau Deintyddol Cyffredinol Iechyd Cyhoeddus Cymru a'r GIG

1.3.1. Mae Iechyd Cyhoeddus Cymru yn darparu arbenigedd iechyd deintyddol cyhoeddus i Lywodraeth Cymru, byrddau iechyd a rhanddeiliaid allweddol eraill yng Nghymru. Tîm Iechyd Deintyddol Cyhoeddus Iechyd Cyhoeddus Cymru sy'n cynnal Rhaglen Diwygio Gwasanaethau Deintyddol Cyffredinol y GIG. Rydym yn gweithio'n agos gyda Llywodraeth Cymru (Polisi Deintyddol), (timau) gwasanaethau deintyddol, byrddau iechyd a rhanddeiliaid eraill i ddatblygu Rhaglen Diwygo Gwasanaethau Deintyddol Cyffredinol y GIG. Sefydlwyd grŵp llywio amlranddeiliaid er mwyn sicrhau bod datblygiad a gwelliant y rhaglen yn cael ei ddylanwadu gan gronfa o arbenigedd sy'n cynnwys amryfal randdeiliaid ym maes iechyd y geg.

1.3.2. Amcanion presennol Rhaglen Diwygio Gwasanaethau Deintyddol Cyffredinol y GIG yw:

I. Cynnwys rhanddeiliaid deintyddol allweddol er mwyn datblygu Rhaglen Diwygio Gwasanaethau Deintyddol Cyffredinol y GIG a mabwysiadu model gwella parhaus.

II. Sicrhau bod y gwasanaethau deintyddol yn cynnal asesiad o risgiau ac anghenion iechyd y geg cleifion unigol o leiaf unwaith y flwyddyn gyda phecyn cymorth safonedig a defnyddio'r wybodaeth er mwyn:

[1] Mae 'cymysgedd sgiliau' yn derm sy'n cael ei ddefnyddio yn y maes deintyddiaeth i ddisgrifio model gofal sy'n golygu bod y tîm clinigol cyfan yn cael ei ddefnyddio er mwyn cyflwyno gofal deintyddol.
[2] Nash et. al. (2014). *A review of the global literature on dental therapists, Community Dentistry Oral Epidemiology*, 42;1-10.

a. Deall beth sy'n bwysig i gleifion
b. Cyfathrebu lefel y risg a'r angen yn effeithiol i gleifion (neu eu gofalwyr) a gweithio gyda'r cleifion er mwyn iddynt ddeall y newidiadau y gallant eu gwneud er mwyn atal clefyd deintyddol.
c. Cytuno ar ganlyniadau iechyd y geg y mae ar y cleifion eisiau eu cyflawni dros gyfnod o amser neu ar ôl cwrs o ofal deintyddol.
ch. Defnyddio egwyddorion penderfynu ar y cyd i ffurfio cynllun gofal deintyddol ataliol
d. Monitro newidiadau i 'risg ac angen' cleifion sy'n derbyn gofal parhaol gan y gwasanaeth.

III. Gwella'r ddarpariaeth o waith atal a thriniaeth sy'n seiliedig ar dystiolaeth.

IV. Cefnogi gweithrediad cyfnodau galw yn ôl deintyddol yn seiliedig ar risg ac angen iechyd y geg

V. Cynyddu'r defnydd o gymysgedd sgiliau yng Ngwasanaethau Deintyddol Cyffredinol y GIG yng Nghymru

VI. Annog timau clinigol i ddatblygu diwylliant o wella ansawdd parhaus er mwyn sicrhau gwell ansawdd a diogelwch i gleifion

VII. Annog timau deintyddol i sefydlu perthnasau gwaith cynhyrchiol gyda gwasanaethau gofal sylfaenol a chymdeithasol

VIII. Gwerthuso a deall y newidiadau yn y gweithgareddau allweddol a'r canlyniadau a sefydlu dangosyddion ansawdd er mwyn cyfrannu at welliant parhaus Gwasanaethau Deintyddol Cyffredinol y GIG a datblygiad gofal deintyddol sylfaenol.

IX. Deall y newidiadau sy'n angenrheidiol er mwyn lleihau annhegwch sy'n gysylltiedig â'r defnydd o ofal deintyddol, a gwella mynediad at wasanaethau deintyddol i unigolion sydd ag angen mawr ond nad ydynt yn gallu/dewis defnyddio gofal deintyddol ar hyn o bryd.

X. Cyfrannu at unrhyw newidiadau y mae eu hangen yn y contractau deintyddol cenedlaethol, unrhyw ddeddfau cysylltiedig a rhaglenni perthnasol eraill (e.e. hyfforddi a chynllunio gweithlu) neu systemau sydd ar waith i hwyluso'r gwaith o wella ansawdd parhaus.

1.4. Un o'r gwersi a ddysgwyd yn sgil cyflwyno Contract Gwasanaethau Deintyddol Cyffredinol presennol y GIG ym mis Ebrill 2006 yw bod goblygiadau andwyol na ellir eu rhagweld yn codi yn sgil newidiadau eang syfrdanol cenedlaethol. Dim ond yn y blynyddoedd ar ôl y newid y daw'r canlyniadau hyn i'r amlwg, wrth i batrymau gwaith newydd ddod yn rhan o'r system. Mae hanes o newidiadau cyffredinol yn y Gwasanaethau Deintyddol Cyffredinol, a llawer ohonynt wedi arwain at ôl-effaith negyddol annisgwyl gan gynnwys effaith ar fynediad a/neu'r math o driniaethau a ddarperir. Mae'n bwysig i Raglen Diwygio Gwasanaethau Deintyddol Cyffredinol y GIG yng Nghymru gael digon o amser i brofi, gwerthuso newidiadau a deall eu heffaith ar wahanol elfennau cydgysylltiedig y system.

2. Sut mae 'arian adfachu' gan y bwrdd iechyd yn cael ei ddefnyddio

2.1. O dan system Gwasanaethau Deintyddol Cyffredinol presennol y GIG, rhoddir cyfanswm y gwerth contract blynyddol i ddeiliaid contractau deintyddol mewn deuddeg rhandal ac, yn gyfnewid am hynny, mae'n ofynnol iddynt gyrraedd eu targedau o ran yr Unedau o Weithgaredd Deintyddol blynyddol a gontractiwyd. Fel rheol gyffredinol, bydd yn rhaid i ddeintyddfeydd gyrraedd o leiaf 95% o'u targed blynyddol er mwyn osgoi 'adfachu arian'. Mae amryfal resymau pam mae practisau deintyddol yn methu â chyrraedd eu targedau Unedau o Weithgaredd Deintyddol blynyddol. Nid yw cyrraedd y targed yn golygu mynediad da a/neu ofal o ansawdd dda. Rydym wedi amlygu cyfyngiadau system Unedau o Weithgaredd Deintyddol yn yr adran flaenorol a pham mae angen i ni bellhau oddi wrth y ffocws llwyr ar gyflawni Unedau o Weithgaredd Deintyddol.

2.2. Yn hytrach nag edrych ar 'arian adfachu' gan bractisiau deintyddol ar wahân, mae'n bwysig dadansoddi a dehongli'r gyllideb gofal deintyddol sylfaenol gyffredinol sydd ar gael, gwariant gwirioneddol, tueddiadau gwariant dros y blynyddoedd a thueddiadau yn lefel a thegwch mynediad deintyddol. Mae'n bwysig hefyd deall yr hyn sy'n digwydd i danwariant/'arian adfachu' a ph'un a oes unrhyw ran o

gyllid y Gwasanaethau Deintyddol Cyffredinol wedi ei ddefnyddio i ddatblygu unrhyw wasanaethau deintyddol eraill, yn enwedig gwasanaethau deintyddol canolraddol ac arbenigol mewn gofal sylfaenol.

3. Materion yn ymwneud â hyfforddi, recriwtio a chadw deintyddion yng Nghymru

3.1. Ni ellir ystyried datblygiad a gwelliant parhaus Gwasanaethau Deintyddol Cyffredinol y GIG ar ei ben ei hun heb waith cynllunio cynhwysfawr o ran y gweithlu deintyddol. Mae angen i Raglen Diwygio Gwasanaethau Deintyddol Cyffredinol y GIG a'r gwaith o gynllunio gwasanaethau deintyddol integredig lleol o fewn y byrddau iechyd gyd-fynd yn agos â chynllunio a hyfforddi'r gweithlu deintyddol.

3.2. Mae anhawster o ran recriwtio a chadw deintyddion sydd â'r gallu i ddarparu gofal o ansawdd uchel yn broblem i ddarparwyr deintyddol mewn rhai rhannau o Gymru, yn enwedig mewn cymunedau anghysbell a gwledig. Caiff hyn effaith negyddol ar fynediad i wasanaethau deintyddol yn yr ardaloedd hyn. Disgwylir y bydd yr anawsterau hyn yn fwy dwys os bydd y trefniadau ar ôl i Brydain adael yr Undeb Ewropeaidd yn cyfyngu ar fewnfudiad deintyddion o'r ardaloedd hyn. Yn 2017, roedd 6,689 o ddeintyddion cymwysedig o Ardal Economaidd Ewropeaidd wedi eu cofrestru gyda Chyngor Deintyddol Cyffredinol y DU. Yn 2012, roedd 15% o ddeintyddion Cymru yn raddedigion o'r Ardal Economaidd Ewropeaidd, ond roedd cyfran llawer uwch ym Mhowys a Hywel Dda.[3]

3.3. Gwyddom y gallai'r gweithlu deintyddol ehangach, y cyfeirir atynt fel Gweithwyr Proffesiynol Gofal Deintyddol, gyflawni cyfran helaeth o'r gweithgareddau atal a thriniaeth[4] a ddarperir gan ddeintyddion ar hyn o bryd, yn enwedig y rhai a ddarperir i blant. Mae trefniadau

[3] Asiantaeth Genedlaethol Arwain ac Arloesi mewn Gofal Iechyd, Dadansoddiad o'r gweithlu deintyddol, 2012
[4] Y Cyngor Deintyddol Cyffredinol, *Scope of Practice*, Medi 2013.

cytundebol deintyddol presennol a'r deddfwriaethau cysylltiedig yn atal a/neu'n gwahardd defnydd llawn o'r cymysgedd sgiliau deintyddol, yn enwedig mewn perthynas â therapyddion deintyddol.

3.4. Mae rhai Gwasanaethau Deintyddol Cymunedol a darparwyr Gwasanaethau Deintyddol Cyffredinol wedi rhoi gwell defnydd o therapyddion deintyddol ar brawf yng Nghymru. Mae'r rhaglen genedlaethol, Cynllun Gwên, i wella iechyd y geg a gyflawnir gan y Gwasanaethau Deintyddol Cymunedol hefyd yn defnyddio sgiliau ychwanegol nyrsys deintyddol er mwyn rhoi triniaethau ataliol. Mae potensial anferth i ddefnyddio sgiliau ychwanegol nyrsys, hylenyddion a therapyddion deintyddol mewn gwasanaethau deintyddol yng Nghymru, a dylai hyn helpu i wella mynediad at ofal ataliol a gofal deintyddol. Ceir rhywfaint o dystiolaeth bod practisiau deintyddol sy'n cynnwys therapydd deintyddol yn darparu dull o gyflwyno gofal iechyd y geg sy'n canolbwyntio'n fwy ar waith atal. Gwelwyd fod y deintyddion yn cyflawni'r gwaith mwy cymhleth a bod y cleifion yr un mor hapus yn gweld deintydd neu therapydd deintyddol.[5]

3.5. Ochr yn ochr â'r newidiadau cytundebol a deddfwriaethol sy'n angenrheidiol er mwyn cael gwared ar y rhwystrau sy'n atal y defnydd llawn o'r 'cymysgedd sgiliau' yn y Gwasanaethau Deintyddol Cyffredinol, mae angen sicrhau cynllun ar gyfer hyfforddi mwy o Weithwyr Proffesiynol Gofal Deintyddol medrus iawn yng Nghymru. Mae angen i GIG Cymru a chyrff sy'n gyfrifol am addysg hefyd sicrhau mynediad at hyfforddiant sgiliau ychwanegol i Weithwyr Proffesiynol Gofal Deintyddol presennol yn unol â'r newidiadau a gynllunnir ar gyfer y Gwasanaethau Deintyddol Cyffredinol a'r Gwasanaethau Deintyddol Cymunedol. Mae angen parhau hefyd i

[5] Barnes *et.al*. (2018), *General Dental Practices with and without a dental therapist: a survey of appointment activities and patient satisfaction with care, The British Dental Journal,* 225;53-58.

gyfathrebu gyda chleifion a'r cyhoedd ynglŷn â swyddogaeth Gweithwyr Proffesiynol Gofal Deintyddol o fewn y tîm deintyddol, yn enwedig gan fod eu sgiliau'n cael eu defnyddio'n ehangach o fewn y system ddeintyddol.

3.6. Bydd angen i fyrddau iechyd fod yn ddyfeisgar wrth gynllunio gofal deintyddol i'w poblogaeth leol, yn enwedig mewn ardaloedd gwledig. Mae rhai byrddau iechyd, lle nad oedd modd iddynt ddenu darparwyr y Gwasanaethau Deintyddol Cyffredinol, wedi profi model ymarferwyr cyflogedig. Efallai fod angen cymhelliant ychwanegol er mwyn recriwtio a chadw deintyddion a Gweithwyr Proffesiynol Gofal Deintyddol yn y rhannau o Gymru lle mae angen datblygu gwasanaethau deintyddol a/neu lle mae recriwtio a chadw wedi bod yn broblem. Dylid edrych ar y mesurau sy'n angenrheidiol er mwyn denu mwy o fyfyrwyr lleol i'r cyrsiau hyfforddi deintyddol yng Nghymru ac er mwyn eu cadw ar ôl iddynt ddilyn hyfforddiant israddedig ac ôl-raddedig.

3.7. Mae angen cynllunio'r gweithlu ar gyfer deintyddion arbenigol a deintyddion â sgiliau uwch. Dylai cyllid er mwyn hyfforddi deintyddion arbenigol a deintyddion â sgiliau uwch gyd-fynd â'r gwaith lleol a chenedlaethol o gynllunio'r gweithlu deintyddol. Mae angen i'r cynllunio hwn gynnwys recriwtio a chadw arbenigwyr hynod gymwys sydd wedi eu hyfforddi'n lleol. Golyga'r newid yn y boblogaeth (oedolion hŷn sydd ag anghenion deintyddol a meddygol cymhleth) bod angen i'r gweithlu arbenigol hefyd weithio gyda'i gilydd mewn tîm gan ddefnyddio model cymysgedd sgiliau.

3.8. Mae angen hefyd i'r gwasanaethau arbenigol, a arweinir gan ymgynghorwyr ac a ddarperir ar hyn o bryd gan leoliadau gofal eilaidd, weithio'n agosach â gofal deintyddol sylfaenol fel bod cleifion yn derbyn gofal di-dor wrth dderbyn gwasanaethau gan bractis deintyddol cyffredinol ac arbenigwyr/ymgynghorwyr mewn gofal eilaidd. Mae angen i recriwtio (a hyfforddi) deintyddion arbenigol

mewn rhai arbenigeddau penodol fod yn flaenoriaeth uchel. Rydym yn deall bod swyddi allweddol sy'n wag ar hyn o bryd (e.e. Ymgynghorydd Deintyddiaeth Adferol i Fwrdd Iechyd Prifysgol Betsi Cadwaladr, Arbenigwr mewn Deintyddiaeth Bediatrig i Fwrdd Iechyd Aneurin Bevan).

4. Darpariaeth gwasanaeth orthodonteg

4.1. Mae'n bwysig ystyried darpariaeth a'r defnydd o wasanaethau deintyddol canolraddol ac arbenigol/ymgynghorol (gan gynnwys orthodonteg) ochr yn ochr â darpariaeth y gofal deintyddol brys a rheolaidd sydd ar gael i boblogaeth Cymru. Mae ystyried y system ddeintyddol gyfan a chynllunio integredig ar lefel leol, rhanbarthol a chenedlaethol yn bwysig er mwyn osgoi gwaith cynllunio a darpariaeth dameidiog ym maes arbenigedd ddeintyddol.

4.2. Mae blaenoriaethu'n realiti mewn system sy'n brin o adnoddau ac mae cynllunio integredig yn bwysig er mwyn gwella gwerth gofal deintyddol.

4.3. Dyma rai o'r cwestiynau i'w hystyried:

4.3.1. Beth yw lefel y mynediad at ofal deintyddol brys (gan gynnwys y Tu Allan i Oriau) a gofal deintyddol cyffredinol rheolaidd i blant ac oedolion, gan gynnwys y rhai sy'n dioddef o orbryder a ffobia deintyddol?

4.3.2. Beth yw'r amrywiad yn lefel y mynediad at ddeintyddiaeth (gofal deintyddol brys a rheolaidd) ar draws grwpiau economaidd-gymdeithasol a grwpiau sy'n agored i niwed yn y gymdeithas (Deddf Gofal Gwrthgyfartal)?

4.3.3. Beth yw darpariaeth gwasanaethau deintyddol canolraddol (a ddarperir gan ddeintyddion sydd â sgiliau uwch mewn gwahanol arbenigeddau clinigol) ac arbenigol (e.e. deintyddiaeth bediatrig, endodonteg, periodonteg, prosthodonteg, orthodonteg, meddyginiaeth y geg,

llawdriniaeth y geg ac ati) ym mhob bwrdd iechyd ac a yw'n bodloni anghenion y boblogaeth?

4.3.4. Beth yw'r tueddiadau o ran y ffordd y defnyddir y gwasanaeth (gofal sylfaenol ac arbenigol) ym mhob bwrdd iechyd?

4.3.5. Pa ganlyniadau (a adroddir gan gleifion a chanlyniadau chlinigol) y mae'r gwasanaethau deintyddol yn eu cyflawni i boblogaeth y cleifion y maent yn eu gwasanaethu a beth yw'r amrywiad yng nghanlyniadau'r cleifion rhwng y byrddau iechyd?

4.4. Darperir cyfran helaethaf o driniaeth orthodonteg y GIG i blant 12-17 mlwydd oed. Dylid ystyried asesiad o'r angen a darpariaeth gwasanaethau orthodonteg fel rhan o'r gwaith cyffredinol o gynllunio gwasanaethau deintyddol, ac yng nghyd-destun y lefel uchel o bydredd dannedd ymysg plant Cymru. Yn 2016/17, roedd gan bron i 30% o'r plant 12 oed o leiaf un dant parhaol a oedd wedi pydru, wedi ei dynnu (oherwydd pydredd dannedd) neu wedi ei lenwi, sy'n dangos bod cyfleoedd atal neu ofal deintyddol wedi eu colli. Dylai mynediad at ofal deintyddol ataliol ac adferol i'r plant hyn fod yn flaenoriaeth.

4.5. Mae meini prawf derbyn eglur sy'n seiliedig ar dystiolaeth ar gyfer triniaeth orthodonteg (yn seiliedig ar Fynegai yr Angen am Driniaeth Orthodontig) a safonau y cytunnir arnynt mewn perthynas â chanlyniadau triniaethau. Gall amrywiol ffactorau effeithio ar yr amser aros am driniaeth orthodonteg e.e. trin camlinelliad cymhedrol (h.y. y rhai nad ydynt yn gymwys i gael y driniaeth orthodontig gan y GIG), atgyfeiriadau amhriodol ac a gamgyfeiriwyd, atgyfeirio plentyn at amryfal ddarparwyr gwasanaethau orthodonteg, triniaethau orthodonteg ailadroddus, trosglwyddo gofal orthodonteg ar ganol triniaeth o un practis i bractis arall ac ati. Mae amseroedd aros lleol ar gyfer triniaeth orthodonteg mewn gofal sylfaenol hefyd yn ddibynnol ar feini prawf derbyn y gwasanaethau gofal orthodonteg

a’r gwasanaethau a arweinir gan ymgynghorwyr ac a ddarperir mewn ysbytai.

4.6. Nid yw’r gwasanaethau orthodonteg ar hyn o bryd yn/yn gallu darparu gwybodaeth ddibynadwy am:

- nifer y cleifion sy’n aros am asesiad,
- nifer y plant sydd wedi eu hasesu, sy’n gymwys i gael triniaeth gan y GIG ac yn cael eu hysgogi i ymgymryd â thriniaeth orthodonteg faith,
- cyfnod aros rhwng atgyfeirio ac asesu a
- cyfnod aros rhwng asesu a ‘dechrau triniaeth’
- rhesymau dros beidio â gorffen cyrsiau triniaeth orthodonteg.

4.7. Mae’n bwysig bod Ymarferwyr Deintyddol Cyffredinol yn cael mynediad at y wybodaeth a amlinellwyd uchod fel bod modd iddynt gael trafodaeth wybodus gyda’r rhieni (a’r plant) ynglŷn â’r amrywiad yng nghyfnodau aros darparwyr gwasanaethau, ochr yn ochr â gwybodaeth ynglŷn â statws presennol iechyd y geg, meini prawf cymhwysedd ar gyfer triniaeth y GIG, risgiau a manteision triniaeth orthodonteg, argaeledd gwasanaethau orthodonteg lleol a’r amser teithio cysylltiedig.

4.8. Canfu astudiaeth ddiweddar a gynhaliwyd yn Ne-ddwyrain Cymru fod gwasanaethau gofal orthodonteg arbenigol yn yr ardal yn arwain yn gyffredinol at ganlyniadau clinigol da. Fodd bynnag, ni ddylai 4% o’r cleifion a gafodd driniaeth orthodonteg yn sampl yr astudiaeth fod wedi derbyn triniaeth y GIG yn seiliedig ar feini prawf triniaeth orthodonteg y GIG. Mae rhai plant yn mynd drwy ail gwrs o driniaeth tra bod eraill yn aros am y cwrs cyntaf.

4.9. Ni ddylai fod yn rhaid i’r system ddibynnu ar archwiliadau/ astudiaethau ad hoc er mwyn deall y canlyniadau a gyflawnir gan wasanaethau deintyddol. Dylai’r gwaith o gasglu gwybodaeth am

ganlyniadau triniaethau (clinigol a chanlyniadau a gofnodir gan y cleifion) gael ei integreiddio i'r system wybodaeth bresennol. Gellid addasu'r ffurflenni hawlio a gyflwynir gan wasanaethau orthodontig y GIG er mwyn casglu gwybodaeth am y canlyniadau clinigol a gyflawnir gan ddarparwyr y gwasanaethau.

4.10. Mae system E-atgyfeirio ar gyfer deintyddiaeth wedi ei hariannu gan Lywodraeth Cymru ac wedi ei chaffael yn ddiweddar gan Wasanaeth Gwybodeg GIG Cymru. Pan fydd byrddau iechyd yn rhoi'r system e-atgyfeirio ar waith yn gyfan gwbl, disgwylir y bydd yn help i fyrddau iechyd gael gwybodaeth er mwyn gwella mewn perthynas â nifer o'r sialensiau a amlinellwyd uchod. Dylai'r system wybodaeth E-atgyfeirio gael ei chynllunio i roi gwybodaeth ddibynadwy i rieni/cleifion, atgyfeirio ymarferyddion, darparwyr gwasanaethau arbenigol. Gellid dadansoddi'r data a gynhyrchir drwy'r system hon hefyd er mwyn deall tegwch yn y defnydd o wasanaethau deintyddol arbenigol, profiad cleifion, canlyniadau, ac i adnabod meysydd posibl i'w gwella ar gyfer pob gwasanaeth/bwrdd iechyd.

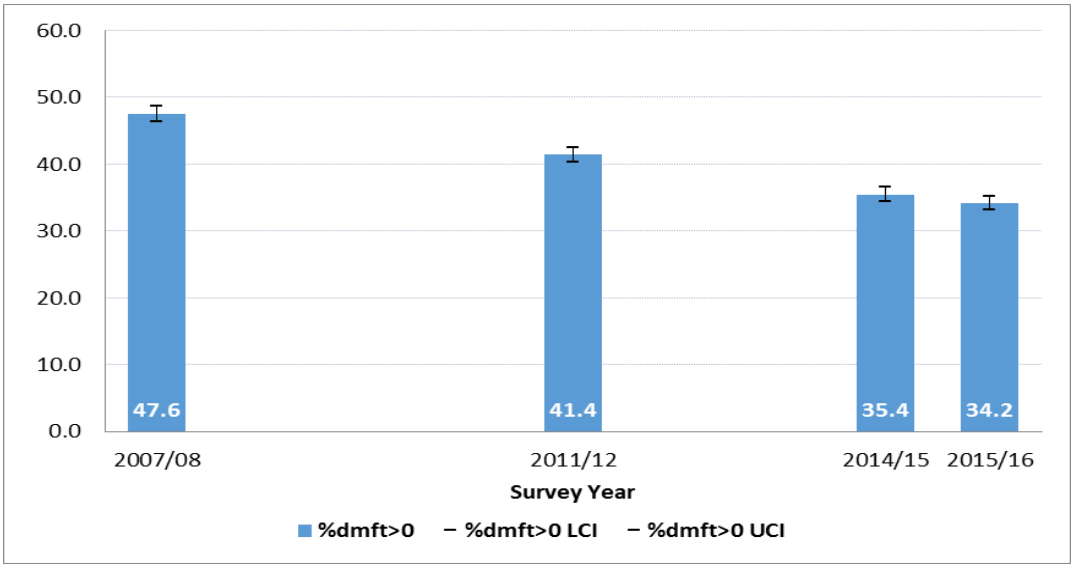
4.11. Bydd angen newid contractau orthodonteg cenedlaethol a chomisiynu mewn modd sy'n canolbwyntio ar ganlyniadau a rhoi pwyslais ar ddefnyddio mwy ar y cymysgedd sgiliau (e.e. swyddogaeth therapyddion orthodontig) er mwyn gwella gwerth gofal orthodonteg. Mae angen ystyried cyflenwad y therapyddion orthodonteg yn y gweithlu fel rhan o'r gwaith o gynllunio'r gweithlu deintyddol ehangach.

5. Effeithiolrwydd rhaglenni gwella iechyd y geg lleol a chenedlaethol i blant a phobl ifanc.

5.1. Mae'r Rhaglen Arolygu Ddeintyddol yn casglu gwybodaeth ynglŷn ag iechyd deintyddol plant pump a deuddeng mlwydd oed, fel rhan o'r

drefn reolaidd o arolygon deintyddol.[6] Er bod arolygon diweddar wedi dangos bod iechyd deintyddol plant yng Nghymru yn gwella (Ffig 1 a 2), mae pydredd dannedd yn dal yn gyffredin iawn. Dangosodd canlyniadau arolwg cenedlaethol bod 34% (2015/16) o blant pump oed a 29.6% (2016/17) o blant deuddeg oed yng Nghymru wedi cael profiad o bydredd dannedd.[7]

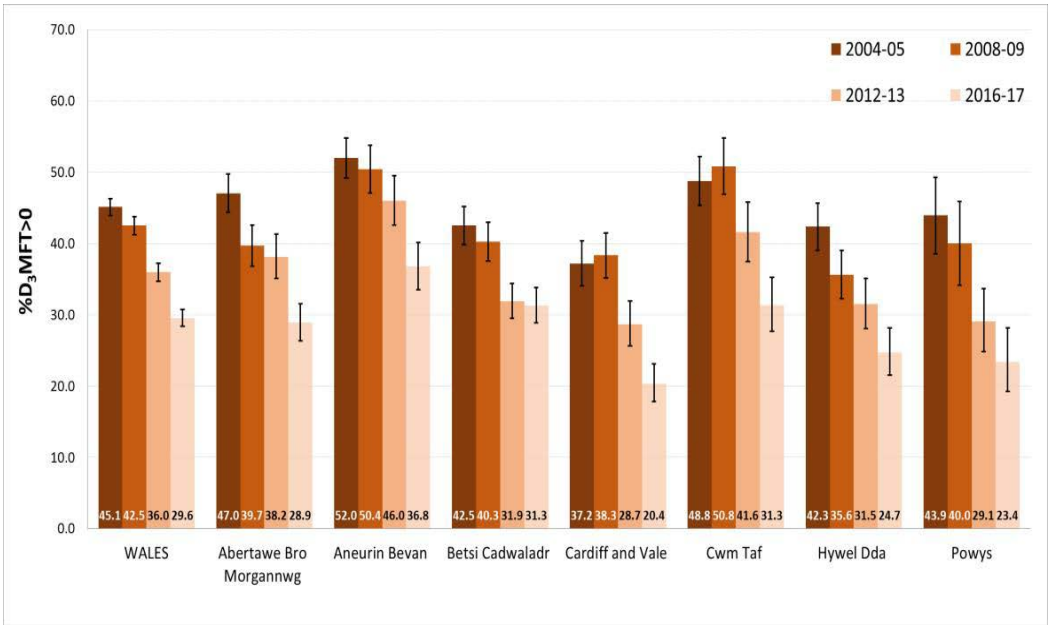
Ffigur 1: Tuedd o ran profiad o bydredd dannedd ymysg plant pum mlwydd oed (blwyddyn 1 yr ysgol) yng Nghymru.



[6] Mae canlyniadau'r arolygon hyn ar gael yn http://www.cardiff.ac.uk/cy/research/explore/research-units/welsh-oral-health-information-unit

[7] Profiad o bydredd yn y dannedd = O leiaf un dant yn cynnwys pydredd amlwg neu'n cynnwys llenwad neu wedi ei golli (ei dynnu allan oherwydd pydredd yn y dannedd)

Ffigur 2: Tuedd o ran profiad pydredd dannedd ymysg plant 12 oed yng Nghymru.



5.2. Er y dylai ymyriadau a gofal deintyddol ataliol gan weithwyr deintyddol proffesiynol sy'n seiliedig ar dystiolaeth fod yn rhan ganolog o Wasanaethau Deintyddol Cyffredinol, bydd yn anodd cyflawni gwelliannau ar raddfa fawr i iechyd ceg poblogaeth Cymru heb ymyriadau iechyd cyhoeddus ar lefel y boblogaeth.

5.3. Mae'r Cynllun Gwên yn rhaglen gwella iechyd y geg genedlaethol wedi'i thargedu sy'n cyflwyno ymyriadau yn seiliedig ar dystiolaeth i blant ifanc (0-5) yng Nghymru. Yn ei hanfod, mae'n rhaglen sy'n dod â dannedd plant i gysylltiad â fflworid drwy frwsio dannedd dan oruchwyliaeth a defnyddio fflworid cryfder uchel (farnais fflworid) mewn meithrinfeydd ac ysgolion cynradd mewn ardaloedd o amddifadedd yng Nghymru. Dengys data fod plant sy'n byw mewn ardaloedd o amddifadedd yn fwy tebygol o gael pydredd dannedd, ond mai hwy hefyd sydd leiaf tebygol o fynychu gwasanaethau deintyddol rheolaidd.

5.4. Y boblogaeth hon yw poblogaeth darged y Cynllun Gwên. Mae'r cynllun yn gweithredu fel 'rhwyd ddiogelwch' i'r plant hyn drwy gyflwyno ymyriadau ataliol sy'n seiliedig ar dystiolaeth e.e. lleoliadau gwasanaethau deintyddol traddodiadol yn rhoi'r rhaglen farnais fflworid ar waith fesul y tu allan i leoliadau gwasanaethau deintyddol traddodiadol er mwyn lleihau anghydraddoldeb sy'n gysylltiedig ag iechyd y geg a lleihau effaith y Ddeddf Gofal Gwrthgyfartal.

5.5. Mae Llywodraeth Cymru wedi ymrwymo i barhau â'r rhaglen Cynllun Gwên (Ymateb y Gwasanaethau Deintyddol ac Iechyd y Geg, Cymru Iachach) ac mae Iechyd Cyhoeddus Cymru yn cefnogi parhad y rhaglen yn llwyr a pharheir i ddarparu arbenigedd Iechyd Deintyddol Cyhoeddus i'r rhaglen. Yn y blynyddoedd ers i'r Cynllun Gwên gael ei dreialu (fe'i rhoddwyd ar waith fesul cam yn 2010/11), mae'r achosion o bydredd dannedd ymysg plant sy'n byw mewn ardaloedd o amddifadedd wedi lleihau ym mhob cwintel amddifadedd ac nid yw'r anghydraddoldeb yng nghyffredinolrwydd pydredd dannedd wedi gwaethygu. Mae'n werth cofio y bydd manteision ymyriadau iechyd cyhoeddus fel hyn yn cynyddu'n raddol wrth barhau i'w gweithredu. Bydd effaith y Cynllun Gwên ar iechyd dannedd plant yn parhau i gael ei fonitro drwy raglen oruchwyliaeth ddeintyddol wedi'i chynllunio.

5.6. Mae graddiant cymdeithasol yn dal i fodoli o ran y profiad o bydredd dannedd yn ystod plentyndod, gyda 42.2% o'r plant 5 oed yn yr ardaloedd â'r amddifadedd mwyaf yn dioddef o bydredd dannedd, o gymharu â 22.3% o blant 5 oed yn yr ardaloedd mwyaf cefnog. Yn 2013/14, roedd 20.2% o blant tair oed yn y cwintel o amddifadedd mwyaf wedi cael profiad o bydredd dannedd. Mae'r plant hyn o ardaloedd o amddifadedd dan anfantais bellach gan fod llai o fynediad i wasanaethau deintyddol (oherwydd nifer o rwystrau posibl). Rhaid i gyllideb y Cynllun Gwên barhau i gael ei chlustnodi a rhaid canolbwyntio ar dargedu plant sydd â risg uchel o bydredd

dannedd a hybu iechyd y geg i bob plentyn drwy wasanaeth ymwelwyr iechyd a gwasanaethau/rhaglenni eraill sydd wedi eu targedu at yr un boblogaeth.

5.7. Mae pydredd dannedd yn gysylltiedig hefyd â phenderfynyddion iechyd cymdeithasol a masnachol. O'r herwydd, mae llwyddiant ymdrechion ataliol a gyflwynir drwy'r gwasanaethau deintyddol a rhaglenni iechyd y geg megis y Cynllun Gwên yn ddibynnol ar benderfynyddion iechyd cymdeithasol a masnachol. Mewn termau syml, gallai ymdrechion ataliol y gwasanaethau deintyddol a rhaglen y Cynllun Gwên gael eu negyddu gan lefel uchel y siwgr sy'n cael ei fwyta a'i yfed (sydd hefyd yn effeithio ar ordewdra ymysg plant yng Nghymru).

5.8. Er mwyn gwella iechyd y geg ymysg plant, bydd angen rhaglen eang o gamau hefyd er mwyn gostwng lefel y siwgr y mae'r boblogaeth yn ei fwyta:

- lleihau'r siwgr rhydd sydd mewn bwyd a diod, gan gynnwys defnyddio trethi ac ardollau;
- cyfyngu ar farchnata a hyrwyddo cynhyrchion sy'n cynnwys siwgr;
- lleihau'r gwerthiant o fwydydd a diodydd sy'n cynnwys siwgr;
- cynghori, addysgu a helpu pobl i fwyta llai o siwgr;
- lleihau faint o siwgr a gynhyrchir.

5.9. Bydd angen i'r Byrddau Iechyd, drwy weithio â'u partneriaid ar y Bwrdd Gwasanaethau Cyhoeddus a'r Bwrdd Partneriaeth Rhanbarthol, sicrhau bod ganddynt raglen gynhwysfawr er mwyn lleihau'r siwgr sy'n cael ei fwyta yn eu hardal. Dylid cymryd rhai camau brys ar y mater hwn, gan gychwyn gydag ymroddiad gan y partneriaid ar y Bwrdd Gwasanaethau Cyhoeddus a'r Bwrdd Partneriaeth Rhanbarthol y bydd gwerthu diodydd a bwydydd afiach,

llawn siwgr yn cael ei wahardd/leihau yn eu hadeiladau (gan gynnwys bwyd sydd â lefel uchel o halen a braster dirlawn) a mabwysiadu polisïau arlwyo bwyd iach a pholisïau gweithle iach.

5.10. Mae tystiolaeth bod pobl o gymunedau o amddifadedd yn y DU yn bwyta mwy o siwgr. Mae lleihau faint o siwgr sy'n cael ei fwyta felly'n rhan allweddol o leihau'r anghydraddoldebau yn iechyd y geg rhwng gwahanol gymunedau a grwpiau poblogaeth. Nid oes gymaint o ddewisiadau bwyd iach i'r rhai sy'n dioddef o dlodi bwyd oherwydd eu pris uwch a'r nifer fawr o gynigion arbennig ar fwydydd llawn siwgr. Mae hyn yn arwain at fwy o wahaniaeth ym mhris bwyd iach a bwyd sy'n llawn siwgr[8]. Bydd angen polisïau gan y Llywodraeth (Llywodraeth Cymru a'r DU) a deddfwriaethau priodol er mwyn lleihau faint o siwgr sy'n cael ei fwyta er mwyn sicrhau nad yw'r siwgr rhydd yn cyfrif am fwy na 5% o gyfanswm egni dietegol grwpiau oedran o 2 oed i fyny, yn unol ag argymhelliad y Pwyllgor Cynghori Gwyddonol ar Faetheg.

[8] Datganiad sefyllfa Cymdeithas Prydain ar gyfer Astudio Deintyddiaeth Gymunedol ar y camau a argymhellir er mwyn gostwng faint o siwgr rhydd a fwytir a gwella iechyd y geg.

Diwygio Contract Deintyddol Llywodraeth Cymru

Mae'r Contract Gwasanaethau Deintyddol Cyffredinol cyfredol a gyflwynwyd ym mis Ebrill 2006 yn rhoi gwerth contract blynyddol i ddeintyddion er mwyn iddynt ddarparu lefel gytunedig o Unedau Gweithgarwch Deintyddol. Mae'n dra hysbys nad yw Ymarferwyr Deintyddol Cyffredinol yn hapus gyda'r contract presennol gan eu bod yn teimlo bod gweithio tuag at darged gweithgarwch fel 'bod ar y felin droed'. Hefyd, mae rhai ymarferwyr deintyddol cyffredinol yn gyndyn i dderbyn cleifion newydd gan nad ydynt yn gwybod faint o driniaeth y gallai fod angen ar y cleifion hynny. Caiff Unedau Gweithgarwch Deintyddol eu dyrannu yn seiliedig ar gyrsiau triniaeth a chaiff triniaeth ddeintyddol ei chategoreiddio yn y gwahanol fandiau, felly er enghraifft, byddai deintydd yn derbyn yr un nifer o Unedau os oedd angen 1 llenwad dant neu 5 ar y claf. Hefyd yr Unedau Gweithgarwch Deintyddol yw'r prif fesur o berfformiad deintyddol ond nid yw'n rhoi sicrwydd o ansawdd y gwasanaeth.

Mae Bwrdd Iechyd Prifysgol Cwm Taf yn cefnogi diwygio'r Contract Deintyddol a chymeradwywyd 3 deintyddfa ar gyfer y Cam 1af ym mis Medi 2017 a bydd o leiaf 1 practis ychwanegol yn dechrau'n ddiweddarach eleni. Felly, bydd 10% o bractisau deintyddol yn ardal y Bwrdd Iechyd Prifysgol yn gweithredu o dan ddiwygio'r contract deintyddol eleni.

Ar hyn o bryd, mae'r Bwrdd Iechyd Prifysgol yn gyndyn o gymeradwyo mwy o bractisau deintyddol gan fod lleihau'r Unedau Gweithgarwch Deintyddol a gontractiwyd gan 10% hefyd yn lleihau'r Refeniw o Daliadau Cleifion y mae'r Bwrdd Iechyd Prifysgol yn ei dderbyn o ran taliadau cleifion; mae'r dyraniad deintyddol yn cael ei roi i Fyrddau Iechyd llai'r Refeniw o Daliadau Cleifion felly mae unrhyw ddiffyg mewn incwm yn cael effaith ar sefyllfa ariannol y Bwrdd Iechyd Prifysgol. Mae Llywodraeth Cymru wedi cytuno ar gyllid ychwanegol pe bai Byrddau Iechyd yn cymeradwyo o leiaf 10% o bractisau deintyddol. Mae'r arian ychwanegol hwn yn talu am y diffyg amcangyfrifedig mewn Refeniw o Daliadau Cleifion ar gyfer 4 practis deintyddol, felly mae'n risg i sefyllfa ariannol y Bwrdd Iechyd Prifysgol pe bai'n cymeradwyo mwy. Bydd unrhyw leihad sylweddol mewn Refeniw o Daliadau Cleifion yn effeithio ar wasanaethau deintyddol sylfaenol eraill.

Un o'r beirniadaethau ar y contract Gwasanaethau Deintyddol Cyffredinol presennol yw na chafodd ei brofi cyn ei gyflwyno yn 2006. Felly, mae'r Bwrdd Iechyd Prifysgol o'r farn ei bod yn bwysig treialu diwygio'r contract deintyddol

ar nifer fach o bractisau er mwyn dysgu gwersi, nid yn unig mewn perthynas ag unrhyw risg sy'n ymwneud ag ariannu, ond hefyd y broses asesu risg, lle mae sawl newid wedi bod eisoes ers cyflwynwyd Cam 1 ym mis Medi 2017. Mae angen i'r seilweithiau TGCh fod ar gael hefyd i gefnogi'r ffordd newydd o weithio ac nid yw pob practis deintyddol yn defnyddio systemau cwbl gyfrifiadurol ar hyn o bryd.

Os yw % yr Unedau Gweithgarwch Deintyddol yn cael ei leihau ymhellach o dan gontract newydd, mae angen penderfynu sut y caiff contractau deintyddol eu monitro er mwyn sicrhau uniondeb a gwerth am arian. Pan gyflwynwyd y contract presennol, cymerodd sawl blwyddyn i'r broses gael ei chytuno a'i gweithredu'n llawn. Mae angen i Ymarferwyr Deintyddol Cyffredinol fod yn gwbl ymwybodol o'r hyn a ddisgwylir o'r cychwyn er mwyn osgoi unrhyw gamddealltwriaeth.

Mae'r gwaith o Ddiwygio'r Contract Deintyddol yn canolbwyntio ar atal a hefyd defnyddio amrywiaeth o sgiliau staff o fewn y practis. Fodd bynnag, adborth gan rai deintyddion yw eu bod yn pryderu sut y bydd hyn yn gweithio mewn meddygfa sengl neu bractis bach, lle na fydd ganddynt ddigon o le efallai i letya ymarferwyr eraill. Pan ofynnodd y Bwrdd Iechyd am ddatganiadau o ddiddordeb i gymryd rhan yn y broses o ddiwygio'r contract deintyddol, ychydig iawn o bractisau oedd â diddordeb. Felly, un rhwystr rhag ehangu nifer y practisau fydd argyhoeddi deintyddion y byddant yn gallu gweithio'n effeithiol o dan y trefniadau newydd.

Wrth i nifer y practisau sy'n gweithio o dan y contract newydd gynyddu, mae angen ymgyrch i godi ymwybyddiaeth y cyhoedd hefyd. Os na roddir cyhoeddusrwydd i'r ffyrdd newydd o weithio, mae'n bryder bod risg y ceir cynnydd mewn cwynion gan gleifion.

Sut y defnyddir 'arian adfachu'

Mae'r Contract Gwasanaethau Deintyddol Cyffredinol yn nodi bod Darparwr ond yn gallu cario uchafswm o 5% o ddiffyg o ran Unedau Gweithgarwch Deintyddol i'r flwyddyn ariannol ddilynol, felly mae unrhyw achos o dorri contract sy'n fwy na 5% yn meddwl bod rhaid ad-dalu arian i'r Bwrdd Iechyd Prifysgol.

O'r sefyllfa ganol blwyddyn ym mhob blwyddyn ariannol (h.y. 30ain Medi) mae'r Bwrdd Iechyd Prifysgol yn monitro gweithgarwch yn ofalus, gan gymharu perfformiad gwirioneddol bob mis â'r lefelau cyrhaeddiad disgwyliedig. Gan fod y contract presennol wedi dechrau ym mis Ebrill 2006 mae gan y Bwrdd Iechyd Prifysgol 12 mlynedd o ddata tueddiadau erbyn hyn i helpu gyda'r broses fonitro.

Mae'r Bwrdd Iechyd Prifysgol yn cyfathrebu â darparwyr yn ystod y flwyddyn ariannol pan fo pryderon bod y practis yn debygol o dangyflawni yn erbyn eu contract. O bryd i'w gilydd bydd Darparwyr yn hysbysu'r Bwrdd Iechyd Prifysgol eu bod yn disgwyl methu â chyflawni 95% o'r Unedau Gweithgarwch Deintyddol a byddant yn cytuno i'r arian gael ei ddal yn ôl yn ystod y flwyddyn ariannol.

Mae hyn yn galluogi'r Bwrdd Iechyd Prifysgol i gynnig cyllid wedi'i ddal yn ôl i bractisau deintyddol eraill neu i fuddsoddi mewn gwasanaethau deintyddol eraill yn ystod y flwyddyn ariannol felly ni chaiff cyllid ei golli i ddeintyddiaeth y GIG.

Fodd bynnag, nid yw'r mwyafrif o ddarparwyr deintyddol yn cytuno i ostyngiad dros dro yn eu contractau yn ystod y flwyddyn ariannol, hyd yn oed pan fo'r Bwrdd Iechyd Prifysgol o'r farn y byddant bron yn sicr o fethu â chyrraedd targed y contract. Gan fod gan y Bwrdd Iechyd Prifysgol 12 mlynedd o ddata tueddiadau, gellir gwneud penderfyniad yn ystod y flwyddyn ar y canlyniad ariannol tebygol, felly gellir penderfynu a ddylid buddsoddi mewn gwasanaethau deintyddol eraill yn ystod y flwyddyn ariannol.

Ar hyn o bryd mae gan y Bwrdd Iechyd Prifysgol gontractau Gwasanaethau Deintyddol Cyffredinol gyda 35 o bractisau deintyddol cyffredinol gwerth £13m. Bob blwyddyn ariannol ers cyflwyno'r contract Gwasanaethau Deintyddol Cyffredinol nid yw rhai darparwyr deintyddol yng Nghwm Taf wedi cyflawni eu targedau contract; mae nifer a gwerth yr ad-daliad wedi amrywio bob blwyddyn. Nid yw'r Bwrdd Iechyd Prifysgol yn chwilio am arbedion ar gontractau Gwasanaethau Deintyddol Cyffredinol ond pan gaiff arian ei ad-dalu, mae'n ail-fuddsoddi:

- Trwy gynnig Unedau Gweithgarwch Deintyddol ychwanegol i bractisau eraill pan fydd arian yn cael ei ryddhau yn ystod y flwyddyn ariannol sydd wedi golygu bod yr Unedau ychwanegol yn cael eu buddsoddi ym Merthyr Tudful a Chwm Cynon
- Trwy brynu offer er mwyn cychwyn Gwasanaeth Llawdriniaeth Mân-geneuol a gwasanaeth tawelyddu i gleifion pryderus ym maes Gofal Sylfaenol.
- Trwy drefnu sesiynau Gwasanaeth Llawdriniaeth Mân-geneuol Gofal Sylfaenol ychwanegol ar benwythnosau er mwyn lleihau'r rhestr aros.
- Trwy gymeradwyo grantiau gwella ar gyfer nifer o bractisau deintyddol i'w gwneud yn fwy hygyrch i gleifion anabl
- Trwy brynu dolenni clywed ar gyfer derbynfa pob practis deintyddol ynghyd â dyfeisiau clyw Sonido i'w defnyddio mewn cymorthfeydd.
- Trwy ariannu tri chwrs Farnais Fflworid a'u cynnig i'r holl bractisau deintyddol cyffredinol i'w nyrsys eu mynychu am ddim
- Trwy brynu brwsys dannedd, past dannedd a chwpan i Ymwelwyr Iechyd i roi i'r holl blant dan 3 oed
- Trwy darparu adnoddau ar gyfer yr ymgyrch “Mae Dannedd Babanod YN Bwysig”

Amcangyfrifir y bydd gwerth yr adennill cyllid ar gyfer tanberfformio 2017/18 yn 2.2% o gyfanswm y contractau Gwasanaethau Deintyddol Cyffredinol ond nid yw'r Bwrdd Iechyd Prifysgol wedi cwblhau'r broses adolygu diwedd blwyddyn eto felly efallai nad hwn fydd y swm gwirioneddol a adenillir.

Mae Bwrdd Iechyd Prifysgol Cwm Taf wedi cymeradwyo Cynllun Tymor Canolig Integredig ac felly nid yw'r gyllideb ddeintyddol bellach wedi'i chlustnodi. Fodd bynnag, mae'r Bwrdd Iechyd Prifysgol yn ymrwymedig i wella iechyd geneuol cleifion Cwm Taf ac nid oes ganddo broblem mynediad gyda

mwy na hanner y practisau deintyddol yn derbyn cleifion GIG newydd. Pan gaiff arian ei ad-dalu oherwydd torri contract, mae'r Bwrdd Iechyd Prifysgol yn manteisio ar y cyfle i ariannu mentrau deintyddol newydd, fel y disgrifiwyd uchod.

Materion yn ymwneud â hyfforddiant, recriwtio a chadw deintyddion yng Nghymru

Nid yw recriwtio yn broblem i'r rhan fwyaf o bractisau deintyddol yng Nghwm Taf ar hyn o bryd, ac mae'n debyg bod hyn oherwydd ei agosrwydd at Gaerdydd a'r ysgol ddeintyddol. Fodd bynnag, mae'r practisau corfforaethol wedi adrodd eu bod yn cael problemau wrth recriwtio deintyddion, a gallai hyn fod o ganlyniad i Brexit gyda graddedigion o Ewrop â llai o ddiddordeb i ddod i'r DU. Fel gyda'r Ymarfer Meddygol Cyffredinol, awgrymwyd bod deintyddion iau'n ymddangos yn amharod i ymrwymo i berthynas hirdymor neu helaeth â'r GIG ac nad yw'n ymddangos bod ganddynt ddiddordeb mewn dod yn berchenogion practis; gan ffafrio gweithio rhan-amser er mwyn cael cydbwysedd rhwng bywyd a gwaith. Wrth i'r Ymarferwyr Deintyddol Cyffredinol presennol ymddeol gallai hyn ddod yn fwy o broblem gyda deintyddion llai profiadol o bosibl yn amharod i ddarparu triniaeth a wneir yn draddodiadol mewn gofal sylfaenol.

Yn sgil cyflwyno'r broses o Ddiwygio'r Contract Deintyddol a mwy o ddefnydd o gymysgedd sgiliau amrywiol mewn practisau deintyddol, mae angen cynllun gweithlu er mwyn sicrhau bod digon o'r unigolion hyn ar gael i gefnogi practisau deintyddol.

Darparu gwasanaethau orthodontig

Nid oes unrhyw bractis orthodontig arbenigol yn ardal Bwrdd Iechyd Prifysgol Cwm Taf ac yn hanesyddol mae cleifion bob amser wedi teithio i'r practisau arbenigol yng Nghaerdydd. Pan gyflwynwyd y contract presennol yn 2006 rhoddwyd arian i'r Bwrdd Iechyd yn seiliedig ar wariant hanesyddol mewn practisau deintyddol yn hytrach na'i seilio ar boblogaeth cleifion. Felly nid oes gan Fwrdd Iechyd Prifysgol Cwm Taf fawr o ddylanwad ar gontractau orthodontig, gan fod tua £750k o arian ar gyfer cleifion Cwm Taf yn gorwedd gyda Bwrdd Iechyd Prifysgol Caerdydd a'r Fro.

Mae pryderon ynghylch hyd yr amseroedd aros am driniaeth gan fod y Bwrdd Iechyd Prifysgol wedi cael gwybod bod y cyfnod rhwng atgyfeirio a thriniaeth yn para tua dwy flynedd. Dengys arolwg diweddar o'r rhestrau aros mewn practisau Caerdydd a'r Fro fod dros 8,000 o gleifion newydd gyda 1,700 o gleifion eraill yn cael eu hasesu a'u hadolygu ac yn aros i ddechrau triniaeth. Cynhaliwyd adolygiadau blaenorol o wasanaethau orthodontig, sydd wedi datgan bod digon o ddarpariaeth yng Nghymru felly ni fydd buddsoddiad pellach yn y gwasanaeth.

Awgrymwyd bod y rhestrau aros hir hyn yn digwydd oherwydd bod deintyddion yn atgyfeirio cleifion i gael triniaeth yn rhy gynnar ac roedd archwiliad o atgyfeiriadau cleifion newydd a wnaed gan LOC De Ddwyrain Cymru yn 2015 yn dangos bod 15% o gleifion wedi cael eu hatgyfeirio'n gynnar. Mae hyn yn

ganlyniad y gellid ei osgoi yn sgil rhestrau aros hir.

Cyflwynodd y Rhwydwaith Clinigol a Reolir ar gyfer Orthodonteg ffurflen atgyfeirio mewn ymgais i leihau atgyfeiriadau amhriodol/cynnar ond nid yw'n ymddangos bod hyn wedi cael unrhyw effaith ar leihau nifer yr atgyfeiriadau i'r gwasanaeth. Er hyn, mae ansawdd yr atgyfeiriadau yn dangos gwelliannau cadarnhaol. Gobeithir y bydd y System Rheoli Atgyfeiriadau Electronig sydd i'w chyflwyno ledled Cymru erbyn mis Mawrth 2019 yn parhau i wella ansawdd yr atgyfeiriadau ond, yn y pen draw, mae'r dagfa oherwydd y capasiti i drin.

Yng Nghwm Taf mae arbenigwyr orthodontig yn gweithio i'r Gwasanaeth Deintyddol Cymunedol ond nid ydynt yn derbyn atgyfeiriadau oddi wrth Ymarferwyr Deintyddol Cyffredinol. Ar hyn o bryd caiff y Gwasanaeth Deintyddol Cymunedol ei reoli gan Fwrdd Iechyd Prifysgol Caerdydd a'r Fro ond caiff ei drosglwyddo i Fwrdd Iechyd Prifysgol Cwm Taf ym mis Ebrill 2019. Yna caiff y gwasanaeth ei adolygu o ran sut y gall weithio'n agosach â'r gwasanaeth orthodontig ysbytai.

Mae cleifion yn tueddu i gael eu hatgyfeirio i'r gwasanaeth ysbyty er nad ydynt yn bodloni'r meini prawf ar gyfer triniaeth gymhleth gan nad yw rhieni o'r ardaloedd mwyaf difreintiedig yn gallu teithio i Gaerdydd gan nad oed ganddynt gludiant. Mae hyn wedyn yn cael effaith ar y rhestrau aros am driniaeth mewn ysbytai, yn enwedig yn Ysbyty'r Tywysog Siarl, sydd ar hyn o bryd yn 2½ i 3 blynedd.

Yng Nghwm Taf mae 3 Deintydd â Sgiliau Gwell mewn orthodonteg sy'n gweithio mewn practisau gofal sylfaenol. Mae'r 3 Deintydd â Sgiliau Gwell yn gweithio gyda'r ymgynghorwyr yn yr ysbyty a byddent yn gallu trin mwy o gleifion ond fe'u cyfyngir gan eu Hunedau Gweithgarwch Orthodontig sydd wedi'u contractio. Mae ganddynt nifer fach iawn o Unedau Gweithgarwch Orthodontig yn seiliedig ar eu henillion yn ystod y cyfnod cyfeirio cyn Ebrill 2006.

Pa mor effeithiol yw rhaglenni gwella iechyd y geg lleol a chenedlaethol ar gyfer plant a phobl ifanc

Dechreuodd y Cynllun Gwên yn 2009, ac mae timau'n ymweld ag ysgolion cynradd i gyflwyno brwsio dannedd a farnais fflworid i blant ifanc. Mae tîm y Cynllun Gwên yn ymweld ag ysgolion yn ardaloedd Cymunedau yn Gyntaf ond mae'r Bwrdd Iechyd Prifysgol hefyd yn ariannu tîm i ymweld â'r holl ysgolion cynradd eraill nad ydynt yn dod o dan y Cynllun Gwên. Felly, mae pob ysgol gynradd yng Nghwm Taf yn cael cyfle i gyflwyno brwsio dannedd a farnais fflworid dan oruchwyliaeth mewn ysgolion. Yn anffodus, ni fydd pob pennaeth yn cytuno i'r rhaglen gwella iechyd y geg hon yn eu hysgol. Mae mwyafrif yr ysgolion sy'n cymryd rhan yn ymwneud yn llawn â'r fenter ac mae'r rhaglen yn rhan o'u hachrediad dan y Wobr Ysgolion Iach.

Mae'r arolwg diweddaraf o blant 5 oed yn dangos bod iechyd y geg ymhlith plant wedi gwella'n sylweddol ledled Cymru yn ystod y 10 mlynedd diwethaf. Fodd bynnag, ni welwyd y gwelliant hwn yng Nghwm Taf. Yr hyn nad ydym yn ei wybod yw a fyddai'r lefelau pydredd wedi cynyddu oni bai am y rhaglenni

iechyd geneuol presennol sydd ar waith? Mae'r Bwrdd Iechyd Prifysgol wedi rhoi blaenoriaeth i wella iechyd geneuol plant ac ers mis Medi 2017 mae bellach wedi cyflwyno rhaglen farnais fflworid ar gyfer yr ysgolion hynny nad ydynt yn cael eu cynnwys yn y Cynllun Gwên.

Ers mis Ebrill 2017 mae'r Bwrdd Iechyd Prifysgol bellach yn ariannu brwsys dannedd/past dannedd i ymwelwyr iechyd i roi i fabanod/twdlod ddwywaith y flwyddyn. Maent hefyd yn rhoi cwpan yfed am ddim i'r plentyn i annog y plentyn i roi'r gorau i ddefnyddio potel.

A yw'n ffactor nad yw iechyd geneuol plant yng Nghwm Taf wedi gwella oherwydd bod nifer y plant sy'n cael gwasanaethau deintyddol wedi gostwng dros y blynyddoedd? Yn 2009, mynychodd 36,271 o blant ddeintydd yn ystod y ddwy flynedd flaenorol, fodd bynnag, erbyn 2017 roedd y nifer hwnnw wedi gostwng i 35,158.

Mewn ymgais i gynyddu nifer y plant sy'n mynychu practis deintyddol, penderfynodd y Bwrdd Iechyd Prifysgol dreialu menter “Mae Dannedd Babanod YN Bwysig” yn ardal Merthyr Tudful (mae gan 56.5% o blant dan 5 oed bydredd dannedd). Nid yw'r Bwrdd Iechyd Prifysgol wedi buddsoddi o'r contract Unedau Gweithgarwch Deintyddol yn y fenter hon, ac eithrio swm bach i dalu am hysbysebu a hyrwyddo. Ar hyn o bryd, mae 3 deintyddfa ym Merthyr Tudful yn cymryd rhan yn y cynllun peilot ac maent yn gysylltiedig â phractisau Meddygon Teulu. Mae deintydd neu therapydd deintyddol yn ymweld â'r clinigau babanod i siarad â rhieni babanod/twdlod i'w hannog i fynychu deintyddfa. Roedd y 3 practis deintyddol wedi cael gostyngiad o 5% yn eu contractau Unedau Gweithgarwch Deintyddol ond arhosodd eu gwerth contract blynyddol yr un fath. Defnyddiwyd y 5% o gyllid i dalu'r deintydd neu'r therapydd deintyddol i fynychu sesiynau yn y practisau Meddygon Teulu.

Dim ond ym Merthyr Tudful mae'r peilot ar hyn o bryd ond rhoddwyd cyhoeddusrwydd i'r ymgyrch ymwybyddiaeth ledled Cwm Taf.

Dechreuodd y cynllun peilot ym mis Ebrill 2017 ac yn ystod 2017/18 mae nifer y plant sy'n mynychu practis deintyddol cyffredinol wedi cynyddu:

- Mae cyfanswm nifer y plant wedi cynyddu o dros 1,500 o blant (4.48%)
- Mae cyfanswm nifer y plant 0-2 oed ym Mwrdd Iechyd Prifysgol (grŵp oedran targed) wedi cynyddu gan 16.9%
- Cafwyd cynnydd o 39.53% yn nifer y plant 0-2 oed ym Merthyr Tudful (lle mae'r peilot o ran “Mae Dannedd Babanod YN Bwysig”).

Mae'r arolwg diweddaraf o blant 12 oed yn dangos bod gostyngiad o 18.5% wedi bod yn y % o blant sydd â dannedd pwdr, dannedd coll neu ddannedd wedi'u llenwi o'i gymharu ag arolwg 2008/09. Felly mae'r Cynllun Gwên wedi bod yn effeithiol o ran lleihau lefelau pydredd ymhlith plant 12 oed.

Mae angen i'r Bwrdd Iechyd Prifysgol barhau i roi blaenoriaeth i blant o dan 3 oed a bydd ail-ffocysu'r rhaglen Cynllun Gwên yn canolbwyntio ar hyn. Nid oes un fenter yn unig a fydd yn gwella iechyd y geg ymhlith plant ond mae angen i rieni glywed negeseuon cyson gan bob gweithiwr gofal iechyd proffesiynol.

D10
Ymchwiliad i Ddeintyddiaeth yng Nghymru / Inquiry into Dentistry in Wales
Ymateb gan y Cyngor Deintyddol Cyffredinol
Response from the General Dental Council

Ymateb y Cyngor Deintyddol Cyffredinol i'r alwad am dystiolaeth gan Bwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Cynulliad Cenedlaethol Cymru ar ddeintyddiaeth yng Nghymru

Cyflwyniad

1. Mae'r Cyngor Deintyddol Cyffredinol (GDC) yn falch o'r cyfle i roi ei farn i'r ymchwiliad undydd gan Bwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Cynulliad Cenedlaethol Cymru.

2. Mae'r GDC wedi nodi cylch gorchwyl yr ymchwiliad, ac mae'r ymateb hwn yn canolbwyntio ar y materion hynny sy'n dod o fewn cwmpas pwerau'r GDC. I'r perwyl hwn, mae'r ymateb hwn yn ymdrin â hyfforddi, recriwtio a chadw deintyddion yng Nghymru.

Cefndir

3. Cyhoeddwyd Cynllun Cenedlaethol Cymru ar gyfer Iechyd y Geg 2013-18[1] ym mis Mawrth 2013. Ymhlith pethau eraill, nododd y cynllun fod:

- Mynediad i ddeintyddion yn amrywio'n helaeth yn dibynnu ar yr ardal
- Angen dybryd i gadw gwasanaethau deintyddol yn fforddiadwy
- Mynediad i wasanaethau arbenigol yn amrywio cryn dipyn mewn gofal sylfaenol a gofal eilaidd
- Angen i bob Bwrdd Iechyd fonitro'r gweithlu deintyddol er mwyn mapio ac asesu angen i'r dyfodol
- Newidiadau rheoleiddiol a gyflwynwyd gan y GDC yn ddiweddar wedi cynorthwyo i gynyddu'r cyfleoedd i wella'r cymysgedd sgiliau yn y tîm deintyddol

4. Roedd y Cynllun yn disgrifio camau gweithredu i fynd i'r afael â'r pwyntiau uchod; o ran monitro'r gweithlu deintyddol, roedd y Cynllun yn nodi'r canlynol:

Dylai pob Bwrdd Iechyd fonitro ei weithlu deintyddol o ran ei anghenion nawr ac yn y dyfodol. Bu cynnydd mawr yn yr hyfforddiant a roddir i weithwyr gofal deintyddol proffesiynol ac mae hyn, ynghyd â'r newidiadau rheoleiddiol a wnaed gan y Cyngor Deintyddol Cyffredinol, yn golygu ei bod yn llawer mwy tebygol y bydd y tîm deintyddol yn cynnwys cymysgedd o sgiliau. Mae angen i Fyrddau Iechyd ystyried cynllunio ar gyfer olyniaeth; adolygu'r cymysgedd sgiliau; addysg a hyfforddiant; recriwtio a chadw; DPP; a datblygu gyrfaoedd. Yn amlwg, drwy gynllunio

[1] https://gov.wales/docs/dhss/publications/130322oral-healthcy.pdf

gwasanaethau deintyddol yn lleol, gall y GIG ddatblygu'r gwasanaethau mwyaf priodol a thargedu adnoddau at y mannau lle mae eu hangen fwyaf. Mae'r data sydd ar gael ar hyn o bryd ar y gweithlu deintyddol yng Nghymru yn amrywio, ac mae angen gwella ansawdd y wybodaeth sydd ar gael.

Sefyllfa gyfredol

5. Mewn dogfen ddiweddar (Mawrth 2017) yn amlinellu blaenoriaethau ar gyfer deintyddiaeth a gwaith yn y dyfodol (Symud Ymlaen i Wella Iechyd y Geg a Gwasanaethau Deintyddol yng Nghymru)[2] , nodwyd bod iechyd y geg wedi gwella yng Nghymru ond bod mynediad at wasanaethau deintyddol yn amrywio'n fawr o hyd. Hefyd, nodwyd bod recriwtio a chaffael i ddenu mwy o ddeintyddion yn anodd mewn rhai ardaloedd.

6. Ni fu unrhyw ddatblygiadau o bwys mewn perthynas â hyfforddiant deintyddion yn y pum mlynedd diwethaf. Fodd bynnag, yn unol â chamau a gymerwyd i foderneiddio'r drefn reoleiddio ar gyfer deintyddion, mae'r ffordd mae Datblygiad Proffesiynol Parhaus yn cael ei ddefnyddio i gynorthwyo deintyddion i gynnal a datblygu eu gwybodaeth, dealltwriaeth a sgiliau proffesiynol wedi cael ei diwygio hefyd. Dechreuodd system Datblygiad Proffesiynol Parhaus ddiwygiedig ar gyfer deintyddion ar 1 Ionawr 2018.

7. Mae yna ysgol ddeintyddol sefydledig yng Nghaerdydd, sydd fel rheol yn cynhyrchu 70-75 o ddeintyddion cymwysedig bob blwyddyn ac yn symud i swyddi hyfforddi. Mae nifer y deintyddion sy'n cael eu hyfforddi yng Nghymru a'r cyllid ar gyfer hyfforddiant yn cael ei bennu'n flynyddol gan Lywodraeth Cymru. Fodd bynnag, nid yw swyddogaethau statudol y GDC yn ei gwneud hi'n ofynnol iddo fonitro faint o raddedigion sy'n aros yng Nghymru, nac a ydynt yn aros yn y sector gofal sylfaenol neu ofal eilaidd nac i ba raddau maent yn ymarfer yn breifat. Yn hytrach, rydym ar ddeall bod darlun mwy cywir yn debygol o fod ar gael drwy'r trefniadau comisiynu ar gyfer gwasanaethau deintyddol ac mae gan y Byrddau Iechyd ddiddordeb brwd yn y rhain.

8. Gan ystyried bod y Gymraeg yn cael ei defnyddio o ddydd i ddydd mewn sawl rhan o'r gogledd a'r gorllewin, rydym o'r farn y byddai o gymorth cael mentrau i gymell a denu darpar israddedigion Cymraeg eu hiaith addas o'r ardaloedd hyn i hyfforddi yn Ysgol Ddeintyddol Caerdydd ac yna i raddedigion gael cymhellion pellach i ddychwelyd i'r ardaloedd hyn i ymarfer.

9. Rydym wedi nodi bod esboniad clir o fanteision mynediad gwell at weithlu deintyddol mwy hyblyg yng Nghymru wedi'i roi yn "Symud ymlaen i wella iechyd y geg a gwasanaethau deintyddol yng Nghymru"[3]. Mae'r dull a ddisgrifir yn cefnogi ymarfer deintyddol clinigol gwell a mwy o ffocws ar wella effeithiolrwydd clinigol a chanlyniadau cleifion, ynghyd â defnyddio'r tîm deintyddol cyfan i wella iechyd y geg

[2] https://gov.wales/docs/phhs/publications/170815oralhealthcy.pdf
[3] https://gov.wales/docs/phhs/publications/170815oralhealthcy.pdf

gydol oes drwy gynhyrchu a chyfathrebu negeseuon clir ar atal, y cyfan gyda'r bwriad o leihau'r galw am wasanaethau yn y dyfodol.

11. Deallwn fod bwriad i gynyddu'r capasiti hyfforddi ar gyfer gweithwyr gofal deintyddol proffesiynol yng Nghymru. Rydym yn cydnabod y bydd hyn yn rhoi mwy o gyfle yn y pen draw i gynyddu gweithio hyblyg mewn timau deintyddol yng Nghymru, gan gynyddu'r cyfleoedd i ddeintyddion cymwysedig ganolbwyntio ar ddarparu'r gwasanaethau mai nhw yn unig sydd â'r caniatâd cyfreithiol i'w cyflawni.

Casgliad Cyffredinol

12. Mae'r GDC yn cydnabod y manteision amlwg a ddaw yn sgil cyhoeddi cyfeiriad strategol clir ar gyfer iechyd y geg ymysg poblogaeth Cymru, sy'n cynnwys cynllunio ar gyfer darparu gwasanaethau deintyddol ac esboniad o'r gweithlu sydd ei angen i gyflawni hyn. Credwn hefyd fod adrodd yn rheolaidd ar gynnydd o ran gweithredu'r strategaeth yn cynorthwyo pawb i asesu'r blaenoriaethau cymharol (a gwneud penderfyniadau addas am y defnydd o adnoddau) ac i werthuso'r canlyniadau llwyddiannus yn ogystal â'r meysydd lle mae angen ymyrraeth barhaus o hyd.

13. Nodwn fod Prif Swyddog Deintyddol Cymru wedi dangos arweiniad cadarn wrth gyfathrebu (yng Nghylchlythyr Iechyd Cymru CIC 019 – Sicrhau'r cydbwysedd cywir yng Nghymru) y trefniadau ar gyfer ymchwilio'n effeithiol ac yn gymesur i gwynion yn erbyn deintyddion sy'n ymarfer yng Nghymru. Mae hyn yn amlinellu'r model a fydd yn sicrhau y gall y cyhoedd, y proffesiwn deintyddol, byrddau iechyd a'r GDC fod yn hyderus bod perfformiad deintyddol sy'n destun pryder yn gallu cael ei nodi'n brydlon a chael sylw cymesur er mwyn diogelu cleifion a chefnogi aelodau cofrestr y GDC. Mae hyn yn cyd-fynd â rhaglen ar gyfer rheoleiddio priodol sy'n cael ei datblygu o fewn y GDC a bydd yn sicrhau mwy o eglurder i gleifion a'r cyhoedd yn gyffredinol.

14. Rydym yn bwriadu gweithio'n agos gyda Llywodraeth Cymru wrth i ni ddatblygu ein rhaglen i ddiwygio a moderneiddio'r system reoleiddio ar gyfer y tîm deintyddol. Nodwn ein bod wedi cael ymateb adeiladol iawn i'n hymgynghoriadau (ffurfiol ac anffurfiol) eisoes ac rydym yn gwerthfawrogi'r wybodaeth a phrofiad y gall cydweithwyr yng Nghymru eu cyfrannu o ran sut bydd unrhyw drefniadau newydd yn esblygu. Yn arbennig, byddwn yn parhau i wneud asesiad ar y cyd o effaith canlyniad y trafodaethau ynghylch y DU yn ymadael â'r Undeb Ewropeaidd a'r effaith ar hyn o bryd ac yn y dyfodol ar ddarparu gwasanaethau deintyddol ataliol a deintyddol nid yn unig yng Nghymru ond yn ehangach yn y DU.

Cyngor Deintyddol Cyffredinol
Llundain
Awst 2018