National Assembly for Wales
Health, Social Care and Sport Committee

A Fresh Start
Inquiry into dentistry in Wales

May 2019

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About the Committee

The Committee was established on 28 June 2016. Its remit can be found at: www.assembly.wales/SeneddHealth

Committee Chair:

Dai Lloyd AM
Plaid Cymru
South Wales West

Current Committee membership:

Dawn Bowden AM
Welsh Labour
Merthyr Tydfil and Rhymney

Jayne Bryant AM
Welsh Labour
Newport West

Angela Burns AM
Welsh Conservatives
Carmarthen West and South Pembrokeshire

Helen Mary Jones AM
Plaid Cymru
Mid and West Wales

Lynne Neagle AM
Welsh Labour
Torfaen

David Rees AM
Welsh Labour
Aberavon

The following Members were also members of the Committee during this inquiry.

Rhun ap Iorwerth AM
Plaid Cymru
Ynys Môn

Neil Hamilton AM
UKIP Wales
Mid and West Wales

Julie Morgan AM
Welsh Labour
Cardiff North

Rhianon Passmore AM
Welsh Labour
Islwyn

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Recommendation 2. We recommend that the Welsh Government ensures and monitors the consistent reinvestment of clawback money recovered by health boards back into dentistry services until a new system for monitoring outcomes is in place (as referred to in recommendation 1). .... Page 26

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1. Background

1. The Welsh Government's *Together for Health: A National Oral Health Plan for Wales 2013-18* sets the direction for oral health and dental services improvement in Wales. The plan provides an overview of the action needed to improve delivery of oral health services and the quality of these services and makes provision for annual reports to be published to reflect on what has been achieved and to identify priorities for the next 12 months.

2. 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*.

3. This framework sets out the key priorities for oral health improvement and dentistry in Wales in the short to medium term. The document outlines a future work programme that will inform an update of the Oral Health Plan for Wales. One of the three key areas for action within the framework is contract reform and expanding new ways of working within primary care general dental services.[1]

4. We agreed to undertake a one day inquiry to look at dental and orthodontic contracts, along with wider workforce issues within the dental profession including training places and recruitment, and specifically to:

- scrutinise the Welsh Government's dental contract reform;
- consider how "clawback money" from health boards is being used;
- consider issues with the training, recruitment and retention of dentists in Wales;
- consider the provision of orthodontic services; and
- consider the effectiveness of local and national oral health improvement programmes for children and young people.

5. We took evidence for this one day inquiry at our meeting of 27 September 2018. From 1 April 2019, Abertawe Bro Morgannwg University Health Board became known as Swansea Bay University Health Board and Cwm Taf University Health Board became known as Cwm Taf Morgannwg University Health Board.

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[1] Welsh Government, Taking Oral Health Improvement and Dental Services Forward in Wales: A Framework outlining priorities for dentistry and a future work programme, March 2017, page 3

2. General Dental Services contract

6. The NHS General Dental Services (GDS) contract came into force on 1 April 2006 in England and Wales. The contract changed the way that dentists were contracted from individual "fee for item" payment claims, to an agreed annual contract value with stable monthly payments through the introduction of the Unit of Dental Activity (UDAs).

7. The current contract's system consists of three bands that determine how much a patient is charged for their treatment, and how much a dental practice is then remunerated by the health board.

8. In written evidence, the British Dental Association Wales (BDA Wales) detailed the courses of treatment included in each band:

- Band 1 includes diagnosis, treatment planning and maintenance, for example a clinical examination, assessment and report and an x-ray.
- Band 2 includes all necessary treatment covered by band 1 plus additional treatment such as fillings, root canal therapy and extractions.
- 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.[2]

9. UDAs are linked to this three-band system; Band 1 is classed as 1 UDA, Band 2 is 3 UDAs and Band 3 is 12 UDAs.[3] Consequently, the value of a UDA does not reflect numbers of patients attending a practice but broadly relates to courses of treatment regardless of the time taken and the cost of materials required.

10. UDA values vary considerably between practices and between health boards. As suggested by the BDA Wales, average health board values can vary between £23.38 and £29.96, and many UDA values are too low to be workable.[4]

11. Dental practices are evaluated on the UDAs they achieve against their contracted allowance of UDAs allocated by the health board. The majority of NHS practices are GDS contract providers working within this 2006 contract and are monitored by UDAs. The contract requires health boards to pay dental practices

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[2] Written evidence, D14

[3] Written evidence, D14

[4] Written evidence, D14

100 per cent of its contract if it has delivered at least 95 per cent of its contractual activity as expressed in its UDAs. This is the percentage of activity that must be delivered if a practice is to avoid the health board "clawing back" funds.

12. In written evidence, the BDA Wales highlights the costs of treating high needs patients. It suggests that these costs are unaccounted 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. The contract therefore acts as a strong disincentive for dentists to treat high needs patients, with over 90 per cent of dentists saying the 2006 contract has limited their capacity to treat patients with high needs.[5]

13. In areas where good oral health predominates, the BDA Wales states that dentists are not remunerated should they attempt to treat more patients than their contract allows because of the cap imposed by the contract, adding that this creates a barrier to improving patient access generally.[6]

14. Tom Bysouth, Chair of the Welsh General Dental Committee, British Dental Association Wales, emphasised this point in oral evidence, saying that as the current contract only provides funding for the contracted allowance of UDAs; dentists must spread this dental activity over the course of a year as no funding is provided if extra work is undertaken.[7] He suggested that taking on new NHS patients can become a difficult consideration for dentists, as practices might be reluctant to take on patients with high needs due to the risk to them and their overall viability.[8]

15. He stated clearly that:

> "Dentists would like the UDA put in the bin.
>
> The UDA and its meaningless value have contributed to the situation that we're in. So, yes, we appreciate there has to be some sort of measure. You can't just say, 'Here you go and get on with it'…These measures have got to be meaningful. They've got to show the quality of

[5] Written evidence, D14

[6] Written evidence, D14

[7] RoP, 27 September 2018, paragraph 110

[8] RoP, 27 September 2018, paragraphs 116-118

> what's being done and take into consideration the type of patients that you are treating."[9]

16. He went on to tell us that "morale has been on the slide for some time" and attributes this to the current contract. He added that there is general concern in the sector that various tests to the dental contract have been undertaken over the last 10 years, in various guises, but not much has changed.[10]

Welsh Government's dental contract reform

17. 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 was developed. It ran from 2011 to 2015 and focused on widening access; improving quality; and incentivising prevention.

18. Two of the eight pilot practices participating in the programme moved on to a trial of a more advanced "prototype" of the contract in 2016. Following the announced contract reform by the new Chief Dental Officer in 2017, the prototype contract was not rolled out. However, the two prototype practices within Abertawe Bro Morgannwg University Health Board remained as such and did not return to UDAs.

19. Instead, in September 2017 a new pilot scheme began, now with 22 practices taking part. Health boards across Wales selected and supported a number of dental practices within their localities to take part in the programme. This pilot scheme works with 10 per cent of UDAs given over to oral health needs assessment data collection.

20. Lindsay Davies, Head of Primary Care, Primary and Community Services Delivery Unit, Abertawe Bro Morgannwg University Health Board (ABMU), told us that the health board was pleased to support the continuation of the two prototype practices and four dental contract reforming practices in its area, as it recognised the "serious flaws within the existing dental contract" that "militated against the provision of good oral health". She added that the small reduction in the UDA target as part of the contract reform was providing "some elbow room" both financially and in terms of time for practices to work towards delivering a more holistic approach. She acknowledged the potential for an adverse effect on patient income but added that ABMU had been happy to take on this risk. It was noted that only 10 practices in the health board area have come forward with

[9] RoP, 27 September 2018, paragraphs 100-102

[10] RoP, 27 September 2018, paragraph 32

expressions of interest for the next wave because of these associated risks and capacity issues particularly for smaller practices.[11]

21. Tom Bysouth, BDA Wales, indicated his support for providing "a bit of leeway" for practices within the contract. Although he emphasised the need for the support of health boards given the potential for reduced revenue. However, he added that he believes the approach will not result in true behavioural change, as he suggests that the main drivers of the problem remain; the activity targets.[12]

22. Dr Caroline Seddon, Director, BDA Wales, spoke of her visit to the two practices still operating a capitation contract in Swansea:

> "…it was very striking, when we spoke to the dentists and the other members of staff, that morale was actually very good. And the way they described it, because they weren't constrained by these UDAs, because they were working on a preventative contract and working to help patients improve their oral health, they felt that they were practicing the dentistry that they'd been trained to do."[13]

23. Dr Seddon suggested that one of the criticisms of the prototype contract was that the number of patients being seen was reduced. She acknowledged this but suggested that a preventative programme takes time to embed as dentists have to spend more time with patients. Dr Seddon said that later figures demonstrated that access numbers were improving. She added that the BDA Wales would have wished to see the prototype contract extended more widely and was disappointed that it was not given more time to set in before contract reforms were introduced by the Welsh Government.[14]

24. Andrew Powell-Chandler, Head of Dental Policy, Welsh Government, agreed that early evidence from the pilot practices has indicated an increase in access. He said that practitioners are able to identify individual needs and discuss care pathways, resulting in less frequent visits for patients and creating capacity for dentists.[15]

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[11] RoP, 27 September 2018, paragraphs 254-256

[12] RoP, 27 September 2018, paragraph 9

[13] RoP, 27 September 2018, paragraph 39

[14] RoP, 27 September 2018, paragraph 39

[15] RoP, 27 September 2018, paragraph 505

Feedback for the Health, Social Care and Sports Committee on the impact of the General Dental "Prototype" Contract on Belgrave Dental Centre, Swansea

By Huw Hopkins B.D.S. Principal Dentist/Director at Belgrave Dental Centre and Pontardawe Dental Centre

Introduction

We have been involved in General Dental Service (GDS) contract reform at Belgrave Dental Centre since 2011. As a Dental Provider we are in an unique position within Wales in that we have two GDS contracts at two different sites, one of which is the GDS Prototype (Belgrave) and the other is the standard GDS "Unit of Dental Activity (UDA)" based contract (Pontardawe).

The background of the contract reform process has been covered in a separate document supplied by ABMU Health Board. It is a comprehensive and accurate account so I shall not duplicate its information here. I would like to thank ABMU Health Boards continued support of the Prototype Contract.

I would like to quickly outline the important issues that relate to the last two NHS Dental Services Contracts, the pre 2006 "fee per item" contract and the 2006 UDA contract.

Pre 2006 "Fee per item" Contract

Previously, under the pre-2006 "fee per item" contract NHS Dentists were paid depending on the complexity of the treatment delivered and time spent delivering those treatments to patients. There was an extensive, complicated and very prescriptive "menu" of different fees for different items of dental treatment. Long and complicated treatment plans where attributed proportionally higher fees compared to shorter, simpler treatments. There was patient registration and practices also received a separate monthly capitation payment depending on how many patients it had registered on its list. There was little in the way of payment for preventive care but there was some provision for prevention in the contract.

The Fee per item contract was far from ideal. The treatment list was vastly complex and difficult for patients to understand. High value complicated courses of treatment were sometimes delivered to patients who had a high risk of dental caries resulting in many repeated courses of treatment that was ultimately a waste of NHS funds.

Many years of under-inflationary increases to the fees meant that dentists had to work harder and harder, see more and more patients per day as the years passed, to generate the fees that would cover their ever-increasing practice running costs. Whilst the open-ended nature of the contract allowed practices to expand when they wanted to (there was no fixed contract value for each practice) most dentists complained that they felt like they were on a treadmill, having to run faster and faster just to keep still.

2006 UDA Contract

Whilst initially the "New Contract" appeared to simplify things for both Dentists and patients it soon became apparent that the UDA contract had dramatic unintended consequences.

As dentists got paid the same for carrying out one filling as they did for twenty, most practices stopped accepting new patients as they didn't want to take the risk that the newly accepted patients needed time consuming, long treatment plans i.e. the same payment no matter how many patient visits needed to complete a course of treatment. Whilst this would be feasible if the fee was set to cover the cost of five to ten fillings, it was in reality set for roughly one and a half!

Contracts were now limited with set annual contract values for a set number of UDAs delivered. There was a dramatic variation in the UDA rate across Wales, with some Practices receiving double the UDA rate of others! Patients were no longer registered with the practice and responsibility of out of hours care was removed from practices and transferred to LHBs.

Practices would plan their expenditure for the year with regard to the total Contract Value, however failure to deliver the UDAs resulted in "claw-back" equal to the value of the undelivered UDAs. One quick and easy way to have to give a large percentage of your contract back to the Health Board is to accept new high-need patients. Many dentists feel that this is perverse, as it prevents those that need NHS dentistry the most accessing it.

The top value BAND3 course of treatment, that was meant to cover the cost of the most complex dental treatment, involving laboratory fees e.g. crowns and bridgework or CoCr dentures, was set too low to carry out all but the most simple of acrylic dentures or single crowns. This has resulted in complex or high need patients being referred to secondary care and has also de-skilled Primary Care dentists. Younger GDPs that have qualified since the UDA contract started

have not had the clinical experience of many treatments that were previously regarded as pretty routine for GDS Dentists under the fee per item contract.

The impact of the Prototype Contract on Belgrave

Clinical Freedom

The working environment of the Practice was instantly transformed once the clinicians were "freed" from the constraints of the UDA. Whilst the UDA system drives clinicians to try and finish courses of treatment in the least amount of time possible the Prototype allows Dentists and their teams to exercise clinical freedom and stage treatment appropriately.

Patients that are experiencing urgent problems (e.g. dental pain) get their problems managed appropriately as a matter of urgency. With the patients consent we then build them a tailored "**Care-Pathway**" based on the patients **Risk** and **Need**, which is assessed via the ACORN template.

Patients move through the care-pathway with the aim of progressing through treatment complexity. The prototype allows proper foundations to support the patient's journey.

The principles of Prudent Health-Care underpin the planning of treatment. No longer are complicated, expensive treatments delivered to patients who can't maintain them. High cost treatments are delivered on patients who have lower risk of developing dental decay so that NHS funds are spent more appropriately and have the least risk of premature failure with an emphasis on quality.

Prevention

Prevention is the core to the Prototype way of working. The practice team fosters relationships with patients based on Co-production in which we motivate and support them to help maintain their oral health and progress along a **RED-AMBER-GREEN** traffic light system.

Skill Mix

The Prototype really does give the practice the freedom to utilize Dental Care Professionals (DCPs) within the practice. Dental Nurses, who have been trained to be Oral Health Educators, deliver preventive advice to patients. They also have enhanced skills that enable them to apply topical fluoride as a caries preventive measure.

Clinicians are able to delegate appropriate treatments to Dental Therapists and Dental Hygienists. All clinicians working at the top of their competency increases efficiency and enables increased capacity to see more patients.

Flexibility of services

We have the flexibility to respond to requests from the LHB to deliver targeted services within the prototype contract such as dedicated appointment slots to deliver much needed dental care to those seeking Asylum in the UK. We also deliver in-hours access sessions and offer those access patients a risk based care plan.

A Transformative effect

The Prototype really has transformed both the working environment for the staff within the practice and also the experience of patients receiving care. We would all hate to revert back to the UDA way of working. It would be devastating for the whole practice and for patients.

Since the Prototype it is not uncommon to hear the following comments from patients: -

"For the first time in 30 years I really understand how to look after my mouth"

"Having had one child with dental pain and decay, I now feel confident that I know how to look after my children's dental health as well as my own!"

"I'm happy for you to refer me for help" (smoking cessation)

But what about the Pontardawe Practice ?

Our second practice has unfortunately been left behind with:

- UDAs
- High needs population
- Frustration attempting to treat patients based on a target, not the clinical need/risk/coproduction and prudent healthcare principles
- Staff retention issues – high turnover of Dentist performers who become disillusioned with the UDA system.
- Annual Clawback – funds being sucked out of the practice and local practice population from missing targets due to trying to treat a high needs

> population under UDA GDS contract and low UDA rate. Funding that would otherwise be used for capital investment/improving facilities.
>
> However …
>
> Pontardawe has begun its Contract reform journey by being accepted in the WAG 2017 Contract Reform process. At present PHASE 1 involves only a 10% reduction in the annual UDA target. I can assure you from personal experience that this has minimal effect of the day-to-day experience of staff and patients but it is a starting point. We have implement as much of what we have learned at Belgrave as we can at Pontardawe, even though we still have to hit our UDA target. We are told that further UDA% reduction is planned for PHASE 2 of the process but as yet no date is planned for its implementation. I can't wait until the fantastic patients and hard working staff at our Pontardawe practice sees the real benefits of a UDA free GDS contract.[16]

25. Lindsay Davies, ABMU, told us that many dental practices believe that 10 per cent is not enough flexibility in the contract.[17] This is supported by Dyfed Powys Local Dental Committee who state in written evidence that 10 per cent is not an adequate amount of time for the proper completion of data, adding:

> "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."[18]

26. However, Craige Wilson, Assistant Director of Primary Care, Children's and Community Services, Cwm Taf University Health Board (CTUHB), highlighted that increasing the percentage is not without risk to local health boards from a financial perspective, so if there was a further increase, robust monitoring arrangements would need to be in place around the assessment and treatment of patients, as currently there are fairly limited outcome indicators around the contract.[19]

27. Karl Bishop, Consultant in Restorative Dentistry, Abertawe Bro Morgannwg University Health Board, described how the contract reform programme is evolving as it is being rolled out. He said:

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[16] Evidence paper

[17] RoP, 27 September 2018, paragraph 274

[18] Written evidence, D07

[19] RoP, 27 September 2018, paragraph 275

> "…[it's] a big step, I think, from the 2006 position, where there was an overnight change to the contract, and that caused major problems for everyone, whether it was health boards, or providers of the services as well. It certainly is beginning to show a change in treatment planning. So, we are seeing dentists looking more broadly. It's given them more flexibility, although only limited at the moment, to look at the patients' needs more broadly, rather than being driven by a target."[20]

28. On 12 February 2018, the Welsh Government issued a Written Statement highlighting how the current dental contract is focused on treatment activity, and does not incentivise needs led care, prevention, or make the best use of the skills of the whole dental team. It also states that learning is being used from the previous dental pilots in Wales (2011-2016) and the ongoing dental prototype practices to design the new programme.[21]

29. In oral evidence, Dr Colette Bridgman, Chief Dental Officer for Wales, told us that learning from the piloting of contract reform in Wales has:

> "led us to believe that it's not just tweaking of contract that's going to deliver transformation here and that we need to take a much wider view of the whole system, including supporting patients to take a step up in understanding oral health and oral health literacy, and dental teams being able, and feeling that they've got the conditions right, to deliver prevention, and that the use of the whole team could be so expanded to give us more effective, more efficient services."[22]

30. We asked Dr Bridgman why, given the success of the pilot practices operating without UDAs, are the Welsh Government reforms a tweak of the contract rather than a whole new approach. Dr Bridgman reassured us that the value of the pilots had not been disregarded and stated that the pilots were not only an opportunity to test no targets, but also to change the skill mix within practices, and to consider the needs of patients and begin to produce information on this. Dr Bridgman told us of the intention to build evidence in these areas, and that she hoped over the next five years there would be considerable change. In support of this, the Welsh Government has held a number of engagement events and hosted a symposium in 2017 involving dental practices and health boards.[23]

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[20] RoP, 27 September 2018, paragraph 258

[21] Dental Contract Reform and expanding new ways of working for NHS dental practices

[22] RoP, 27 September 2018, paragraph 493

[23] RoP, 27 September 2018, paragraph 499

31. Frances Duffy, Director, Primary Care and Innovation, Welsh Government, said that the Government was taking an evaluative approach to ensure there are no unintended consequences and to better understand the wider support that's required to achieve the desired outcomes.[24]

32. In response to evidence heard by the Committee about the sector's views of UDAs, Dr Colette Bridgman acknowledged that UDAs are a poor measurement of performance, but stated that there is a need for some mechanism to measure the impact of health spend in this area.[25] She also said:

> "I absolutely understand that the way the targets are monitored and UDAs are applied to practices are demoralising when it results in clawback, particularly when a practice is working in an area of high need or where the price of the UDA is very low."[26]

33. Dr Bridgman added that the Welsh Government is encouraging health boards to "look beyond just a percentage of UDAs to measure performance of an NHS practice, or a practice with an NHS contract".[27]

34. In a Written Statement issued on 21 March 2019, the Minister for Health and Social Services referred to the dental Innovation Fund which supports clinical teams by accelerating an expansion in dental care professionals and noted that the first call for bids resulted in offering direct investment of some £750,000 to 33 practices across all seven health boards. A second call is planned for later in 2019. He confirmed that fifty three dental practices across all health boards are now actively participating in dental contract reform. A further 41 practices have applied to take part in the next phase from April 2019.[28]

Our view

35. We are aware that many dentists are unhappy with the current contract and believe that morale in the sector could be improved if the Welsh Government were to present the changes to the dental contract as a "new contract", as previous changes did not lead to the outcomes needed.

36. We believe that replacing the current UDA targets with a new system would be of benefit to both practitioners and patients, as well as boosting morale within

[24] RoP, 27 September 2018, paragraph 506

[25] RoP, 27 September 2018, paragraph 509

[26] RoP, 27 September 2018, paragraph 500

[27] RoP, 27 September 2018, paragraphs 510-512

[28] Welsh Government Dental Symposium on NHS Dental Contract Reform – Principality Stadium

the sector. We are concerned that the current UDA system may discourage some dentists from taking on high needs patients, particularly in areas of high deprivation where poorer access to dental services already exists.

37. We acknowledge that any new system would need to monitor outcomes and this would need to ensure that preventative care and the treatment of high needs patients is incentivised.

Recommendation 1. We recommend that the Welsh Government replaces the current Unit of Dental Activity targets with a new, more appropriate and more flexible system for monitoring outcomes to include a focus on prevention and quality of treatment, and to provide an update on the progress of these considerations to this Committee in six months.

3. Money recovered by health boards

38. The 2006 GDS contract states that if a dental practice fails to achieve 95 per cent of their UDA target they will face clawback. Clawback is the money recovered by health boards from the agreed annual contract value if the target is not met.

39. In its written evidence, the BDA Wales states that setting UDA targets does not work. It says that a dentist facing clawback could have worked longer hours and helped more patients with more challenging ailments than another dentist who has completed their UDA targets. It suggests that this is in part due to the banding system.[29]

40. Tom Bysouth, BDA Wales, expanded on this point in oral evidence saying that the worry to dentists trying to achieve 95 per cent of their target creates a risk to behaviour. He told us:

> "We want dentists to treat the patient, whatever is in front of them, and treat whoever walks in through that door fairly and equally. Where you've got that sort of threat of money being taken back because you happen to take on a lot of people who are requiring much more work, requiring much more of your time, it almost acts like you're just being judged on your numbers, when that number you're being judged on actually doesn't really mean anything. It doesn't mean you've done more or less work than anybody else; it means that, within this particular contract, you have failed to achieve because of the problems within the contract."[30]

41. In oral evidence, Dr Collette Bridgman stated that clawback can be "very demoralising and it can be unfair". However, she added:

> "…it's public money. If you as a provider have been given a contract, and for reasons such as you haven't been able to recruit, you haven't been able to provide a service, then the health boards—it's legislation—need to take that money back, because a service has not been delivered."[31]

42. In response to a question about clawback, Lindsay Davies, ABMU, suggested that the term "money recovered" for underperformance is a fairer term than

[29] Written evidence, D14

[30] RoP, 27 September 2018, paragraph 29

[31] RoP, 27 September 2018, paragraph 517

clawback, "because that implies we're aggressively taking away moneys from contractors".[32] She said of dental practices:

> "…we expect them to perform up to 95 per cent and then they can keep their moneys. So, at 95 per cent, we as a health board are still paying them 100 per cent. If you looked at it cynically, contractors who deliver to 95 per cent are getting that 5 per cent moneys as a loan from the health boards, and that could be rolled on, year on year, as long as it's hit 95 per cent. What we're most interested in is, obviously, incentivising them to get them up to 100 per cent and clawing back, if you like, moneys from contractors who consistently perform below 95 per cent because we want to reinvest that in people who do, because, otherwise, we end up with a massive underspend."[33]

43. Evidence presented by the BDA Wales around clawback, handback, and contract reductions in all health boards over a three-year period and resulting underspend, suggests that the clawback for Hywel Dda University Health Board and Powys Teaching Health Board is significantly higher.[34] In response, correspondence from Powys Teaching Health Board indicates that this is mainly down to recruitment issues. It states:

> "The majority of Powys contracts are with a Corporate who are currently experiencing recruitment issues which resulted in the clawback.
>
> Powys in an attempt to solve the problem of access has decided to invest in some salaried general dental practitioner posts to complement the general dental service. It has also invested in creating a foundation post to further attract dentists into the area."[35]

44. Hywel Dda University Health Board also reported issues with recruitment and retention for existing practices to either increase capacity within existing contracts or to set up new NHS businesses. It also said:

> "…in 2015/16, 2016/17 and 2017/18 the Health Board saw an unprecedented level of unplanned underperformance against dental Contracts. In both years a significant proportion of the

[32] RoP, 27 September 2018, paragraph 294

[33] RoP, 27 September 2018, paragraph 296

[34] Written evidence, D14

[35] Additional information from Powys Teaching Health Board - 25 October 2018

underperformance (in excess of 80%) related to a specific corporate provider…"

"Generally, and with the agreement of the dental Contractor, the Health Board would not seek to recover any small amounts of underperformance from contractors in return for the contractor agreeing to make good the underperformance in the subsequent financial year. However, where underperformance is of the levels seen over the past three financial years, recovery by the Health Board is expected in line with the Contractual process."[36]

45. The Minister for Health and Social Services states that in terms of the total primary care dental expenditure of £180 million in 2017-18, the amount of clawback, at £6.5 million, actioned by health boards is relatively small (3.6 per cent). The Minister's evidence paper also states that while it is right that health boards monitor contracts and take appropriate action where contracts are not delivering, the Welsh Government is concerned about overly rigid application and a focus only on percentage of UDA delivered in isolation to other measures of contract provision. In addition the "value" of a UDA needs to be adequate to reflect cost of quality care delivery.[37]

46. Dr Colette Bridgman agrees that difficulties arise when the UDA target is seen as the only measure, and practices may be situated in a high need community or the value of that UDA is low. She told us that health boards are being encouraged to look at these wider measures and not to base clawback decisions on a percentage of UDAs alone. She added that a number of health boards have taken quite significant steps towards this.[38]

47. The Royal College of Surgeons of Edinburgh suggest in written evidence that any clawback money should be targeted at the highest need areas.[39] Craige Wilson, CTUHB, detailed how in particular areas of high deprivation where practices have not achieved their UDA targets, it has been possible for the health board to redistribute those UDAs to areas of higher need. He suggested that this has resulted in a higher number of adults and children accessing a dentist, and that UDA levels are now at a more appropriate level for that practice.[40]

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[36] Additional information from Hywel Dda University Health Board - 25 October 2018

[37] Evidence paper

[38] RoP, 27 September 2018, paragraph 519

[39] Written evidence, D17

[40] RoP, 27 September 2018, paragraph 298

48. Lindsay Davies, ABMU, also described how money recovered had been reinvested to raise the UDA rate for those practices that were beneath a certain level in her health board area, subject to meeting certain criteria, to mitigate against patients with high needs needing treatment over multiple visits.[41]

49. In his paper, the Minister for Health and Social Services notes that the Welsh Government wants to see health boards providing greater year-round support to dental providers who are experiencing difficulty in meeting current activity targets, using contract reform principles, and not simply waiting to recover funding at year end. Particularly in cases where the unit price of the practice UDA is below regional averages, or when a practice has increasing access levels, and/or is delivering care to a high need population.[42]

50. Both Lindsay Davies[43] and Karl Bishop from ABMU acknowledged the lack of sector support for the UDA programme. However, Karl Bishop explained how health boards are developing more intelligence around their practices through the collection of data, which is resulting in earlier engagement with practitioners if they are underperforming and generating some flexibility. He told us:

> "So, for example, if we see practices in high-need areas that have taken on lots of new high-need patients and they're not hitting 95 per cent, we don't have any issues with that because it's within a context. So, as long as we're understanding and engaging with practices, we don't have a problem."[44]

51. He confirmed that in cases like this, the money would not be automatically clawed back, although he indicated that this is a decision for each individual health board.[45]

Reinvestment into dentistry services

52. The BDA Wales' written evidence reports that in terms of the reinvestment of clawback money, clawback and handback (which may occur if a dentist chooses to close their practice or if they retire for example) have resulted in millions of pounds that should be used for dentistry not being reinvested. It raises the point that in the last three years, £20 million has been taken out of NHS general

[41] RoP, 27 September 2018, paragraph 300
[42] Evidence paper
[43] RoP, 27 September 2018, paragraph 302
[44] RoP, 27 September 2018, paragraph 303
[45] RoP, 27 September 2018, paragraphs 305-307

dentistry in Wales due to clawback and contract reductions, but it believes only a small fraction of this has been reinvested into dental practice facilities by one or two health boards.[46]

53. The Minister for Health and Social Services notes in written evidence that the Welsh Government continues to ring-fence the dental budget for those health boards without approved Integrated Medium Term Plans. The paper states that the Welsh Government is aware that a number of health boards reinvest some of the clawback resources into dental services, but this is not universal. It indicates that the Welsh Government wants to see financially secure dental services that deliver greater value and which are supported and funded to deliver expectations safely. The paper notes that it is holding health boards to account for the investment it makes in dental services, and has required improvement plans where it feels health boards need to make further and faster progress.[47]

54. In oral evidence, Craige Wilson, CTUHB, provided reassurances that all money recovered by his health board had been reinvested back into dentistry services.[48]

55. The Welsh NHS Confederation's written evidence notes that health boards are using clawback money to invest in primary care dental services and making these services more accessible to vulnerable patient groups.[49] Vicki Jones, Clinical Director of the Community Dental Services and Consultant in Special Care Dentistry, Aneurin Bevan University Health Board (ABUHB), told us:

> "Just to say, from an Aneurin Bevan health board point of view, that clawback moneys have been used to put into place minor oral surgery services. We have a domiciliary service close to home, whereby the community dental service works very closely with the general dental services and, as part of that, we've looked at prevention. We have an oral health improvement practitioner who works with the general dental service practitioners and actually provides the preventative side of the contract for them.
>
> We've increased our prison dental services. We've actually increased our access to urgent care and, also, we've invested some moneys into trying to reduce lists in orthodontics and put in some non-recurring moneys as well. So, anything that has actually come back to the health board,

[46] Written evidence, D14

[47] Evidence paper

[48] RoP, 27 September 2018, paragraphs 311-313

[49] Written evidence, D19

> we've actually tried and looked at population need, looked at the reasonings behind the issues that the LDC are coming up with, and also the other people who are in the health board and actually targeted the funding towards those."[50]

56. However, Lindsay Davies, ABMU, could not provide such reassurance. She said:

> "We've been quite open in ABMU's return about the fact that, two years ago, for various reasons—some inherent in the contract, and others local—we had a significant underspend and we were not in a position to reinvest it at that time. It was £2.2 million. What we've had since then, because we realised that there was a bit of an inevitability about our continuing to underspend and, therefore, it would go to the bottom line, we came up with a three-year investment plan, based on the predictability of underperformance moneys likely to be coming through, and where we needed to reinvest. We came to an agreement within the health board, and then with Welsh Government colleagues, that we would invest additional moneys over a three-year basis until we could guarantee we could spend the whole ring-fenced moneys by a year and half's time.
>
> The particular circumstances that meant that we were unable to invest all the moneys were, no. 1, as we've already talked about, the vagaries of the contract, and, No. 2, for particular local reasons, to do with a perception that the LDC developed that we were not being open and transparent in the way we were re-awarding activity, the health board decided it would adopt a formal tendering process any time it was reinvesting moneys. And though that's marvellous in that it's definitely open and transparent, it takes an awful long time, and we found ourselves unable to reinvest in-year. But now that we have a three-year plan and we've engaged the staff required to ensure that we can keep up to speed, we have illustrated where we invested moneys last year, with £600,000 to £800,000 more this year and next year, and we'll reach the ring fence within two years."[51]

57. In written evidence, Hywel Dda University Health Board said that there are issues that impact on the ability to reinvest funding in a timely manner:

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[50] RoP, 27 September 2018, paragraphs 319-320

[51] RoP, 27 September 2018, paragraphs 314-315

> "Under performance is not normally quantified until the second half of any particular financial year. To reinvest the level of underperformance experienced in Hywel Dda in the years in question there would need to a tender process enacted, in accordance with the SFI and Dental Contract, which can take up to six months. In this sort of time frame it is challenging to re-invest the funding in year and comply with NHS Accounting rules that do not allow the roll forward of resource allocation into subsequent financial years.
>
> In order to mitigate against these occurrences in future, Hywel Dda University Health Board has developed a four year investment plan with the agreement of the Chief Dental Officer for Wales, to cover a period encompassing the years 2017/18 to 2020/21, which ensures that at the end of this period the Health Board will spend the entire ring fenced allocation on sustainable General Dental Services for its population."[52]

58. Andrew Powell-Chandler, Welsh Government, said:

> "I think what we want to see and what we've been holding health boards to account on is that the dental budgets for those health boards without an approved integrated medium-term plan are still ring-fenced. So, the option lies for Welsh Government that if they do not spend that ring-fenced budget, we can recover it. We would want to encourage them, in all instances, to use that money, whether it's what is originally allocated to practices or what may be recovered through underperformance, to be spent on dentistry."[53]

59. In response to a question on NHS dentistry in Wales during Plenary on 13 March 2019, the Minister for Health and Social Services stated:

> "I'm very clear about the way in which money that is allocated and earmarked for dental services should be used, and it should not be used to fill gaps in other budget lines when, actually, we recognise there is more for us to do to provide the quality of care and services that, as I say, each community in Wales deserves and expects."[54]

60. Dr Colette Bridgman said that as part of the contract reform, if the collection of evidence by practices to build a picture of contract performance demonstrates

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[52] Additional information from Hywel Dda University Health Board - 25 October 2018

[53] RoP, 27 September 2018, paragraph 525

[54] RoP, Plenary, 13 March 2019, paragraph 175

improved access and evidence of delivery for high needs patients, then "I think questions would be, 'Why on earth would you clawback if those conditions were present?' But we don't have that evidence yet".[55]

Our view

61. We welcome reassurance from some witnesses that any money recovered by local health boards is being reinvested into dentistry services, but we are concerned that this may not always be the case. We believe that dentistry services in Wales could be further improved through the reinvestment of this money.

Recommendation 2. We recommend that the Welsh Government ensures and monitors the consistent reinvestment of clawback money recovered by health boards back into dentistry services until a new system for monitoring outcomes is in place (as referred to in recommendation 1).

[55] RoP, 27 September 2018, paragraph 527

4. Training, recruitment and retention of dentists in Wales

Training

62. A number of the available career pathways including dental foundation training, dental core training, and specialist training, are now part of UK wide recruitment.[56]

63. The reasons why a UK wide recruitment approach was put in place were explained by Dr Richard Herbert, Associate Dean, Wales Deanery:

> "I think it's important to understand why that national recruitment process came about. It was an agreement between ourselves, England and Northern Ireland to go into a national recruitment process that was a cost-effective, transparent process that was fair to all the applicants. It is a process that very much follows the way the medics have gone with that, and it fills all our places in Wales."[57]

64. Karl Bishop, ABMU, indicated that this approach to recruitment is being used in Wales to help address some of the cross-border issues. However, he cautioned that this approach was not necessarily working. He said:

> "…the idea with that is that we attract people in from England to come into the area, good people, and they will stay. We're finding that they're not necessarily staying; they're coming down, they're doing a year and then moving back to where their roots are. So, national recruitment is almost counter-productive at the moment—that's the feeling we are getting in our health board, that individuals who are coming in under national recruitment are not staying after a year or so."[58]

65. The Welsh NHS Confederation states that 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.[59] However, it believes that overall, health boards are not facing serious challenges in recruiting

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[56] RoP, 27 September 2018, paragraph 328
[57] RoP, 27 September 2018, paragraph 448
[58] RoP, 27 September 2018, paragraph 328
[59] Written evidence, D19

and training dental staff when compared to other professionals within the primary care sector.[60]

66. Professor Alastair Sloan, Head of School, School of Dentistry, Cardiff University, told us that fees are the same across the sector in the UK for undergraduate courses. He indicated that Cardiff University "plays on its strength of being in a capital city the size of a large town. It's cheaper to live here than it is to live in Manchester and to live in London". He echoed that no dental school is struggling to recruit, but the numbers have reduced, possibly as a result of student fees more generally.[61]

67. He said that there are no issues with recruiting to the School of Dentistry in Cardiff, but there is a lack of Welsh students applying; the application rate from Welsh students over the last five years being between 11 per cent to 15 per cent.[62] However, he added that through the UK wide recruitment interview process, almost half of the applicants that were from Wales were being made an offer.[63]

68. He also told us that on taking up his post as head of school in 2017, he undertook a periodic review to look at the recruitment of Welsh-speaking and first language Welsh speakers to the school.[64] He outlined some of the steps already being taken to address this issue, including producing information bilingually and having a fully bilingual website, and echoed his earlier comments about working with partners to try and attract applicants.[65] He indicated that as a result of these actions the school had seen an increase of around 15 to 20 applicants.[66]

69. In written evidence, the Welsh Dental Committee noted that local students from lower socio economic back grounds may not have the same advantages as students in private schools and it may be sensible to offer some applicants alternative pathways into getting into dental school such as completing a "pre-year". They suggested that increasing the number of local applications may also increase the number of Welsh speakers.[67]

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[60] Written evidence, D19
[61] RoP, 27 September 2018, paragraph 403
[62] RoP, 27 September 2018, paragraph 378
[63] RoP, 27 September 2018, paragraph 379
[64] RoP, 27 September 2018, paragraph 425
[65] RoP, 27 September 2018, paragraph 433
[66] RoP, 27 September 2018, paragraph 437
[67] Written evidence, D03

70. The General Dental Council also considered that it would be helpful if there were initiatives to incentivise and attract suitable potential Welsh speaking undergraduates from parts of North and West Wales, where the Welsh language is used on a day-to-day basis in many parts, to train at Cardiff Dental School and then for graduates to receive further incentives to return to these areas to practice.[68] The North Wales Community Dental Service reported that it is encouraging that the Welsh Baccalaureate is now accepted as an A-level for entry to the Cardiff School.[69] While Morgannwg Local Dental Committee suggests that discussions around a new dental school in North Wales might be appropriate.[70]

71. We asked the Chief Dental Officer about the low numbers of Welsh-domiciled students studying dentistry in Wales. Dr Bridgman told us that discussions about this issue had taken place with Cardiff School of Dentistry, and that further conversations about why this is happening and what can be done would continue.[71] Andrew Powell-Chandler, Welsh Government, highlighted that for access reasons, students from North Wales prefer to attend dental schools in Manchester or Liverpool and this would need to be part of those considerations.[72]

72. Local health boards told us what they believed to be the main challenges facing training new dentists in Wales. Karl Bishop, ABMU, said that he believed there to be a generational issue at play, where young dentists do not want to own their own practice or have a mortgage. Instead, they are seeking flexibility, work-life balance, and are looking more broadly in the sense of their career over 30 to 40 years and what they want to do within that period.[73]

73. Reaching students in schools and similar environments and raising the profile of a career in dentistry was considered to be an issue by Professor Alastair Sloan, Cardiff University. He said that Cardiff University is working with the Welsh Dental Society to use practitioners and other students as ambassadors to go into schools to talk about dentistry as a career.[74] The Community Dental Service Directors Group also raised in its evidence that ways of investing in the education of Welsh students, wishing to study dentistry, should be explored.[75]

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[68] Written evidence, D10

[69] Written evidence, D22

[70] Written evidence, D13

[71] RoP, 27 September 2018, paragraph 542

[72] RoP, 27 September 2018, paragraph 543

[73] RoP, 27 September 2018, paragraphs 325-326

[74] RoP, 27 September 2018, paragraph 381

[75] Written evidence, 23

Recruitment and retention of dentists

74. Professor David Thomas, Director Postgraduate Dental Education, Wales Deanery, talked about the need to develop a new process for dental training. He told us that undergraduate and postgraduate training can no longer be viewed as separate entities and we should be thinking about a longitudinal approach, which would mean developing a new approach from the undergraduate perspective, having a hub-and-spoke system.[76]

75. Professor Alastair Sloan, Cardiff University, elaborated on this, saying:

> "…my vision would be a smaller hub,[ ] where you have specialist clinics, oral surgery, oral medicine, orthodontics, paediatrics, a phantom head clinical skills laboratory and an initial clinic for our very junior students to have clear supervision. But the opportunity to build on what is a key success for the school, which is our outreach, is there, and I would like to see more—managed carefully—creative spokes, working with colleagues in postgraduate where we have the establishment, and we can get foundation trainees, with undergraduates, with dental care professionals."[77]

76. Dr Richard Herbert, Wales Deanery, told us that the number of graduates from Cardiff University that remain in Wales to practice afterwards averages at about 30. The number of students who go on to do dental foundation training in Wales, and remain in Wales in their first year afterwards, is between 45 and 50 (a range of 38 to 60 in any given year, resulting in between 50 per cent and 65 per cent retention). However, he stated that the marked difference in the salary for dental core training in Wales compared to England was a real disincentive, with dental core trainees in Wales worse off by £4,000, in addition to the levels of student debt being accrued.[78]

77. Instances where individuals have taken up dental core training posts in Wales, only to reject the post upon realising the difference in salary compared to England were reported by Professor David Thomas, Wales Deanery. However, he added that this training is entirely voluntary, to move towards speciality training, and that eighty per cent of dental graduates go straight into general practice.[79] He indicated that, working with health boards and Welsh Government, thought

[76] RoP, 27 September 2018, paragraph 439

[77] RoP, 27 September 2018, paragraph 440

[78] RoP, 27 September 2018, paragraphs 450-453

[79] RoP, 27 September 2018, paragraphs 456-457

needs to be given to what is available for students following postgraduate training in Wales.[80]

78. Dr Colette Bridgman told us that the Welsh Government was currently working on an agreement in relation to UK wide recruitment and post qualification students embarking on a dental foundation training year, where consideration would be given to whether those students want to stay and work in Wales and what could be done to enable this.[81]

79. 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. Some dental specialities do not exist outside the Dental School in Cardiff.

80. In oral evidence, Vicki Jones, ABUHB, noted difficulties in recruiting to specialist posts, and suggested this is a result of a lack of specialists being trained in Wales.[82]

81. When asked, Professor David Thomas, Wales Deanery, suggested that Wales could look to successful initiatives being used elsewhere in the UK to help with issues of recruitment and retention, particularly in Scotland:

> "…there are golden hellos, there are incentives to move to areas of difficulty—the Highlands and Islands would be an example—different rates of pay for different places…I notice some deaneries are offering to pay people's specialty exam, their first attempt, and things like that that wouldn't cost a lot of money, but may just make the difference in getting people to work in places that are hard to fill."[83]

82. Concerns around a lack of succession planning in Wales and specific training for the specialist posts required were raised by Karl Bishop, ABMU. He told us that training programmes need to be service-driven going forward and that "we're not really good sometimes at thinking ahead four or five years to say, 'Actually, this is what we want from a service point of view'".[84]

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[80] RoP, 27 September 2018, paragraph 463

[81] RoP, 27 September 2018, paragraph 545

[82] RoP, 27 September 2018, paragraphs 335-336

[83] RoP, 27 September 2018, paragraph 465

[84] RoP, 27 September 2018, paragraph 329

83. Dr Richard Herbert, Wales Deanery, suggested that the skill mix needs to be considered. He said:

> "There are initiatives that we could think about, but, you know, we're talking about the skill mix— what we want from those people is we want to develop them as professionals. We want them to have the opportunity to enhance their skills, to deliver tier 2 level treatments that might previously have been carried out in a hospital. That can be delivered much more cost effectively in primary care and we need to promote those individuals to acquire the skills to do that. They will be the leaders of the future, and we need to help them become leaders, developed and trained to have the leadership skills, and then support them to have practices where they lead, or to have units that the health boards are providing where these individuals can be employed to lead."[85]

84. Professor David Thomas, Wales Deanery, added:

> "So from my perspective, we need to be setting up a scheme in HEIW where we do actually gain the relevant demographic data that we can use to plan services effectively."[86]

Our view

85. We are pleased to hear that there are no issues with recruiting into dental schools in Wales, although we are aware that these figures can be low for Welsh domiciled students.

86. We heard evidence about the difficulty in retaining dentists to work in Wales following their training period and we would encourage the Welsh Government to consider how this can be addressed.

Recommendation 3. We recommend that the Welsh Government undertakes an evaluation to determine if the UK wide recruitment system effectively supports a strategy to increase the recruitment of those who are Welsh domiciled and the levels of retention of students generally following training.

[85] RoP, 27 September 2018, paragraph 468

[86] RoP, 27 September 2018, paragraph 472

5. Provision of orthodontic services

87. Orthodontic treatment aims to improve the appearance, position and function of crooked or abnormally arranged teeth. NHS funded orthodontic treatment is usually only available to people who are under the age of 18, have an adequate level of oral health, and who meet certain criteria.

88. The Welsh Government's Together for Health: A National Oral Health Plan for Wales 2013-18 noted that the majority of orthodontic services in Wales are provided to children by dentists working in primary care. NHS Wales spends around £13 million on these services each year, corresponding to approximately 10 per cent of the primary care dental budget, and 40 per cent of the total spend on children's dentistry in primary care dental services.

Progress made to improve the efficiency of orthodontic services

89. During the Third Assembly (2007-2011), the Welsh Government set up a Task and Finish Group on Orthodontics to identify and discuss key issues around orthodontic provision in Wales, chaired by Professor Stephen Richmond. Following the group's initial report in September 2010, a joint orthodontic Managed Clinical Network (MCN) was established for South West Wales between Abertawe Bro Morgannwg University and Hywel Dda Health Boards. The network consists of representatives from orthodontic providers, health board management and Public Health Wales, and works on liaising with health boards to establish appropriate clinical pathways and improve management of referrals. The 2010 review has been updated by Professor Richmond in reviews published in February 2015 and December 2016.

90. In written evidence[87], the British Orthodontic Society (BOS) states that orthodontic MCNs have since been established in North Wales and 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, the BOS believes it is essential that they have full engagement from all the relevant stakeholders within the profession and the health board.

[87] Written evidence, D15

91. In oral evidence, Benjamin Lewis, Consultant Orthodontist, Wrexham Maelor and Glan Clwyd Hospitals, British Orthodontic Society, told us:

> "…the instigation of managed clinical networks and the strategic advisory forum in orthodontics has been instrumental in changing the landscape, from an orthodontic perspective. The vision of Welsh Government, the vision of the previous chief dental officer, Professor Thomas, and the current dental officer, Colette Bridgman—it's leading the way. And, in fact, Wales is way ahead of England with regard to orthodontic strategic advice. The establishment of the MCNs across the three areas of Wales actually makes the interconnection between the health boards and the providers much more linked, and I think it's crucial that all stakeholders are fully involved in that process."[88]

Waiting times

92. The review undertaken by Professor Stephen Richmond in December 2016 noted that the number of orthodontic service providers had decreased since 2012 across all but one health board in Wales. Problems accessing orthodontic treatment in some areas and long waiting lists are issues that have previously been raised with Members of the Committee.

93. Tom Bysouth, BDA Wales, explained that Hywel Dda University Health Board in particular is experiencing far greater issues with access to treatment than other health boards. He told us that the contract has been awarded by the health board to one practice, that at present has two orthodontists who cover a large geographical area.[89]

94. Benjamin Lewis, BOS, reflected on this and identified access to specialists and the challenges surrounding the number of orthodontic practices in Wales, their localities, and the accessibility of these as issues for the provision of equitable care across Wales.[90] He agreed that there needs to be some flexibility within each individual health board as each will have its own challenges, but emphasised the important role MCNs can play.[91]

95. According to the BOS, within Wales there are substantial waiting times for orthodontic assessments and treatments and the processes of managing referrals

[88] RoP, 27 September 2018, paragraph 155
[89] RoP, 27 September 2018, paragraph 47
[90] RoP, 27 September 2018, paragraph 159
[91] RoP, 27 September 2018, paragraph 161

varies between providers. Written evidence states that the current waiting times are a result of a discrepancy between need and demand for orthodontic treatment and commissioned orthodontic activity as well as issues with the recruitment and retention of appropriately trained clinicians.[92]

96. Previous reports have recommended a one off initiative to clear the treatment backlog. The BOS suggests that this would need to be carefully thought through with regards to the overall service provision and there may be greater merits in distributing any additional 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.[93]

97. Benjamin Lewis, BOS, said:

> "I think in an ideal world, you have a clean sheet of paper and you design a service that is fit for the population that you've got. The problem is that we have so many legacy issues and legacy waiting times. In Wales, we've got in excess of 25,000 patients waiting either for treatment or for assessment…"[94]

98. He outlined the need for an increase in activity to deal with long waiting lists and echoed how a one-off treatment waiting list initiative would not work in this setting, as treatment is typically undertaken over 18 months to a two year period:

> "You can't magically make orthodontists appear out of the system to deal with that backlog of patients and all the other infrastructure that goes along with it. I think you've got to have a much more cohesive plan about how you're going to get those waiting times down, and that means increasing activity."[95]

99. Benjamin Lewis told us how waiting lists are made up of both patients waiting to be assessed, and those who have been assessed and require orthodontic treatment. He detailed how as a result, some patients can wait 18 months to be told they are not suitable for treatment.[96]

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[92] Written evidence, D15

[93] Written evidence, D15

[94] RoP, 27 September 2018, paragraphs 166-168

[95] RoP, 27 September 2018, paragraph 170

[96] RoP, 27 September 2018, paragraph 229

100. Tom Bysouth, BDA Wales, suggested that when waiting lists get long it has an impact on dentists' behaviour. He told us:

> "…so they're, 'I need to refer this person in a couple years; I'll refer them now so that I know that they're going to—by the time we work through the waiting list—get seen at the appropriate time', which makes it worse. Whereas, if that waiting list were a manageable size, then that wouldn't happen and so you'd get a much more streamlined view and patients would follow through."[97]

101. Dr Colette Bridgman also acknowledged that a number of health boards do have legacy issues with the numbers of children waiting for orthodontic treatment, and that many primary care dental practitioners aware of those waits will perhaps refer too soon, which inevitably adds to the problem.[98]

102. Benjamin Lewis, BOS, suggested that the solution to the long waiting times for orthodontic services was to ensure that the amount of funding available is used in the best possible way.[99]

103. This was echoed by the Chief Dental Officer, who agreed that "some of that legacy wait needs investment and I know that the health boards, where that's a particular issue, have plans to do exactly that".[100]

104. An Electronic Referral Management System (eRMS) for all dental referrals has been commissioned following an open tendering process by the Welsh Government. In a Written Statement by the Minister for Health and Social Services on 21 March 2019, it was confirmed that the dental e-referral management system has been successfully implemented in Hywel Dda and Abertawe Bro Morgannwg University Health Boards, and is to follow in the remaining five health boards by June 2019.

105. Benjamin Lewis, BOS, suggested that the introduction of the new system is expected to make improvements to patient triage; referrals to the right care provider including preventing duplicate referrals; and data collection. Although he noted that the system will not address issues of capacity (as patients who are referred to multiple practices do not attend multiple appointments).[101] He cautioned that any gains made to waiting times by the introduction of the eRMS

[97] RoP, 27 September 2018, paragraph 44

[98] RoP, 27 September 2018, paragraph 567

[99] RoP, 27 September 2018, paragraphs 239-240

[100] RoP, 27 September 2018, paragraph 569

[101] RoP, 27 September 2018, paragraph 244

would not be seen for many years.[102] He also indicated that the new referral system is expected to help prioritise patients depending on clinical need, as many patients are "not going to come to any harm if they wait, so they're going to have to wait". However, he highlighted the psychological impact this can have on patients, especially during formative years.[103]

106. In written evidence, an individual told us:

> "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."[104]

107. Tom Bysouth, BDA Wales, agreed that the electronic referral system will bring some benefits. He told us that it will improve monitoring, allowing both dentists and patients to see where a referral is in the system, which will reduce the time spent dealing with related queries. However, he added:

> "Simply just moving to a system where, instead of posting a referral off, we do it online, that itself won't suddenly take three years off the waiting list. It will help in terms of transparency of the system and seeing where things are—helping dentists, helping patients. However, I'm not sure that without, again, further investment in the orthodontic service and reforming how the contract awarded, that will provide the necessary reduction in wait time."[105]

108. Dr Colette Bridgman said of the local health boards:

> "I think the electronic referral will give them timely evidence and information…if the waiting lists are just in the practice and providers, it's hard for a health board to plan the services around that until they fully understand and validate who and what is on those lists."[106]

[102] RoP, 27 September 2018, paragraph 242
[103] RoP, 27 September 2018, paragraph 248
[104] Written evidence, D01
[105] RoP, 27 September 2018, paragraph 53
[106] RoP, 27 September 2018, paragraph 576

109. In written evidence, the North Wales Orthodontic Managed Clinical Network highlights that it is essential that the local IT infrastructure is sufficient to support the operation of the electronic management system.[107]

Training, recruitment and retention of the orthodontic workforce

110. Benjamin Lewis, BOS, outlined in oral evidence the lengthy training pathway options available for orthodontists and the need to demonstrate a broad range of experience in a very competitive area.[108]

111. In written evidence, the BOS indicates that 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 UK wide 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 led to increased challenges in recruitment of specialists in Wales following completion of their training. Discussions have been held about the benefits of undertaking a regional recruitment process outside UK wide recruitment.[109]

112. Benjamin Lewis, BOS, suggested that usually "people settle where they've put down roots"[110] saying that the long training pathways lead to trainees staying near to where they have trained and not returning to work in Wales. He added that north Wales has been successful in offering bursaries to encourage dental trainees to return to the area to undertake vocational training. However, the training places have to be available for this to work.[111]

113. In written evidence, the BOS notes that upcoming retirements are going to compound problems, leading to disruptions to service delivery, and an exacerbation of the excessive waiting times.[112] The South East Wales Local Orthodontic Committee and South East Wales Orthodontic Managed Clinical Network report similar concerns as there will be at least two consultant retirements in South East Wales in the next two years. Adding that "national

[107] Written evidence, D18

[108] RoP, 27 September 2018, paragraphs 176-186

[109] Written evidence, D15

[110] RoP, 27 September 2018, paragraph 200

[111] RoP, 27 September 2018, paragraph 201

[112] Written evidence, D15

recruitment in orthodontics has led to the appointment of excellent trainees but not necessarily those with a commitment to a future in Wales".[113]

114. Another potential barrier for trainees to accept orthodontic training posts within Wales is the differential pay scales 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.[114] This can lead to an income differential of £23,000 per annum between a trainee in England and Wales. Benjamin Lewis, BOS, confirmed that course fees are set by the universities.[115] He added that trainees are having to be more financially aware when considering potential training pathways.[116] This was also highlighted as an issue by the Welsh Consultant Orthodontic Group.[117]

115. Professor Alastair Sloan, Cardiff University, confirmed in oral evidence that course fees for orthodontic postgraduate qualifications at Cardiff University would no longer feature as one of the highest in England and Wales "from this year onwards".[118]

116. In further correspondence, Professor Sloan stated that discussions are still taking place regarding fee setting for postgraduate programmes. He believes the University's current fees are competitive and is line with other universities. He highlighted the different funding models between England and Wales including the methods of covering costs and the fact that courses in Wales are fully consultant led.[119]

117. Benjamin Lewis, BOS, spoke of an example in North Wales where a candidate had trained in Wales and had become a specialty doctor at Bangor as part of a succession plan. However, "the logistics of actually getting through the recruitment process in the difficult financial climate that we had meant that she went to Ireland and worked in Waterford. And you just think, after all that effort that has gone into getting someone who was a perfect candidate for that job, succession planning, all those sorts of things, it just went to nothing—extremely disappointing".[120]

[113] Written evidence, D11
[114] RoP, 27 September 2018, paragraph 221
[115] RoP, 27 September 2018, paragraph 223
[116] RoP, 27 September 2018, paragraph 225
[117] Written evidence, D20
[118] RoP, 27 September 2018, paragraphs 409-411
[119] Evidence paper
[120] RoP, 27 September 2018, paragraph 226

Our view

118. We are pleased that front line staff within the sector believe that the Welsh Government is putting the correct strategies in place, with the establishment of Managed Clinical Networks.

119. We recognise that primarily waiting times are as a result of recruitment issues, resulting in patients having to wait longer for treatment, but we are concerned about the method of referring and prioritising patients.

120. We note the introduction of the eRMS and recognise that while the system may not increase capacity, we would expect it to have a positive impact on ensuring appropriate referrals, prioritising patients and reducing waiting times. This is to be welcomed, particularly given the psychological impact on patients, especially children and young people during formative years.

Recommendation 4. We recommend that the Welsh Government works with health boards to develop a clear strategy to ensure that the e-referral system for orthodontic services in Wales has a positive impact on ensuring appropriate referrals, prioritising patients and reducing waiting times.

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

Designed to Smile

121. Designed to Smile (D2S) is the Welsh Government's national oral health improvement programme to improve the dental health of children in Wales, which was introduced in 2009 and is mainly school based.

122. Written evidence from the Welsh NHS Confederation notes that health boards across Wales are supportive of D2S. According to the Welsh Oral Health Information Unit, 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 per cent to 29.6 per cent. In some health boards, the reduction has been even more significant, down from 47 per cent to 28.9 per cent in Abertawe Bro Morgannwg University Health Board, for example.[121]

123. The D2S programme mainly targets schools in the most deprived areas, (e.g. schools within the former Communities First areas) but some health boards have funded designated Primary Care Teams to attend primary schools that fall outside these areas by working with Healthy School programme co-ordinators and local authorities.[122]

124. Despite the success of D2S and local initiatives, the Welsh NHS Confederation highlights that inequalities in children's oral health persist. Public Health Wales say that 42.2 per cent of five-year olds in the most deprived areas have tooth decay, compared to just 22.3 per cent of five-year olds in the least deprived areas. Those from the most deprived areas are further disadvantaged due to their poorer access to dental services. To address these inequalities, the Welsh NHS Confederation suggests it is important that professionals work collaboratively and recognise the benefits of a multi-disciplinary approach to oral health improvement.[123]

[121] Written evidence, D19

[122] Written evidence, D19

[123] Written evidence, D19

125. In July 2017, the Welsh Government outlined in a Written Statement that there would be a re-focus of the D2S programme on the 0-5 age group, and that this would mean shifting activity from older children.

126. As stated in a Welsh Health Circular (WHC) in June 2017[124], a comparison of data from the first dental epidemiological survey of 3 year olds in Wales (2013-14) undertaken by Cardiff University in 2015 with data from recent dental epidemiological surveys of 5 year old children in Wales has highlighted that in some areas, much of the dental caries present at age 5 has already developed by age 3. It suggests that these results show a need for a greater focus on the very youngest children. As a result, the WHC directs that for the elements of D2S delivered in schools, D2S resources (for treatment such as fissure sealing) will not be used beyond school year 2 (children aged 6 and over). It suggests that 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.

127. Morgannwg Local Dental Committee says that while the scheme has enjoyed successes such as a tooth decay prevalence falling by 12% among five-year olds, the recent D2S refocus to include children 0 to 3 years old 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.[125] The Royal College of Surgeons of Edinburgh notes that dental decay requiring multiple extractions is still the number one reason why 5-9 year olds are being admitted to hospital.[126]

128. In written evidence, the BDA Wales outlines how the refocus now excludes children from fluoride varnish treatment just as their permanent teeth arrive and offers over 5's only tooth brushing, with these children expected to receive fluoride varnish under the GDS instead. As there is very low access to dentists for new child patients in many parts of Wales, the BDA Wales notes that the number of children treated in future is likely to go down not up. The BDA has previously called for additional funding of approximately £2m per annum to maintain children over 5 years old's inclusion and suggests that one third of the GDS clawback would cover this.[127]

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[124] Welsh Health Circular (WHC) (2017) Number 23: Re-focussing of the Designed to Smile child oral health improvement programme (June 2017)

[125] Written evidence, D13

[126] Written evidence, D17

[127] Written evidence, D14

129. When asked about using clawback funds to support the preventative agenda, Craige Wilson, CTUHB, told us:

> "I certainly can assure you that, in Cwm Taf, that's exactly what we've done, because we employed our own oral health educators and we've trained them in fluoride varnishing. Therefore, those schools not covered now by Designed to Smile are now being covered by our own oral health educators, who are applying fluoride to children in those non-Designed to Smile schools."[128]

130. The Faculty of Dental Surgery at the Royal College of Surgeons views the impact that D2S 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 the programme's work with children aged 6 and over to be maintained. Noting the commitment in the framework document that those schools that want to continue daily tooth brushing for this group will be supported to do so through health boards' oral health strategies, the written evidence urges health boards to ensure that sufficient funding is available to enable this.[129]

131. Vicki Jones, ABUHB, suggested that health boards are having to be creative in the way that they are starting to look at those children who are not accessing dental care:

> "For example, in Aneurin Bevan Local Health Board, we have dental therapists who used to do the fissure sealing programme who are now working with Flying Start health visitors, going into the health visitor hubs, using mobile dental units, using those dental therapists who have actually got those skills to be able to do check-ups, but also to apply fluoride varnish to try and target those very difficult-to-reach children, and therefore working as well with local—. We have, in Aneurin Bevan, seven access dental practices, whereby we're then referring those children on to those practices so that they're seen."[130]

132. In written evidence, Public Health Wales states that 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. It reports that there is some evidence that practices with dental therapists provide a more preventive-focused approach to oral health-care

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[128] RoP, 27 September 2018, paragraph 317

[129] Written evidence, D12

[130] RoP, 27 September 2018, paragraph 362

delivery, with dentists left to complete more complex work, and that patients are equally happy after seeing a dentist or dental therapist.[131]

133. The Royal College of Paediatrics and Child Health report 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 and state that all children should therefore have timely access to dental services.[132]

134. Vicki Jones, ABUHB, also agreed that the aim should be universal access to dental care for all children and restated how a more integrated working approach is being undertaken, as is strongly advised in the Welsh Health Circular. She said:

> "We've basically made sure that our primary care team, our Designed to Smile and CDS teams, work like that, and if they find, as they sometimes do, that a dentist is not accepting children, they're on the phone straight away and we sort that out."[133]

135. She added that the D2S e-learning programme also acts as a link for general dental practices to help fully understand the concept of the initiative and prevention agenda.[134]

136. In relation to funding for fissure sealing specifically, Lindsay Davies, ABMU, told us "there's actually provision in the circular that has changed the direction of Designed to Smile to pass resources across to general dentists to facilitate them being able to do that".[135]

137. Dr Collette Bridgman reflected on the D2S programme stating that Wales should be proud of the excellent population oral health programme that D2S is. However, she also had to consider the effectiveness of the different aspects of the programme. She said:

> "There was a research paper[136] published by Professor Ivor Chestnutt, from Cardiff University, which demonstrated that the fissure sealant as a preventative intervention was as effective as fluoride varnish

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[131] Written evidence, D05

[132] Written evidence, D08

[133] RoP, 27 September 2018, paragraphs 364-365

[134] RoP, 27 September 2018, paragraph 366

[135] RoP, 27 September 2018, paragraph 367

[136] Seal or Varnish? A randomised controlled trial to determine the relative cost and effectiveness of pit and fissure sealant and fluoride varnish in preventing dental decay – April 2017

> application, but one costs very much more. So, one of the things that we did was to look at the Designed to Smile programme and say, 'This needs to go from good to great'. We had a specialist from Public Health Wales join on the strategic leadership of that and we also are aware that our poorest access is in the nought to fives and that some of the disease that is present at five is beginning at an earlier stage. So, we need to start the brushing and to start primary care access much younger. The Designed to Smile teams—. We really wanted to make it—. It's everybody's business, oral health. We really need health visitors, general dental practice teams, to understand that getting fluoride on the teeth through a daily brushing habit is what we're trying to achieve. And by removing some of what we saw was less effective—fissure sealant delivery at a later stage—we were able to use that resource more effectively and expand the number of children actually receiving the benefits of Designed to Smile."[137]

138. It is worth noting that in written evidence, Age Cymru, welcomed the intention to 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, specifically older people.[138]

Local initiatives

139. The Welsh NHS Confederation in its written evidence indicates that health boards are also working at a local level to improve dental health among children in Wales.[139]

140. Craige Wilson, CTUHB, detailed a programme in his health board area:

> "So, last year, we started off an initiative called Baby Teeth Do Matter, and we started that off initially in Merthyr Tydfil where we've aligned general practice with dental practitioners so that either the dental practitioner or a dental therapist actually goes into the baby clinics…and are part of the team there. And we're encouraging mothers that as soon as the first tooth appears, actually, they need to go to the dentist.

[137] RoP, 27 September 2018, paragraph 579

[138] Written evidence, D04

[139] Written evidence, D19

> We've run that pilot now for just over a year and as well as the concerted effort in Merthyr Tydfil, we've also advertised more widely within Cwm Taf. Consequently, in Merthyr Tydfil, we've seen nearly a 40 per cent increase in the number of under-twos who've attended, and we've also seen significant increases across Cwm Taf. There's been a ripple effect and we've got 1,500 more children who are now attending the dentist than the reference period in the previous two years."[140]

141. He added that access to this programme was not an issue as in the Cwm Taf area over 50 per cent of practices were in a position to take on new patients, and that the next stage would be to expand the service with another nine practices across Cwm Taf that are interested in adopting this initiative.[141]

142. Vicki Jones, ABUHB, outlined a programme called, Lift the Lip, which has just been piloted:

> "I know that it was in Swansea and in north Wales. It comes from Australia and New Zealand, where you have healthcare professionals asking parents to lift the lip so that they are able to see whether or not these very young children have already got decay in their teeth. It's been very successful."[142]

Data availability in relation to children

143. Written evidence from the BDA Wales references the difficulty in accessing relevant data regarding dentistry in Wales and that some data is not available. It believes that the Welsh Government and health boards have a crucial role to play in ensuring this evidence is comprehensively gathered, fully analysed and made publicly available.[143]

144. Cardiff University's School of Dentistry states that a key strength in Wales is seen to be the work with the Oral Health Information Unit based in the School. This unit is seen by the School as vital to the Welsh Government as it provides data and trends regarding oral health (including children) in Wales. It is also vital to the School of Dentistry as it undertakes "real-time" research providing data which influences policy. The School of Dentistry goes on to say that teaching in Dental Public Health is delivered to the students and this places the students in a

[140] RoP, 27 September 2018, paragraphs 350-351

[141] RoP, 27 September 2018, paragraphs 355-356

[142] RoP, 27 September 2018, paragraph 369

[143] Written evidence, D14

unique position compared to their peers in other schools as they are able to see how this research delivers for a community.[144]

145. Professor Alastair Sloan, Cardiff University said of the unit:

> "What it's done, I think, is give us data that puts Wales in quite a unique and strong position, because I think, compared to England, we have a good handle on the oral health of the nation as it stands at the moment, and where interventions may be needed. It certainly is critical to driving success in research applications in large-scale clinical trials such as the sealant varnish, which is one of our more successful ones, and also the Designed to Smile trial that we've had."[145]

146. Professor David Thomas, Wales Deanery, added:

> "From my perspective, it's provided the evidence for the effectiveness of Designed to Smile. It's shown that the number of general anaesthetics in Wales has reduced substantially in the last five or six years. So, I think it's, essentially, of absolute importance that we retain something like that…"[146]

147. However, Christie Owen, Policy and Committee Officer, BDA Wales, reports that there is little data available for private dentistry, and as a result, "when we're looking at Wales, it's very hard to see a big picture of where people can access dentistry, how they're accessing dentistry, when there's a large part of dentistry that we can't see".[147] Tom Bysouth, BDA Wales, added that there is no obligation for private practices to collect this data.[148]

148. The Chief Dental Officer told us:

> "So, one of the things is that we know the numbers of children, by age group, who attend general dental practices through NHS contracts in any given two-year period, and it's quite high—it's about 66 per cent. What we don't know is the numbers who are attending community dental services, and those are our specialist services that would be open to children perhaps who've got additional needs, perhaps

144 Written evidence, D21

145 RoP, 27 September 2018, paragraph 484

146 RoP, 27 September 2018, paragraph 486

147 RoP, 27 September 2018, paragraph 139

148 RoP, 27 September 2018, paragraph 141

> medical needs or who perhaps don't have routine attendance patterns in their family."[149]

149. Dr Bridgman added that the D2S programme has started to link this work beyond the community dental services and integrate it with health visitors. She explained how health visitors involved in local initiatives such as Lift the Lip are now collecting data as part of their routine visits, and this is helping to build "a fairly accurate picture beyond who's not attending and why, and then what we need to do about that".[150]

Older children and young teenagers

150. The Faculty of Dental Surgery at the Royal College of Surgeons notes concerns that there may be particular "pockets" of severity amongst older children, with late teenagers being one example. It suggests that consideration should be given to whether a refocused D2S 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.[151]

151. The BDA Wales also suggests that there is evidence showing that many older children and young teenagers in Wales still have poor oral health. It states that of those BDA members who took part in a survey it carried out, 90 per cent said they would like to see new oral health programmes for older primary school children.[152]

152. In oral evidence, Karl Bishop, ABMU, noted:

> "We're also seeing, when we talk about children, that the late adolescents are becoming a vulnerable group with high needs because they're going outside parental control, et cetera."[153]

153. The Minister for Health and Social Services notes that there is evidence that some young people (those in the 14 years old plus groups) who did not experience the benefits of D2S and who are from regions of material deprivation are experiencing the impact of dental disease severely. Many are losing permanent

[149] RoP, 27 September 2018, paragraph 529
[150] RoP, 27 September 2018, paragraph 530
[151] Written evidence, D12
[152] Written evidence, D14
[153] RoP, 27 September 2018, paragraph 370

teeth and some are even experiencing a clearance of all their natural teeth which is not uncommon.[154]

154. Dr Colette Bridgman confirmed that three years ago it was found that nearly 60 per cent of 15 year olds in Wales had active decay.[155]

155. The Welsh Government has commissioned an epidemiological survey of 18-25 year olds to understand the particular needs of young people and support any service redesign and population public health action, as it states this is such an important group of the population to be oral health literate and economically active.[156]

156. Dr Colette Bridgman said:

> "…we're doing an epidemiological survey to understand the problem, and I think that's where our primary dental care teams come in—by stepping up prevention, increasing access. And, I think, sometimes, when I hear some of the experiences—and I went up to Tredegar to meet some of these teenagers, some of whom are losing their permanent teeth in large numbers. It's quite a surprise that that even happens when it's a preventable disease. And I think that goes right back to why we want to open up access for all groups, particularly those in high needs groups in Wales, and to support practices that may need to take a teenager with that level of disease through quite a long process of change in a given year to try and turn around and maintain and get on top of that disease process. So, it is a group that we're looking at."[157]

Our view

157. We recognise the positive impact D2S has had in Wales to date, and welcome the extension of the programme to include very young children. However, we believe there is a strong case to ensure that the over 5s do not lose out on some treatments as a result of the refocus of the programme. It is a concern that at a critical age when a child's permanent teeth erupt, there may be no application of fluoride varnish to protect them, unless it is received through the GDS. We are mindful that the children who are in most need of intervention can

[154] Evidence paper

[155] RoP, 27 September 2018, paragraph 586

[156] Evidence paper

[157] RoP, 27 September 2018, paragraph 586

be less likely to visit a high street dentist, and may face problems in accessing an NHS dentist to begin with. It is unacceptable that any child should be without regular access to dental treatment and we should be aiming for nothing short of universal access.

158. It is also disappointing to hear of the oral health issues in older children and young teenagers that can sometimes lead to the loss of permanent teeth. We would like to see an oral health programme put in place to address these problems in this age group.

159. We welcome the work being undertaken by individual health boards to develop local initiatives and would encourage this to continue across each area.

Recommendation 5. We recommend that the Welsh Government funds the Designed to Smile programme sufficiently to enable children over 5 years old to receive the same benefits of inclusion as they did prior to the refocus of the programme.

Recommendation 6. We recommend that the Welsh Government builds upon existing oral health improvement programmes to address and improve the oral health of older children and young teenagers in Wales.