Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Deintyddiaeth

This response was submitted to the Health and Social Care Committee consultation on Dentistry

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Ymateb gan: | Response from: Conffederasiwn GIG Cymru | Welsh NHS Confederation

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Welsh NHS Confederation
Conffederasiwn GIG Cymru

	The Welsh NHS Confederation response to the Health and Social Care Committee's consultation on dentistry
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Introduction

1. The Welsh NHS Confederation (WNHSC) welcomes the opportunity to respond to the Health and Social Care Committee's consultation on dentistry.

2. The WNHSC represents the seven Local Health Boards, three NHS Trusts, Digital Health and Care Wales and Health Education and Improvement Wales (our Members). We also host NHS Wales Employers.

3. Dental services have been severely impacted by the COVID-19 pandemic due to the proportion of dental treatments which involve aerosol generating procedures. Strict infection, prevention and control measures were required to reduce the risk of COVID transmission.

4. In the short term, dental services will require focus to address the backlog. However, the sustainability of dental services also needs to be considered and the role that dental services, and other services, should play in tackling poor oral health.

5. As a range of research has highlighted, the COVID-19 pandemic has negatively affected socio-economic and ethnic inequalities, which will have a knock-on effect on oral health inequalities. More action needs to be taken in the prevention space if the burden of disease is to be reduced within the population and ultimately reduce the need for urgent or complex treatments.

The extent to which access to NHS dentistry continues to be limited and how best to catch up with the backlog

6. The COVID-19 pandemic has had a damaging effect on dentistry services across Wales, with infection, prevention and control (IPC) measures limiting the number of patients which could be seen. As the de-escalation process has begun, services are beginning to slowly resume a full range of treatments. However, services face a growing backlog, with increases in patients who have complex needs and require urgent care.

7. Workforce is a significant barrier to addressing these issues, with no simple solution presenting itself due to the numbers being trained and the number leaving or retiring from the profession. Our members raised the importance of a greater use of the workforce skill mix, in particular dental therapists. Consideration needs to be given to allowing dental therapists to open treatment plans for patients who have low/medium

dental needs. There also needs to be a mechanism in place to reduce the risk adverse culture of some dental professionals as this is undermining the role of the generalist and ultimately leads to an increase in the number of inappropriate referrals.

8. There is also a need to understand general dental services (GDS), community dental services (CDS) and hospital dental services (HDS) as an integrated system, with current delays across all three resulting in additional urgent dental cases. Additional capacity will be needed within primary care to ensure dental services can also work across other local health and care services. Innovative digital solutions should also be considered and supported.

9. Contract reform is understood to be a positive move towards a learning oral healthcare system, which educates the population on the importance of prevention. The two main dental diseases, tooth decay and gum disease, are largely preventable and ultimately reducing the burden of disease will facilitate access to dental services and be more cost-effective.

10. The shifting of resources for general dental services through contract reform is important to ensure those with the most needs are seen in preference to those with the least risk of dental disease. However, there are also concerns that patients affiliated to NHS dentists are not able to access routine care, with reports that check-up appointments are being cancelled or postponed. This is in line with Welsh Government guidance to prioritise higher-need patients but makes a preventative approach difficult to attain as delayed check-ups could result in deteriorating oral health for those waiting in the longer term.

11. In light of these challenges, there is a need to develop a sustainable plan which grows capacity and mitigates the risk of the situation getting worse as the population ages. Without such an approach, there is a risk the issues will continue to grow.

Improved oral health intelligence

12. Unmet population need is difficult to determine as only patients accessing dental services can be reported on and data collected. A number of people do not access services regularly, and some choose to only access care in an emergency when in pain or seek private treatment.

13. During the pandemic all dental practices in Wales were required to collect Assessment of Clinical Oral Risks and Need (ACORN) data. Practices on the contract reform programme are now obliged to complete an Acorn Toolkit assessment with each patient once a year, which should provide a needs profile for each practice over time. However, some of our members noted that the information provided via the ACORN is sometimes not reflective of the treatment provided to patients.

14. Dental practices are subject to strict IPC guidance, which is monitored in various ways including Health Inspectorate Wales (HIW) inspections considering the environmental element. Due to these factors, our members were clear that the public need to be assured that practices are safe environments.

15. As part of any public communication, it will be important to highlight messages around prevention and what measures people can take to improve their oral health and what online support is available to help people avoid using dental services in the first instance.

Incentives to recruit and retain NHS dentists

16. Workforce is a primary factor in addressing the issues within dentistry and our members noted a number of issues which are currently affecting recruitment/retention including, burnout, lack of access to NHS pensions and development and training opportunities. Investment in the workforce will be vital in ensuring oral health and dental transformation, with a needs-based and flexible approach to workforce planning.

17. A dental workforce situational analysis could help address the issues of educating, training, recruiting, distributing, retaining, motivating and managing the overall oral health and dental care workforce in Wales. This also includes improving the knowledge about the impact of the UK leaving the EU, the pandemic, ongoing changes in NHS dentistry and career aspirations of current and future workforce.

18. It was suggested by our members that a clear understanding of dental career pathways and how these can be tailored to suit colleagues at different points in their careers would also be helpful in attracting and retaining dental professionals. It will also be important to have a discussion with the younger cohort of dental professionals to better understand their ambitions and preferred means of working to better understand how to make dentistry an attractive career option.

19. Our members highlighted the 'Modified Monash Model', where communities are graded by need, with higher pay incentives for certain higher need areas. Financial support could also be effective in supporting relocation as well as exposing more dental undergraduates to rural areas through placements.

20. It was also suggested that the future of dental contract reform needs to be clearly mapped out to ensure it supports the delivery of care for high needs areas. Transport links for those dentists working in rural areas also needs consideration, as feelings of isolation impacts negatively on young professionals.

21. Recruitment campaigns are needed to increase interest for Welsh domiciled students to remain and work in Wales. Our members also suggested that more dental student placements, scholarships and shadowing opportunities are needed. Financial incentives should be offered which aim to attract new staff, but this needs to be balanced with opportunities for career development to ensure retention.

Oral health inequalities

22. Prevention and early intervention will be key if the dental services are to be made sustainable in the long-term and address inequalities in oral health, which are borne by those living in the most deprived areas of Wales.

23. In July 2022, 50 organisations working across health and social care endorsed the recent Welsh NHS Confederation Health and Wellbeing Alliance, in partnership with the Royal College of Physicians, paper Mind the gap: What's stopping change?. The paper called for a cross-government approach to tackling health inequalities by consolidating commitments on inequality in one delivery plan, making it clear that the levers of change do not reside entirely within the health service and the key role that other sectors, including education, play. Whilst initiatives such as Designed to Smile (D2S) and Gwen am Byth (GAB) are hugely important in addressing issues amongst certain groups of vulnerable people, they must form part of wider action on inequality.

24. Members were clear on the importance of restarting the D2S programme to pre-pandemic levels, as experiencing tooth decay at a young age has damaging effects both in relation to the pain experienced and can worsen existing inequalities. As with other areas of dentistry, there are issues around recruitment into the programme and consideration should be given to the future D2S model that can be most effectively delivered within the resources and workforce available. Members also supported the programmes expansion to 6–10-year-olds.

25. Children can often be lost in the dental services system until they require urgent treatment, with our members suggesting a targeted approach to ensure secondary school children, at high risk for poor oral health, are linked to good mouthcare and healthy eating messages.

26. There was also support to expand the GAB to include care homes for younger vulnerable people with learning disabilities, autistic spectrum disorders, brain injuries, severe physical disabilities and enduring severe mental illness. Poor oral health can negatively impact on residents in care homes and the full GAB programme works to ensure that care homes are supported in delivering and addressing their oral health needs. Maintaining this public health initiative is fundamental to improving the quality of care received and residents' quality of life.

27. Dental domiciliary care is also an area that is likely to require further investment, with more joined-up thinking in service planning needed for the older population across primary, community and social care. Capital funding is also required for modern mobile dental units which are imperative in keeping vulnerable people in good health, enabling people living in rural areas or people living in more deprived areas of Wales to access dental services.

28. Our members have voiced concerns over a two-tier system emerging, with patients feeling they have to pay privately for treatment due to current long waiting times following the pandemic. A third tier may surface whereby some patients will only ever be able to access urgent NHS dental care, some will have regular access to an NHS dentist, and some will choose to have private dental care.

The scope for further expansion of the Community Dental Service (CDS)

29. The strengthening of CDS should be prioritised, so it is able to address the oral health needs of vulnerable groups in society. This should form part of a commitment to a long-term vision of radical transformation in the oral health system, which is required to scale up prevention inside and outside dental clinical settings.

30. Members were clear that CDS resources must be focused on the backlog as a result of the pandemic and the care of vulnerable people, with insufficient access to GDS impacting on CDS due to increased referrals and reduced ability to discharge patients back to the GDS.

31. CDS has also had difficulty in recruiting and retaining specialists and it is important to ensure inequalities do not widen due to lack of capacity. Information systems will need to improve to understand the service need, demand and current provision for different vulnerable groups, including the workforce required to provide preventative and dental care.

32. There is an opportunity to look at a wider salaried dental model when considering the expansion of the CDS. To develop this further there will be a requirement to invest in the workforce to develop wider skills, training and development opportunities and consider an integrated care model.

33. There is also scope to consider CDS' role within primary care clusters and supporting wider dental services. Work is ongoing with the national programme around how dentistry and the dental collaboratives can play a part in addressing wider health and wellbeing issues as part of the primary care Accelerated Cluster Development programme. This is an area which requires continued attention to understand its full potential.

Welsh Government spend on NHS dentistry in Wales, including investment in ventilation and future-proofing practices

34. NHS dentistry spend has been based on the historical delivery of care to patients and the funding model is based on 50% of the population accessing dental care through GDS. As it is not based on the oral health needs of the population, modelling is required on service need and access levels to establish whether the current funding is sufficient. Any increase in spend could be directed towards models which can respond to how the public wish to access services.

35. Our members also highlighted the need for more capital investment and grant opportunities, suggesting the expansion of dentistry practices or the purchase of new builds could be supported through an 'Improvement Grant' scheme. If non-recurrent funding has become available, our members have found it difficult to ensure meaningful improvements as it is time limited and sometimes delivered at short notice.

36. National guidance for funding and delivering ventilation compliance within the constrained capital resources available would be welcomed. Members also suggested a national group to review options, give direction and provide expertise to design and procure premises, equipment and ventilation would also be useful.

37. Consideration could be given as to whether delivery of NHS dentistry should be provided from numerous high street practices going forward, or whether centres of excellence provide better coverage and economies of scale for limited resources. However, provision on this level would require a long lead in time to be established and implemented.

The impact of the cost-of-living crisis on the provision of and access to dentistry services in Wales.

38. Increasingly more people are unable to meet their basic living needs due to the cost-of-living crisis. Families are having to make difficult choices as to whether to spend money on mouthcare products, which will lead to worsening oral health and widening inequalities if they are unable to. In addition, calorie dense affordable food often contains sugar and until healthy alternatives are as inexpensive then this will also impact on oral health. Transport to appointments can also act as a barrier to dental care due to fuel poverty and reduction in affordable public transport and taxis.

39. There will be a lack of preventative dental care if increasing costs lead people at higher risk of dental disease to avoid attending appointments due to the costs involved. This could result in increased use of urgent and out of hours dental services and emergency hospital dental services. Vulnerable patients will especially be at a greater disadvantage.

40. With the increase in the cost-of-living, many people could choose to discontinue their private dental subscriptions, and this has the potential to add further pressure into NHS dental services. The consequence of this would be rising waiting lists and there could be an increase in the use of emergency and urgent dental services.

41. There is also an impact on staff, with practices and health boards finding it difficult to cope with staff costs. Therefore, it is imperative that the workforce is prioritised, and more people are recruited and retained within the profession.

42. Our members suggested that healthcare workers, food banks and organisations working with families in deprived areas should be provided with mouthcare products to offer to those who are struggling as a result of the increase in cost-of-living.

43. With the increase in energy prices, dental practices may also be affected as they are heavy energy usage environments and all materials have increased in price. A fixed contract value and treatment tariff does not allow these increased costs to be passed on or recovered thus reducing profitability. This encourages practices to do more private work, where costs can be adjusted to allow for increased expenditure as in most other business models.

Conclusion

44. The scale of the challenge to recover dental services cannot be overstated, due to the particular detrimental effect of the COVID-19 pandemic and cost-of-living crisis.

45. There is a balance which needs to struck between the long-term preventative agenda, whilst considering the current challenges within services. The high levels of urgent and active oral disease mean that a preventative approach cannot work alone, however a sustainable service will only be achieved if the burden of disease is reduced within the population.

46. Addressing those wider issues around prevention and oral health are interlinked with growing social inequalities, with a cross government approach needed to improve oral health education and access to healthier food.