Agenda – Health and Social Care Committee

Meeting Venue:
Hybrid – Committee room 3 Senedd and video conference via Zoom
Meeting date: 19 October 2022
Meeting time: 09.00

For further information contact:
Helen Finlayson
Committee Clerk
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Private pre-meeting (09.00-09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Dentistry – evidence session with Community Dental Services and Welsh Committee of Community Dentists

(09.30-10.45) (Pages 1 – 39)

Vicki Jones, Clinical Director of Community Dental Service, Aneurin Bevan University Health Board
Rob Davies, Associate Dental Director, Cwm Taf Morgannwg, University Health Board
Ruwa Kadenhe, Chair of Bro Taf Local Dental Committee
Manolis Roditakis, Chair, Welsh Committee of Community Dentists

Research brief
Paper 1 – Bro Taf Local Dental Committee

Break (10.45-11.00)

3 Dentistry – evidence session with Cardiff University and Public Health Wales

(11.00-12.00) (Pages 40 – 72)

Professor Ivor Chestnutt, Professor and Hon Consultant in Dental Public Health, Cardiff University
Anup Karki, Consultant in Dental Public Health, Public Health Wales
Angela Jones, Interim Director of Health and Well-being, Public Health Wales

Paper 2 – Cardiff University
Paper 3 – Public Health Wales

4 Paper(s) to note

(12.00)

4.1 Letter to the Chair of the Joint Committee on the Draft Mental Health Bill

(Pages 73 – 78)

4.2 Letter to the Chair from the Professional Standards Authority

(Pages 79 – 80)

5 Motion under Standing Orders 17.42 (vi) and (ix) to resolve to exclude the public from the remainder of this meeting and for all items other than items 1 and 2 at the meeting on 26 October 2022

(12.00)

6 Dentistry: Consideration of evidence

(12.00-12.05)

7 General scrutiny of Ministers with responsibility for health and social care: correspondence

(12.05-12.15) (Pages 81 – 90)

Paper 4 – Correspondence with the Ministers with responsibility for health and social services

8 Forward work programme

(12.15-12.20) (Pages 91 – 94)

Paper 5 – Forward work programme

Agenda Item 2

Document is Restricted

Bro Taf local dental committee is the statutory committee that represents the interests of GDS/ PDS providers performers and foundation dentists in the Cardiff and Vale and Cwm Taf Morgannwg Health Boards in line with Welsh statutory instrument 2010 number 2846 (w.234)

We welcome the Welsh Government initiative and commitment to dentistry as evidenced by this enquiry and the opportunities provided to colleagues to input information.

Background to Bro Taf LDC

Bro Taf LDC is a group of dentists who volunteer to represent the interests of the dental communities of Cardiff & Vale, and Cwm Taf Morgannwg. The committee is made up of NHS dental performers, with representatives from various fields (community, hospital, orthodontics etc.) The LDC meets regularly throughout the year and has an open general meeting every 2 years. We are the largest of 5 LDCs in Wales and we represent 127 NHS practices. A large part of the role of the LDC is in its interactions with the health boards. The LDC conveys the opinions and concerns of dental communities to the LHB, and the LHB consults with the LDC on matters of local interest, including contract issues and disputes. The LDC strives to keep local dentists up to date with new regional guidance. LDCs have a good working relationship with, but are independent of, BDA Wales.

RESPONSE

- The extent to which access to dentistry continues to be limited and how best to catch up

We believe in the two health boards that we represent performers, the current centralised waiting list not including those in practices' own waiting lists combines to a total of 15,000 patients that have contacted health boards during and after the pandemic for dental care. Anecdotal evidence from practices show that the uptake of private care has increased post pandemic. This is supported by evidence from NASDAL (an association for specialist dental accountants). Whilst the increase in private treatment is partly due to cosmetic dentistry most cases emanate from lack of access to NHS dentistry.

Positively the access element of the contract variation has increased the number of practices taking on new patients. However, it has not addressed the capacity to take on new patients according to need or deprivation. Another positive is the new care pathways which adopt prudent healthcare principles to underpin the planning of treatment. Complicated and expensive treatments are no longer delivered to patients who can't maintain them. High-cost treatments are delivered to 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. Also,

positive uptake of dental care and appointments is at a post pandemic high, with most practices reporting patient appointment books being 'very busy and this is supported by the data collection of NHSBSA for Welsh Government,

This progress is hampered by a recruitment crisis, which is well recorded by the BDA and HEIW. The evidence depicts that the dental workforce crisis is no longer an issue in rural areas only but even in urban areas and for the second year running to young dentists entering foundation training. Immediate action is needed to address recruitment issues. Measures can include a possible new dental school, release of funds by the education branch of Welsh government for the training of dental nurses, acceleration for plans for escalator models of upscaling current staff and removals of barriers to apprenticeships in dental nursing such as 5 GCSE's. Other measures include working together with the GDC to remove barriers to international recruitment, fair pay, and access to NHS pension for dental care professionals.

The costs of treating high needs patients even in contract variation are still unaccounted for within the contract and are often forcibly subsidised by dental practice businesses. This results in losses for dental practices, associate dentists working without earning and dental care professionals earning less. There is a very strong financial disincentive for dentists and their teams to treat high needs patients. While dentists are caring and hardworking this and all other contracts before have failed to address the fundamental issue of inequality.

- On Incentives to recruit and retain NHS dentists in rural areas and areas of high need.

We welcome and fully support the work that is being considered to incentivise welsh dental students to stay within wales. We call on welsh government to fund these incentives and to consider enticing English dental students to work in welsh rural dental settings, precedent being set by schemes such as train work live that has been successfully used to recruit our medical counterparts to rural wales. Consideration must be given to encourage welsh students from poorer social economic backgrounds Welsh speaking students to be incentivised to undertake dental foundation training within Wales and further incentivised to stay in the NHS host foundation training

- On well-being workforce and morale

Morale is particularly low, with a BDA post pandemic survey of dentists revealing 86% of dentist went to work without feeling emotionally well enough to do so. The insistence of health boards to enforce unreasonable targets as currently posed by contract variation and imposed on those practitioners that were forced into a quick decision to remain on the more familiar UDA contract, only serve to add stress to practitioners. We have received numerous complaints about confusion caused by the very short notice given to practitioners about the new contract variation and then the multiple ongoing problems in submitting claims and information to NHSBSA. In every practice dentists are working longer and longer hours to fill out and fix paperwork.

Dental Care Professionals such as dental nurses and therapists are thankful for being recognised as keyworkers in order to travel to work during the pandemic but remain without access to NHS pensions, sick pay, maternity pay, or agenda pay. Slow progress on removal of legal barriers for dental therapists helping dentists with targets has seen dental therapists leaving for private practice. Dentists want to work in a high trust environment where they are trusted to do what they think is best for their patients.

Of note there has been two large and two smaller dental practices who handed back contracts in fairly urban areas. The rarity of this situation should demonstrate the dip in morale post covid.

- On health inequalities

The LDC fully supports the work done by the designed to smile programme and the wild documented success and bringing down the rate of caries amongst children. The ongoing study into bringing skill mix into care home settings will go a long way to addressing the huge gap in service that is a legacy in Covid 19. There is also potential of training care home staff to collaborate with dental professional to improve the oral health of our ageing population.

- On the impact of the cost of living

The cost of living is affecting all levels of primary care including business owner associates and dental nurses. A 2020 study across the four nations of the average costs, excluding capital costs, of treating a child with one dental cavity in 2018 was average of £250 and if you are to avoid dental pain the cost rises to £330 over a 3-year period. We are aware that dental pain in children is the biggest cause of general aesthetics in children in Wales, dental pain in children also has detriment to their education and time away from work for parents. Over 5 years later the Welsh Government offer is £330 per child including capital costs. This shows how expenses of practices have not been taken into account by DDRB or welsh government, In 2022 it costs more for practices and their teams than welsh government has offered to pay. This must now be urgently addressed either by reducing targets or increasing the contract uplifts. Associates and dental nurses are being asked to subsidise an underfunded service the new contract must put an end to this. The current inflation and rising cost of materials, energy, and fuel has left many of the valued colleagues especially our precious nurses experiencing financial hardships and wallowing in the murky waters of poverty. These hard-working citizens provide a key health and care service and are therefore instrumental in ensuring the enjoyment of the basic human right to health.

Please note that in the interest of brevity , I have deliberately not only referenced widely available statistics and have only sought to use data pertinent to Wales. All other data or evidence unable to be sourced in literature we define as anecdotal, however we have limited this to the experience of practitioners within the Cardiff and Vale and Cwm Taf health Board.

Dentistry

An inquiry into whether the Welsh Government is doing enough to bridge the gap in oral health inequalities and rebuild dentistry in Wales following the COVID-19 pandemic and in the context of rising costs of living.

Evidence provided to Sixth Senedd Health and Social Care Committee

Professor Ivor G. Chestnutt

Professor and Hon Consultant in Dental Public Health

Cardiff University School of Dentistry

5th September 2022

Introduction

1. This evidence is submitted at the request of the Health and Social Care Committee in advance of providing oral evidence to the committee at their oral hearing on 19th October 2022.

Considerations

2. The committee has posed the queries outlined in Table 1. My evidence, where I have sufficient information to substantiate or experience to answer, is provided in the following pages.

The Committee is considering:
1. The extent to which access to NHS dentistry continues to be limited and how best to catch up with the backlog in primary dental care, hospital and orthodontic services.
2. Improved oral health intelligence, including the uptake of NHS primary dental care across Wales following the resumption of services, and the need for a government funded campaign to reassure the public that dental practices are safe environments.
3. Incentives to recruit and retain NHS dentists, particularly in rural areas and areas with high levels of need.
4. Oral health inequalities, including restarting the Designed to Smile programme and scope for expanding it to 6-10 year olds; improved understanding of the oral health needs of people aged 12-21; the capacity of dental domiciliary services for older people and those living in care homes (the 'Gwên am Byth' programme); and the extent to which patients (particularly low risk patients) are opting to see private practitioners, and whether there is a risk of creating a two-tiered dental health service. Workforce well-being and morale.
5. The scope for further expansion of the Community Dental Service.
6. Welsh Government spend on NHS dentistry in Wales, including investment in ventilation and future-proofing practices.
7. The impact of the cost-of-living crisis on the provision of and access to dentistry services in Wales.

Table 1 Considerations defined by the Committee in their consultation Document.

Consideration 1: The extent to which access to NHS dentistry continues to be limited and how best to catch up with the backlog in primary dental care, hospital and orthodontic services.

3. NHS dentistry is at present influenced by a number of factors which together have combined to impact on access to care. These are relevant to the future delivery of dental services. These are:
    a. The direct effects of the pandemic
    b. The limitations of the 2006 NHS Contract
    c. Uncertainty around the impact of contract reform
    d. Workforce shortages

4. The impact of the pandemic on NHS dental care is shown in Figure 1 where it can be observed that the percentage of adults in Wales who had received NHS dental care in the preceding two years fell from 52% prior to the pandemic to 33% on 31st December 2021. The equivalent figures for children fell from 68% to 44%.

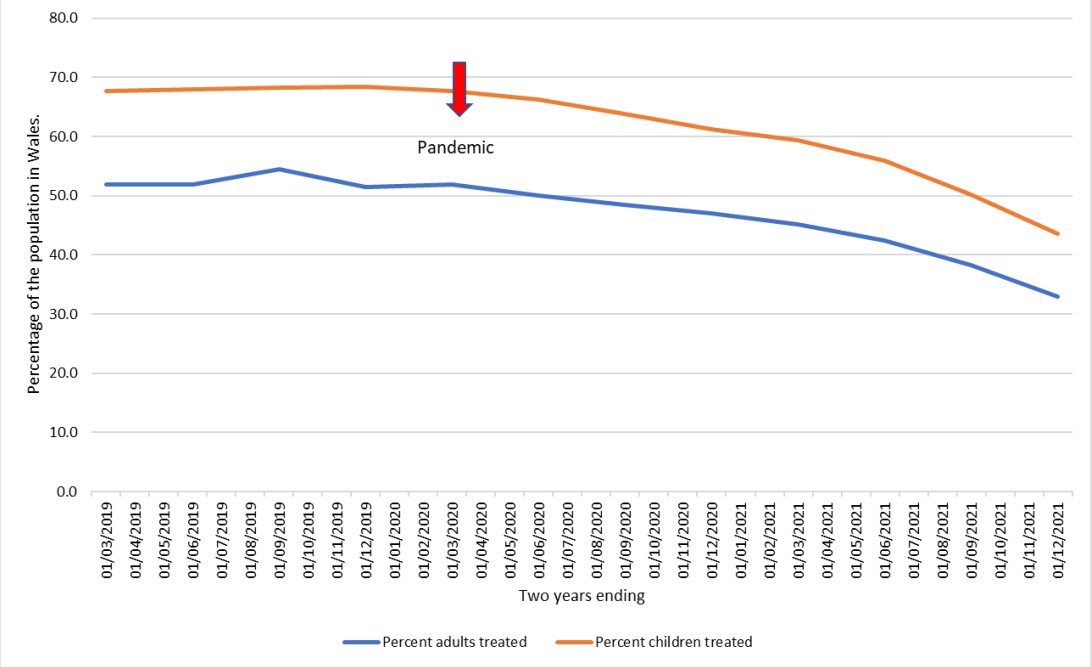


Figure 1 The percentage of adults and children treated under an NHS General Dental Service contract in the preceding two years (STATS Wales 2022).

Direct effects of the pandemic

5. The pandemic impacted on NHS dental care in several ways. In the initial stages many dental surgeries closed or were able to offer only emergency care. In time as the effects of the COVID-19 virus became clearer and appropriate PPE was made available, activity increased but was still reduced due to the need for increased infection prevention and control measures and greater gaps or "fallow time" between patients. This has now been significantly reduced as the threat from the virus has diminished in an adequately vaccinated population.

The limitations of the current contract

6. The pandemic impacted on capacity in other ways. The economics of many NHS practices relied on seeing a high volume of low need patients attending at greater than strictly necessary treatment intervals. The pandemic has broken that model.

7. The recent move by the Welsh Government to restrict dental check-ups for low-risk patients should create additional capacity to see more high-needs patients although how much is a matter for conjecture.

8. The reforms in the contract for 2022/23 require 25% of patients to be "new patients" i.e. to not have been seen in the practice in the previous four years. The degree to which this will be practically feasible will become clear between now and the end of March 2023.

9. However, in my view whilst there is a disconnect between the reward for seeing low need as opposed to high need patients, the system will struggle. That was a fundamental failing in of the 2006 contract. This is discussed further under Consideration 3 below.

10. Contract reform has rightly to date concentrated on a more preventively orientated service, but that cannot be at the expense of recompense tailored to current treatment needs and disease risk.

Uncertainties over what the reformed contract will look like

11. A further issue in rebuilding the service is uncertainties around contract reform. In advance of the 2022/23 financial year details of the contract were issued by the Welsh Government only at the last minute making planning very difficult for both practitioners and health boards. There were understandable reasons for that, but it is imperative that the plans for the next financial year and what the contract will look like in 2023/24 be made clear as soon as is possible and well before March 2023.

Workforce shortages

12. Difficulties in recruiting new associates (junior dentists) is an issue in the recovery. Furthermore, there is currently a chronic shortage of dental nurses. Health Education and Improvement Wales are working to address the recruitment and training of dental nurses. It is impossible to operate without these vital members of the dental team. Attracting both junior dentists and the appropriate support staff are legitimate concerns of those contractors who would consider expanding their NHS dental provision.

Consideration 2: Improved oral health intelligence, including the uptake of NHS primary dental care across Wales following the resumption of services, and the need for a government funded campaign to reassure the public that dental practices are safe environments.

Oral health intelligence

13. The mechanism for monitoring the uptake of NHS general dental services is good. Dental practitioners are required to submit details of NHS patients seen to the NHS Business Services Authority. This occurs electronically and so accurate records of how many patients have been seen and what procedures have been undertaken are available. This is the mechanism whereby NHS Contracts are monitored and dentists paid.

14. There is no central repository of information on the number of patients treated privately.

Patient concerns over safety

15. I am not aware of any evidence that patients are overly concerned about attending dental practices post-pandemic. Clearly a proportion of the population are and always have been anxious about visiting the dentist but it is not clear that this has been worsened by the pandemic, or that patients are anymore anxious about catching covid in a dental environment than they are elsewhere in the community. I do not see a need for a government funded campaign to reassure the public that dental practices are safe environments.

Consideration 3: Incentives to recruit and retain NHS dentists, particularly in rural areas and areas with high levels of need.

Reduced appetite for owing an NHS dental practice

16. Providing sufficient dentists in rural and remote areas of Wales has been a problem since the mid-1990s at least. The traditional model of dental practice whereby one or two dentists practice from a converted Victorian house is no longer tenable or indeed appropriate. Discussion with newly graduating dentists suggest that many fewer aspire to own their own practice. A greater focus on work-life balance, concerns over being able to purchase a family home, student debt and so forth mean that many do not want the "hassle" of owning and running a dental practice. If they do, then they largely envisage that as being in the independent sector, free of the perceived constraints of NHS dentistry.

Corporate bodies and the supply of overseas trained dentists

17. In the past two decades, rural and remote areas have become heavily reliant on dental corporates (companies who employ dentists and contract with Health Boards) to provide dental care. These companies were heavily reliant on overseas dentists. Two factors have combined to limit the current supply of overseas dentists. Rural areas in Wales have been reliant on dentists from Eastern Europe. Whilst some have settled and made their home in Wales many have returned to their homeland. The degree to which this has been influenced by Brexit and the pandemic is difficult to determine.

18. There is no shortage of dentists who have qualified elsewhere in the world who would like to come to practice in the United Kingdom, but unlike European graduates pre-Brexit, there is no reciprocal recognition of their dental qualification. This is appropriate as training standards vary around the world. To work in the UK non-EU graduates must sit and pass an Overseas Registration Examination, facilitated by the General Dental Council. This is creating a very significant "bottle-neck" in the availability of overseas dentists to work in the UK. In summary, dentistry is not in the same position as other healthcare professions where workforce shortages can be addressed quickly by the import of personnel.

Areas of high dental need, access to care and incentives to care for high-need patients

19. Traditionally areas of high dental need were attractive to NHS practitioners. There was plenty of work, and many patients were exempt from paying NHS charges which made practice in such areas attractive. However the 2006 contract, with the

significant disincentives to take on high need patients meant that provision of NHS dentistry in high need areas is more of a challenge than previously.

20. Reforms to the NHS dental contract in 2022/23 require 25% of patients seen to be "new" to the practice, i.e. not have attended that practice within the past 4 years. This should help improve access as should the recent decision by Welsh Government to mandate less frequent "check-up" appointments for low risk patients.

21. The concentration on prevention in contract reform is welcome and should in conjunction with more upstream policies (for example the "sugar tax") prevent dental disease and address inequalities.

22. However, that fundamental failing of the 2006 contract whereby the same number of Units of Dental Activity were available irrespective of the needs of the patient and the reward for treating one cavity was the same as however many more were needed. Whilst Units of Dental Activity have been removed in Wales, my view is that there is a need for the system to pay dentists more for seeing a high need patient. A universal fee irrespective of patient need does not make sense.

23. One further issue relates to the focus on number counting and access. It goes to say that if dentists take on more patients with higher needs, then they cannot be expected to see the same number of patients as previously.

Skill-mix as a solution to workforce shortages

24. It is now thirty years since a Nuffield Report recommended that greater use be made of skill-mix to deliver dental care. Whilst endless research has been undertaken and papers published on the subject, little significant progress has been made in facilitating skill-mix within NHS primary dental care to deliver a preventively orientated service (beyond scaling and polishing of teeth). Dentistry lags way behind Medicine in the use of skill-mix. How dental therapists and to a lesser extent dental hygienists are utilised in the General Dental Service needs to be promoted and necessary changes to legislation pursued.

Bursaries and incentives

25. In the past two decades I have seen several bursary schemes come and go. Designed with the intention of attracting young people from rural and remote areas to study dentistry and to return to their home area. These have been difficult to implement and met with limited success.

26. In line with their widening access agenda Cardiff University has a comprehensive programme designed to facilitate and encourage applications to Dental School from

school leavers in Wales whose background might not have led them to think of dentistry as a career.

27. Over the years NHS Scotland has run specific programmes to incentivise dentists in rural and remote areas and it may be worth revisiting those to see if learning from there could identify approaches applicable in Wales.

Consideration 4: Oral health inequalities, including restarting the Designed to Smile programme and scope for expanding it to 6-10 year olds; improved understanding of the oral health needs of people aged 12-21; the capacity of dental domiciliary services for older people and those living in care homes (the 'Gwên am Byth' programme); and the extent to which patients (particularly low risk patients) are opting to see private practitioners, and whether there is a risk of creating a two-tiered dental health service. Workforce well-being and morale.

Designed to Smile

28. Designed to Smile forms a key component of Wales national oral health improvement plan. Commenced in 2009, this nursery and school based toothbrushing programme is key to implementing and socialising twice daily toothbrushing in those children at greatest risk of dental decay. It is supplemented by the provision of "home-packs" to households where toothbrushes and toothpaste may not be affordable. The scheme has been subject to review previously by both the Children's and Young People Committee (4th Senedd) the Health and Social Care Committee (5th Senedd).

29. Prior to the pandemic (2018/19) 90,602 children attending 1396 nurseries and primary schools participated in daily toothbrushing. That represented 82% of eligible nurseries.

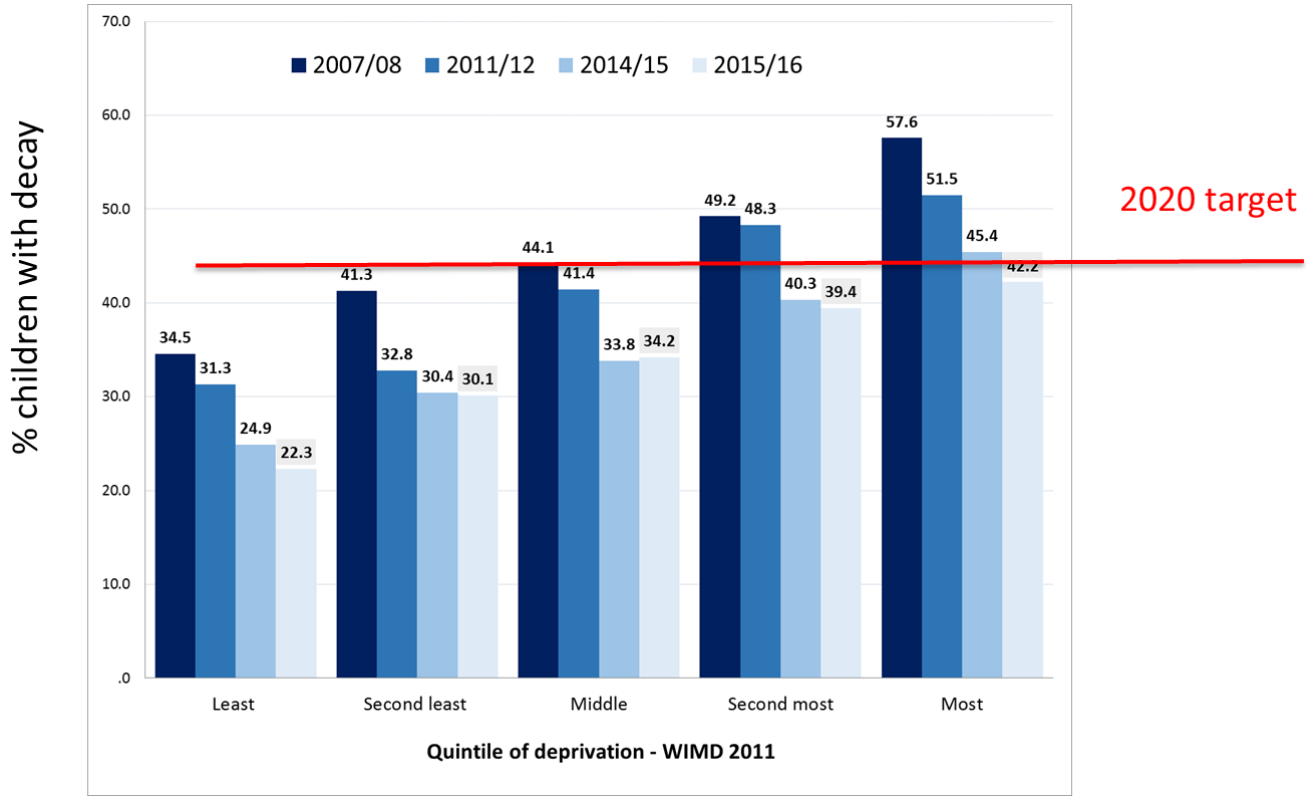


Figure 2 Changes in the prevalence of dental decay in 5 year olds in Wales 2007 – 2016 by quintile of deprivation.

30. Changes in the prevalence of dental decay between 2007/08 and 2016/17 (Figure 2) show that after two decades of stagnation, levels of tooth decay began to fall following the introduction of the Designed to Smile programme. At the time of the last survey in 2016 the prevalence of decay in the most deprived quintile of the population had fallen to 42.2% achieving the child poverty reduction target set by Welsh Government in 2006 (that level of decay in the most deprived quintile in 2020 to fall to that observed in the middle deprived quintile in 2006).

31. The survey being conducted in 2020 had to be abandoned due to the pandemic. We will undertake a survey of 5 year olds in schools in the coming 2022/23academic year. This crucial survey will allow us to determine whether the gains in oral health in 5 year olds observed in the decade leading up to 2020 have been sustained, or whether caries prevalence has stagnated or worsened.

32. Many of the staff delivering the Designed to Smile programme were redeployed during the pandemic – most often to vaccination centres. They have returned and are working hard to get the programme re-established. We have not encountered significant difficulties or reluctance on the part of schools to reengage with the programme.

33. I do not however recommend expansion of the programme to older children. There simply is not the workforce to do this. Further, the ethos of Designed to Smile is to establish twice daily toothbrushing in households where that might not otherwise happen. That having occurred, there are probably diminishing returns in running a school based toothbrushing scheme in 6-10 year olds.

34. We completed a survey of young people (18-25 years) in 2019 and the findings are available at WELSH Dental Survey OF 18-25 YEAR OLDS (cardiff.ac.uk). This provides us with an understanding of oral health needs and demands of this age group. The self-reported oral status of those interviewed in the survey are shown in Table 2.

Self-reported status	Very good	Good	Fair	Bad	Very Bad
Percentage reporting	13.4	43.6	30.5	9.8	2.7

Table 2 Self-reported oral health status of 18-25 year olds in Wales. (WOHIU, 2020)

Dental domiciliary services for older people and those living in care homes

35. The terms of the 2006 contract made domiciliary dental care provision less attractive to general dental practitioners. Whilst some practitioners retain relations with some care homes this is often provided on a private basis. The Community Dental Service provides domiciliary services to a varying degree across Wales though often as a reactive service rather than any routine care provision.

Gwen Am Byth

36. Gwen Am Byth is a programme for older people's care homes. It aims to ensure that in participating care homes :
    - there is an up-to-date mouth care policy in place
    - staff are trained in mouth care (including at induction) and the home keeps a register of training
    - residents have a mouth care assessment at appropriate intervals to identify any changes that will impact on their oral health
    - the assessment leads to an individual care plan, designed to support routine good oral hygiene that is reviewed on a regular basis
    - care homes are aware of how to ensure timely access to appropriate dental care and treatment when required.

37. In 2021-2022, 299 care homes were participating fully in the programme and 199 were partially participating. There are 1266 registered care/nursing homes in Wales.

The extent to which patients (particularly low risk patients) are opting to see private practitioners and whether there is a risk of creating a two-tiered dental health service

38. There are no centrally held data on the number of patients opting to have their dental care privately in Wales to answer this question with any accuracy. Anecdotal evidence suggests that a greater number of patients than ever are either choosing or are being forced to have their dental care outwith the NHS. This has of course been the case for three decades now, the first significant drift to the private sector being occasioned by unhappiness with a revised dental contract introduced in 1990.

39. The question of a two-tiered dental health service is interesting. It could be argued that this already exists. Many of the advances in dentistry are not routinely available via the NHS. Dental implants and tooth-whitening are two items of care highly desired by patients which are not available via the NHS and therefore are available only to those who can afford them. Tooth whitening is a cosmetic procedure and it is unreasonable to expect that to be provided under a state funded healthcare system.

40. What is of greater relevance to this enquiry, is exactly what should a state funded general dental services should provide? There remains a perception or perhaps a pretence that all necessary dental care is provided by NHS General Dental Services. That is not the case and I believe it is time for a clear definition and explanation to the public of what is and isn't available via state funded care.

41. If we take for example the provision of partial dentures, necessary when a patient has lost several teeth. In many instances a denture with a metal base will prove a better solution than a plastic denture. However, the current fees payable by the NHS make the provision of a metal denture unviable and a patient can usually only have a metal denture if they can afford to pay privately. Given the current funding base, it is unrealistic to think that the public purse can fund all that patients can benefit from, even when we are not discussing high-end or cosmetic treatments. That the state cannot afford to pay for all the dental care that the public can consume became obvious four years after the inception of the National Health Service when in 1952 patient co-payments for dental care were introduced.

42. I understand the political difficulties in making explicit what is and is not available via state funded care. Perhaps it is time for that to be made clear (via a clear list of simple treatments that the NHS will pay for at an appropriate rate) and for the elephant in the room to be called out – we already have a two tiered dental care system.

Consideration 5: The scope for further expansion of the Community Dental Service.

43. The Community Dental Service plays a fundamental role in service provision to the most vulnerable people in Wales. The scope of the service is well defined in a recent Health Circular.

The functions of the Community Dental service are:

To provide care for the vulnerable

44. Vulnerable people are often at increased risk of dental and oral disease and are likely to include those who are unable to:
    - co-operate with routine dental care
    - understand the need for dental care and good oral hygiene
    - maintain good oral hygiene without assistance
    - readily access dental services (e.g. patients who require a hoist to transfer to the dental chair).

They may also be:

- people with complex health needs which may include medical, physical or mental health needs
- socially disadvantaged, including asylum seekers, homeless people and people with
  substance misuse disorders
- Looked After Children (LAC) or children with dental disease who are severely affected and/or not being taken for dental care
- frail and vulnerable older people, including those living with dementia and people who live in care homes who are unable to access care via the GDS

Specialist Dental Services

45. The CDS has provided some specialist services (at Tier 2 level) in some areas.

Delivery of the national oral health improvement programmes

46. The CDS is responsible for the delivery of the Designed to Smile and Gwen Am Byth programmes

Epidemiology

47. The CDS in collaboration with Public Health Wales and the Wales Oral Health Information Unit is responsible for the conduct of epidemiological surveys on oral and dental health in Wales.

48. There is scope for further expansion of the CDS, but before that, more importantly is a need to stabilise existing services. The priority given to the CDS has varied in different health boards and the service is more robust in some areas than in others. In my view some health boards have focused on the GDS and neglected the CDS.

49. Whilst there is room for expansion of the CDS this should focus on the core functions outlined above. The CDS is not set up to fill gaps in the GDS occasioned by the current access problems.

Consideration 6: Welsh Government spend on NHS dentistry in Wales, including investment in ventilation and future-proofing practices.

50. As discussed above the potential to spend money on dental services is limitless. If additional monies are available the plan for use of these needs to be well planned and used in conjunction with a national oral health plan. Too often in the past, additional monies have been made available, last minute, with unreasonably short timescales to plan to use the monies in a sensible way.

51. I am unable to comment on ventilation schemes.

Consideration 7: The impact of the cost-of-living crisis on the provision of and access to dentistry services in Wales.

52. There is no doubt that at a time of economic hardship some people will find their resources stretched to the point that they cannot afford to attend the dentist. NHS dental examinations and care is free as listed in Table 3.

You get free dental examinations if you are: • aged under 25 • aged 60 or over • Any subsequent treatment as a result of the free examination carries the appropriate charge. You can get free NHS dental treatment if when the treatment starts you: • are aged under 18 • are aged 18 and in full time education • are pregnant or have had a baby within the 12 months before treatment starts • are an NHS in-patient and the treatment is carried out by the hospital dentist • are an NHS Hospital Dental Service out-patient (there may be a charge for dentures and bridges) You are also entitled to free dental treatment if when the treatment starts or when the charge is made: • you or your partner receive certain benefits • you are on a low income, read Low Income Scheme • you are entitled to, or named on, a valid NHS tax credit exemption certificate • You can use the NHS online checker to see if you are entitled to help.

Table 3 Entitlement to free dental Examination and treatment in Wales NHS dental charges and exemptions | GOV.WALES

53. As with any means tested system those most likely to suffer are those who just miss out on qualifying for the benefit. We know that often it is not the cost but not knowing the cost that proves an issue for patients. No one wants to face the embarrassment of being in a dentist's chair and then finding out that the cost is more than can be afforded.

54. To avoid this scenario dentists are required to display a list of charges and to provide a written estimate for treatment before care commences.

55. Charges for NHS dental care is however clear according to three bands of treatment. Current charges (together with the equivalent charges in England) are shown in Table 4.

Course of treatment	**Patient charge 2022/23**	**Patient charge 2022/23**
	Wales	**England**
Band 1	£14.70	£23.80
Band 2	£47.00	£65.20
Band 3	£203.00	£282.80
Urgent Treatment	£14.70	£23.80

Band 1 course of treatment – This covers an examination, diagnosis (including X-rays), advice on how to prevent future problems, a scale and polish if clinically needed, and preventative care such as the application of fluoride varnish or fissure sealant if appropriate.

Band 2 course of treatment – This covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or removal of teeth but not more complex items covered by Band 3.

Band 3 course of treatment – This covers everything listed in Bands 1 and 2 above, plus crowns, dentures, bridges and other laboratory work**.**

Urgent dental treatment – This covers emergency care in a primary care NHS dental practice such as pain relief or a temporary filling.

Table 4 A comparison of NHS Dental charges in Wales and England.

56. Although NHS charges were the same when the 2006 Contract was introduced in England and Wales, successive administrations in Cardiff have increased NHS charges to a lesser extent compared with increases in England resulting in the differences observed in Table 4.

57. Whilst it can be argued that this has resulted in revenue lost to the Service, it does mean that patients in Wales face lesser charges for NHS care than in England which should be a benefit at this time for those who are required to contribute to their care.

PROFILE

This evidence has been submitted by Ivor G. Chestnutt in his role as Professor and Hon Consultant in Dental Public Health at Cardiff University.

Ivor Chestnutt is Professor in Dental Public Health at Cardiff University Dental School, Honorary Consultant to Cardiff and Vale University Health Board and is registered as a Specialist in Dental Public Health. Prof Chestnutt has worked in dental public health in Wales for 23 years. He is a graduate of the University of Edinburgh and received both his MPH and PhD degrees from the University of Glasgow. He holds Fellowships in dental surgery from the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Surgeons, England. Ivor is also a Fellow of the Faculty of Public Health and a Fellow of the Higher Education Academy.

Within the Dental School, he was Director of Postgraduate Studies (2011-2022) and recently completed as six year term as Clinical Director of the University Dental Hospital. He leads the Oral Health workpackage in the Heath and Care Research Wales Funded Primary and Emergency Care Research Centre. Prof Chestnutt hosts the Wales Oral Health Information Unit on behalf of Public Health Wales and Welsh Government.

An inquiry into whether the Welsh Government is doing enough to bridge the gap in oral health inequalities and rebuild dentistry in Wales following the COVID-19 pandemic and in the context of rising costs of living.

Evidence provided to Sixth Senedd Health and Social Care Committee

Public Health Wales is pleased to provide this written submission to the Sixth Senedd **Health and Social Care Committee.** The committee is considering wide ranging areas in oral health and dentistry. We would like to focus our response on prevention, oral health improvement programmes and primary care dental services including workforce challenges.

Summary

1. The burden of oral health diseases is high. The oral health of the population cannot be improved through dental services alone. If legislative interventions like the Well-being of Future Generations (Wales) Act 2015, Public Health (Wales) Act 2017, A More Equal Wales: the Socioeconomic Duty, Minimum Pricing Alcohol and population health programmes like Healthy Weight Healthy Wales and Tobacco Control Delivery Plans have significant impacts on reducing the risk factors for non-communicable diseases, they should also contribute towards improvement of oral health of the population.

2. Tackling overconsumption of free sugar has to now be a mainstream public health priority. The burden of tooth decay in the population should reduce if legislative and public health programmes like Healthy Weight Healthy Wales become successful in reducing free sugar consumption in Wales to the level recommended by the UK Scientific Advisory Committee in Nutrition (SACN) i.e. 5% of total energy intake. Wales should lead the way in setting an ambitious target of reducing free sugar consumption below 5% of energy intake as recommended by SACN.

3. Proactive prevention for better oral health should not be seen as the exclusive responsibility of dental services and oral health programmes. Prevention of oral diseases needs to be an integral part of the objectives of relevant population level prevention strategies and programmes both at national and local level. Additionally the barriers and enablers for dental services to be part of co-ordinated, preventive and proactive primary and social care services need to be explored and an action plan formulated to remove barriers.

4. Population oral health improvement programmes like Designed to Smile are important to stop widening of oral health inequalities. Designed to Smile was severely affected by the COVID19 pandemic. Whilst there are challenges in recovery, the focus of all partner organisations and teams involved in this important programme should be on recovering this programme as soon as possible so that children in deprived areas of Wales do not lose out.

5. The COVID19 pandemic has had a substantial impact on delivery of dental care. A long term vision with commitment to radical transformation of the oral health system is required to scale up prevention both inside and outside dental clinical settings. A new dental contract for General Dental Services (GDS) and strengthening of the Community Dental Services so that they are able to address the oral health need of all vulnerable groups in society should be prioritised, but seen as the start of oral health system reform not the end.

6. Oral health and dental transformation will not be possible without investment in workforce planning, training and development, and health and well-being of the workforce. Workforce planning should be need-based with ongoing adjustment to ensure close alignment with oral health and dental services policy, planning, implementation, and motivation and career aspirations of the dental workforce. Unlike the rest of healthcare, dentistry has fallen behind in maximising the benefits of optimal use of skill-mix. All barriers for optimal skill mix use for prevention and NHS dental care delivery should be addressed with some urgency.

7. There is irrefutable evidence from the dental literature as well as surveys conducted as part of the Dental Epidemiology Programme for Wales that oral health inequalities exist, with people living in the most deprived areas bearing the largest burden of dental disease. Oral health inequalities are unfair, unjust and preventable. Hence, reduction in oral health inequalities should be a priority. This would in line with the Well-being of Future Generations (Wales) Act 2015 and A More Equal Wales: the Socioeconomic Duty.

1. Tackling common risk factors of oral health and non-communicable diseases and their underlying social and commercial determinants should improve oral health and non-communicable diseases

Oral diseases present a significant public health problem affecting over 3·5 billion people across the world, with untreated tooth decay being the most prevalent health condition globally.[1] While overall prevalence of tooth decay has decreased in Wales in both adults[2] and children,[3] dental diseases are still highly prevalent and the cumulative effect of oral diseases into adulthood and later into older age remains a significant population health challenge. There is a very strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases and conditions. Across the life course, oral diseases and conditions disproportionally affect the poor and vulnerable members of societies.[4]

Oral diseases are caused by a range of modifiable risk factors, including sugar consumption, tobacco use, alcohol use and poor hygiene, and their underlying social and commercial determinants. Highly prevalent dental diseases cannot be simply treated away by dental services. Frustratingly debate about oral health in the UK and widely around the world are often rather limited with focus on dental services alone. Solutions sought are often limited to expanding or changing existing dental care services without addressing the causes of the dental diseases and their underlying social and commercial determinants.[1]

Corporate activities shape our environments and determine the availability, promotion and pricing of consumables.[5] Stricter regulation and legislation are needed to overcome corporate strategies that threaten and undermine oral health and non-communicable

diseases. There is emerging evidence that tax on sugar sweetened beverages can potentially have impact on reduction in tooth decay.[6] WHO recommends that both children and adults reduce their free-sugar consumption to less than 10% of total energy intake,[7] and the UK Scientific Advisory Committee on Nutrition (SACN) recommended that the average population intake of free sugars should not exceed 5% of total dietary energy for age groups from 2 years upwards.[8] Even in the presence of optimal fluoride exposure for prevention, tooth decay will still develop in presence of free sugars above 10% of individual's total energy intake. Studies have found higher dental caries with sugar intake greater than 10% energy compared with less than 10% energy.[9]

Food consumption, nutrient intake and nutritional status in children in the UK are captured in 2 large national surveys: the Diet and Nutrition Survey of Infants and Young Children (DNSIYC) and the National Diet and Nutrition Survey (NDNS).The DNSIYC and the latest NDNS indicate that children in the UK are exceeding current UK government recommendations for dietary energy, protein, saturated fats and free sugars while not meeting recommendations for dietary fibre.[10]

Tackling overconsumption of free sugar has to now be a mainstream public health priority. Evidence from studies show that, despite the protection offered by fluoride (for example through programmes like Designed to Smile), the relationship between sugars and dental caries remains.[10] The high burden of tooth decay in the population across the life course with disproportionate amount present in people living in deprived areas in Wales cannot be tackled by an individual personal responsibility approach of focussing on educating patients about risk behaviours without considering how social and commercial determinants of health shape these behaviours.

Wales has a good legislative landscape including the Well-being of Future Generations (Wales) Act 2015, Public Health (Wales) Act 2017, A More Equal Wales: the Socioeconomic Duty, to improve health, including oral health, and reduce inequalities. The sustainable approach within the Well-being of Future Generations (Wales) Act 2015 also requires policymakers to take a long-term view so that their decisions do not impact negatively on future generations.

Reduction in smoking prevalence as per Tobacco Control Strategy for Wales[11] and any impact of Minimum Pricing on Alcohol (MPA) in reducing harmful drinking should also contribute towards improving oral health. If many actions included on the Healthy Weight Healthy Wales Strategy[12] and priority action plan were successful in achieving

their objectives, they should also contribute towards oral health improvement. The following objectives are directly relevant for oral health:

- Shaping the food and drink environment towards sustainable and healthier options being easy options,
- Promoting and supporting families to provide the best start in life, from pre-pregnancy to early years
- Enable our education settings to be places where physical and mental health remains a priority
- Removing barriers to reduce diet and health inequalities across the population

It remains to be seen if programmes like Healthy Weight Healthy Wales and legislative interventions like tax on sugar sweetened beverages (SSB) will be successful in reducing sugar consumption amongst all age groups to the level recommended by WHO and even more towards the SACN recommended target. Any national and local research planned to understand the impact of different legislative interventions and Healthy Weight Healthy Wales should include assessment of its impact on free sugar consumption across all age groups in Wales.

2. Population oral health programmes are important to stop widening of oral health inequalities.

Experiencing tooth decay at a young age can not only cause pain and infection, but also disturb sleep, limit ability to focus attention and eat a varied diet, hinder speech development, and negatively affect self-image and mental health[13, 14, 15, 16, 17, 18, 19]. Tooth decay is one of the most common reasons for childhood hospitalisation[20]. It has a lifelong impact as poor childhood dental health is a predictor of poor adult dental health[21]. Yet, in the vast majority of cases, tooth decay is entirely preventable through education, creating conditions for healthy behaviours, and optimal exposure to fluoride.

a) Designed to Smile

In 2015-16, a third of children aged 5 to 6 years in Wales had experience of tooth decay. On average, 10 children out of class of 30 would have tooth decay, with these 10 having 3.6 decayed teeth[22]. Evidence from the Dental Epidemiology Programme for Wales demonstrates that oral health inequalities exist from as early as 3 years of age, and children living in the most deprived areas have the largest burden of dental disease[23]. Even low levels of tooth decay in children should be of concern because tooth decay is a lifelong progressive and cumulative disease.

Designed to Smile (D2S) is a national programme to prevent dental caries in young children in Wales using evidence-based, cost-effective methods. It is overseen by NHS

Wales Community Dental Services and delivered in partnership with health and education services[24]. It was launched in 2009. It includes:

a) A preventative programme for children from birth involving a wide range of professionals, including health visitors and other early years services. The aims are to help start good habits early by giving advice to families with young children, providing toothbrushes and fluoride toothpaste, and encouraging regular attendance to a dental practice. This element of Designed to Smile is aligned to the Healthy Child Wales programme and its approach to provision of universal and enhanced support.
b) A preventative programme for Nursery and Primary School children involving the delivery of nursery and school-based toothbrushing and fluoride varnish programmes for children to help protect teeth against decay. These aspects of Designed to Smile are targeted to more deprived areas of Wales, with approximately 60% of nurseries and schools invited to participate. Children up to and including Year 2 (6-7 year olds) are included in the provision[25].

Designed to Smile staff across Wales were extremely valued in the NHS Covid-19 response. They were fully redeployed and had key roles in the community testing units and vaccination centres. Those that had returned from redeployment in September 2021 were returned to Covid-19 roles for the Omicron response. This meant that early attempts to restart Designed to Smile faltered in the latter half of 2021, but began again at pace in Spring 2022.

Prior to the pandemic, approximately 90,000 children were participating in daily supervised toothbrushing at 1200 nurseries and schools, and 45,000 children were receiving fluoride varnish applications at nursery or school[26]. Whilst there are multiple and varied challenges in recovering this programme to the pre-pandemic level and ensuring targeting of available resources, the focus of all partner organisations and teams involved in this important programme should be on recovering this programme as soon as possible so that oral health and oral health inequalities do not worsen.

b) Gwên am Byth

A survey of care home residents in Wales in 2010-11 highlighted high levels of poor oral hygiene and dental disease[27]. The Gwên am Byth national programme to improve oral health for older people living in care homes was established as a result. Overseen by the NHS Wales Community Dental Services, it has the aims that in participating care homes:

- an up-to-date mouth care policy is in place;
- staff are trained in mouth care (including at induction) and the home keeps a register of training;
- residents have a mouth care assessment at appropriate intervals to identify any changes that will impact on their oral health;
- the assessment leads to an individual care plan, designed to support routine good oral hygiene that is reviewed on a regular basis; and
- care homes are aware of how to ensure timely access to appropriate dental care

and treatment when required.

Gwên am Byth activity was severely impacted by COVID-19 restrictions, but has seen a good recovery. In 2021-2022, 299 care homes were participating fully in the programme and 199 were partially participating. In comparison, in 2019-2020, 310 care homes were participating fully and 124 were partially participating[28]. It must be noted that this programme does not deliver domiciliary dental care.

3. Dental services reform must ensure dental access based on need and delivery of dental care focussed on patient outcomes

a) General Dental Services

NHS dental services were probably the most affected primary care service during the pandemic because a significant proportion of dentistry involves aerosol generating procedures. Strict infection prevention and control measures were needed to reduce the risk of transmission in dental settings. The impact of the COVID19 pandemic on overall access can be seen in Figure 1 (12 months access for children) and Figure 2 (24 months access for adults) with signs of recovery in the latter months.

Figure 1: Number of children who received NHS dental care in the previous 12 months up to and including the month shown

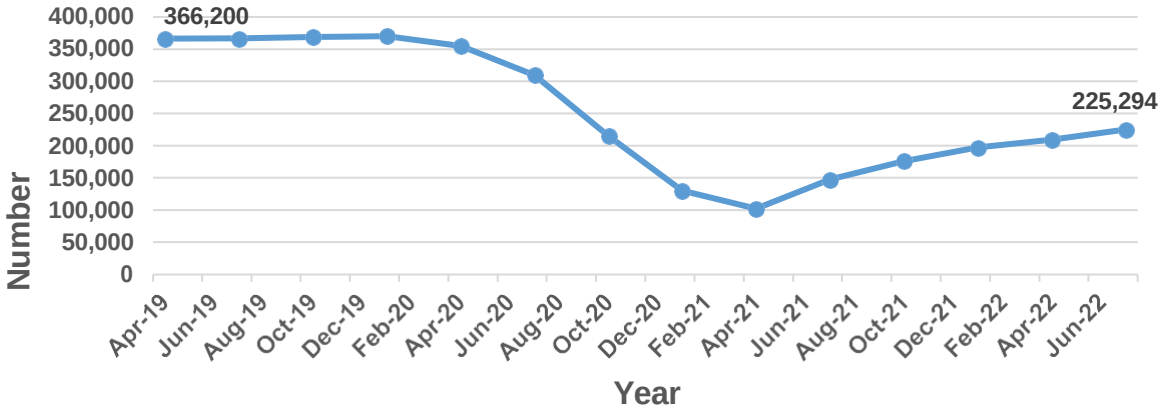


Figure 2: Number of adults who received NHS dental care in the previous 24 months up to and including the month shown

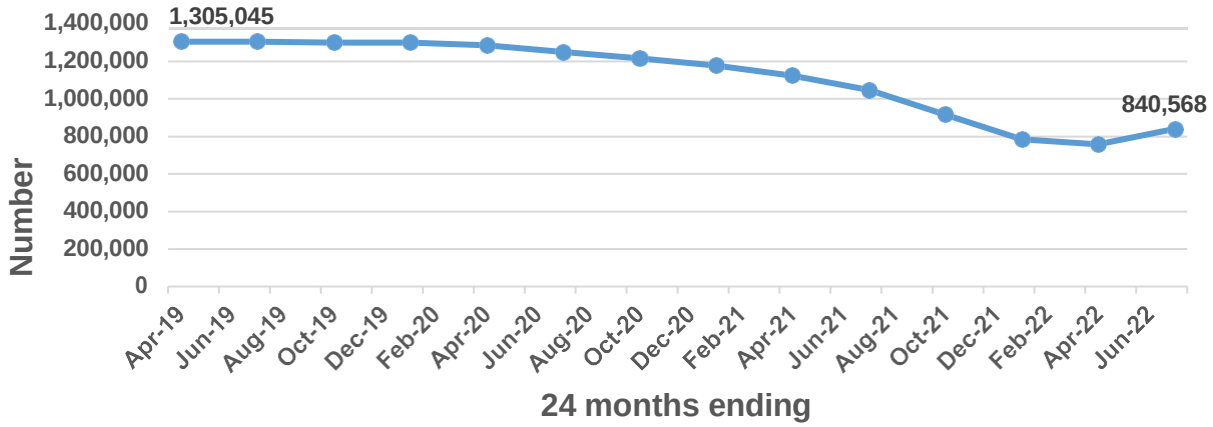


Table 1 shows the level of Band II and Band III treatments that were delivered by NHS General Dental Services in Wales in 2019/20 and how that compares to same treatment bands delivered during pandemic years 2020/21 and 2021/22.

Table 1: Number of Band II and Band III course of treatments delivered by NHS General Dental Services in Wales

Courses of Treatment	2019/20	2020/21	2021/22
Band II	569418	134681	219377
Band III	98443	22363	36372
Total Band II and III	**667861**	**157044**	**255749**

Source: StatsWales

It is clear from the level of treatment delivery during 20/21 and 21/22 compared to pre-pandemic year that there is a significant 'treatment back log' in General Dental Services (GDS) in Wales. A similar situation exists in other UK countries. The COVID-19 pandemic has exacerbated socioeconomic and ethnic inequalities and will undoubtedly worsen oral health inequalities.

It can be expected from Figures 1 and 2 that the GDS in Wales will be able to deliver more dental care in 2022/23 than they did in the last financial year. Regardless of the level of recovery during 2022/23, with the 'treatment back log' from the pandemic, there will be ongoing need for prioritisation of dental access and care for those who are vulnerable, have dental need and thus will benefit the most over patients who have no dental disease and low risk but request regular 'check-up'.

Additional capacity will need to be created within primary care to meet the oral health and dental care need of the population and also to move towards a system where primary care dental services are able to work with other health and care services locally to ensure proactive, preventive and co-ordinated care.

In 2018, the Welsh Government document 'Oral Health and Dental Services response to A Healthier Wales'[29] argued for a needs-based approach to the provision of NHS dentistry across Wales:

a) Increasing access to new patients with higher needs;
b) Adopting a preventive approach to care for all;
c) Extending the use of 'skill-mix' as part of the Prudent Health agenda; and
d) Prompting patients to attend according to need.

These align well with the WHO resolution on oral health at the 74th World Health Assembly in 2021.[30] The resolution recommends a shift from the traditional curative approach towards a preventive approach that includes promotion of oral health within the family, schools and workplaces, and includes timely, comprehensive and inclusive care within the primary health-care system. The resolution affirms that oral health should be firmly embedded within the non-communicable disease agenda. A recent Lancet publication has also highlighted the need to move from a 'cure' to a 'care' culture, which focuses on prevention over simple interventionist approaches.[31]

In the past, there has been too much focus and reliance on designing a new dental contract to deliver treatments, and unrealistic expectation placed on a new dental contract to improve oral health and reduce demand for dental care. There was no associated planning for prevention from clinical settings or the wider population level to reduce the burden of disease in the population. Previous new dental contract introductions in 1990 and 2006 also did not take account of variation in oral health needs of population in different areas and did not encourage local innovation in service commissioning or service provision.

Proposed primary care dental services reform by Welsh Government to replace the current Units of Dental Activity (UDA) based model is a step in the right direction and an opportunity to create a learning oral health care system in Wales. The prevailing idea that one highly prescriptive dental contract (like the Units of Dental Activity based contract) or a particular service model being suitable for all parts of Wales with different levels of population need, demand and workforce challenges is unrealistic.

b) Community Dental Services

The NHS Wales Community Dental Services provide dental care for the most vulnerable groups in society and deliver key dental public health programmes like Designed to Smile, Gwen Am Byth and the Dental Epidemiology Programme. Community Dental Services' role is well described in a Welsh Health Circular.[32]

The Community Dental Services (CDS) in Wales have been impacted by the COVID19 pandemic and long term workforce and infrastructure issues. Many staff from the CDS,

including Designed to Smile, were redeployed long-term to various COVID19 response roles.

There seems to be variation between health boards in their capacity to meet the dental care needs of vulnerable groups in society. CDS have reported difficulty in recruiting and retaining specialists in special care dentistry. It is important to ensure inequalities do not widen due to lack of capacity within the CDS in Wales. Information systems will need to improve to understand the service need, demand and current provision for different vulnerable groups and workforce needed to provide prevention and dental care for these vulnerable groups in society.

c) Integrated service planning for better oral health

Transformation of primary dental care will need ongoing national and local innovation, evaluation and improvement. Hence, the much talked about new NHS dental contract for dental practices should be the start of transforming primary dental care in Wales, not the end. The new General Dental Services model can have positive or negative impact on the CDS and specialist dental services delivered within primary care or secondary care settings. Integrated dental services planning will be important and information systems with analytical support for primary care teams need to be in place so that impact of the GDS service model on the CDS and specialist services can be monitored.

Although concepts for integrating basic oral health care in wider primary health care exist, they have not gained widespread traction, which further contributes to the challenge of providing access to even preventive basic oral health care to a significant proportion of the population who do not or cannot access dental practices. We have an opportunity to change this in Wales. Prevention of oral diseases needs to be part of the objectives of wider population level prevention strategies and programmes at national and local level. Barriers and enablers for dental services to be part of co-ordinated primary and social care service planning at cluster, pan cluster or wider footprint needs to be explored and barriers removed. Proactive prevention for better oral health should not be seen as just dental services' responsibility and in fact as argued previously, a significant proportion of prevention for better oral health should happen outside dental clinical settings.

d) Evidence based dental care

Dental services transformation should also include improvement in delivery of evidence based dental care within dental services. In terms of prevention, this means

implementation of *Delivering Better Oral Health: an evidence based toolkit* which has recently been updated. Health Education and Improvement Wales (HEIW) delivers a number of continuing professional development (CPD) courses and Quality Improvement support mechanisms to dental teams to support them in implementation of evidence based dental care. There are early signs that fluoride varnish application, an evidence based intervention to protect teeth from tooth decay, is now delivered for most patients attending the GDS across all Health Boards in Wales.

This is also a time to stop delivering unnecessary and ineffective treatments/practice. The following are three examples:

1. Practice of standardised six monthly check-up for everyone has been challenged by NICE guidance for many years in favour of risk and needs based tailored approach for each patient[33] but yet an argument for 6 monthly 'check-up' for all persists. A public survey[34] showed that 66.9% of NHS (and mixed) dental service users reported that they would be happy to be seen less frequently (e.g. every 12 months) if a detailed assessment deemed them to be at low risk of developing dental disease.

2. A UK trial showed overall no clinical benefit of regular 6 monthly or 12 monthly scale and polish (teeth cleaning). [35]

3. The UK National Screening Committee has reviewed screening for oral cancer and oral cancer screening of UK population is not recommended.[36, 37, 38] Hence, oral cancer screening should not be used as a reason for continuation of 6 monthly check-up of all dental patients. The focus should be on re-orientating dental services so that the sub-population with risk factors have easy access to dental and medical assessment for early diagnosis and treatment and also delivery of prevention through clinical settings and referral to available support services like Help Me Quit to address risk factors.

It should be noted that some patients do value long established above practices even when they do not need them. Hence, changes in policy and clinical practices will require ongoing engagement and input from the public and dental patients, and effective communication with the public.

5. Relentless focus on reducing in oral health inequalities is needed

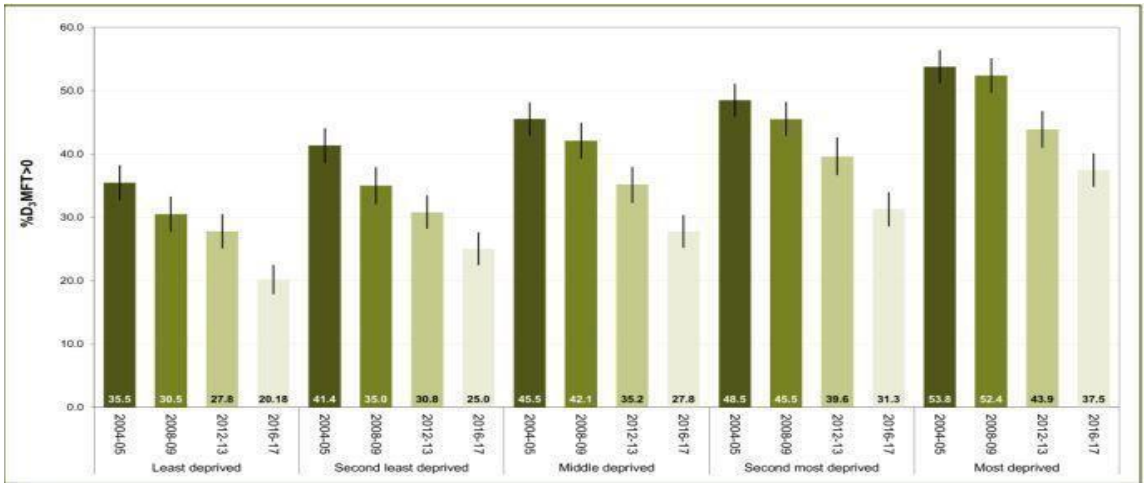
The Socioeconomic Duty, and the Well-being of Future Generations (Wales) Act 2015, both place a requirement on public bodies to take action to enable those facing socio-economic disadvantage to fulfil their potential. Oral health and oral health inequalities should be included in all relevant health and social care policies and programmes at

national level and further at local level during development of implementation plans and delivery.

As mentioned previously there is irrefutable evidence from the dental literature as well as the Dental Epidemiology programme for Wales that oral health inequalities exist with people living in the most deprived areas bearing the largest burden of dental disease.[22, 23] Although dental charges in Wales are much lower than in England, the cost of living crisis is likely to impact on those who just miss out on exemption from NHS dental charges and it may worsen oral health inequalities. It is unknown what proportion of patients who usually use private dental care are now seeking NHS dental care.

An example of the improvements in dental health in children but ongoing high burden of disease across deprivation quintiles and the inequalities present has been demonstrated in Figure 3 below.[3]

Figure 3: Percentage of 12 year old children with decay experience by quintile of deprivation (WIMD) from 2004-2017



Source: Welsh Oral Health Information Unit, Cardiff University

A public survey prior to the COVID19 pandemic shows that self-reported oral health is poorer in deprived areas (Fig 4) where reported sugary and drink consumption (Figure 5), and smoking prevalence is higher[39] while use of regular dental care is lower (Figure 6). 25.9% and 30.9% of adults living in the most deprived and next deprived quintile areas respectively reported that they have not had a dental 'check-up' for more than three years (Figure 6).

Figure 4: Self-reported oral health by deprivation

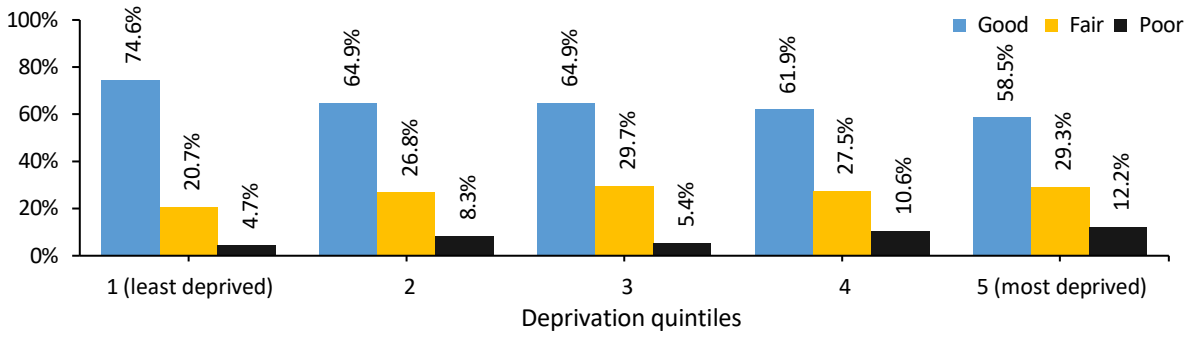


Figure 5: Consumption of sugary foods and drink by deprivation

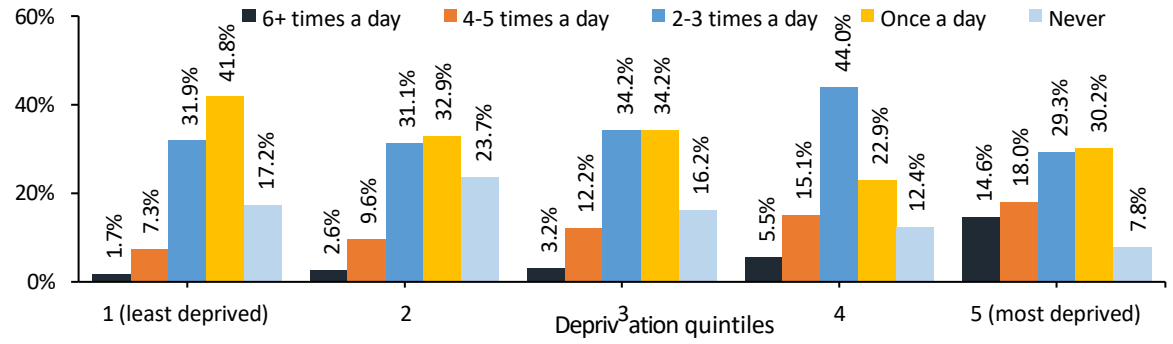
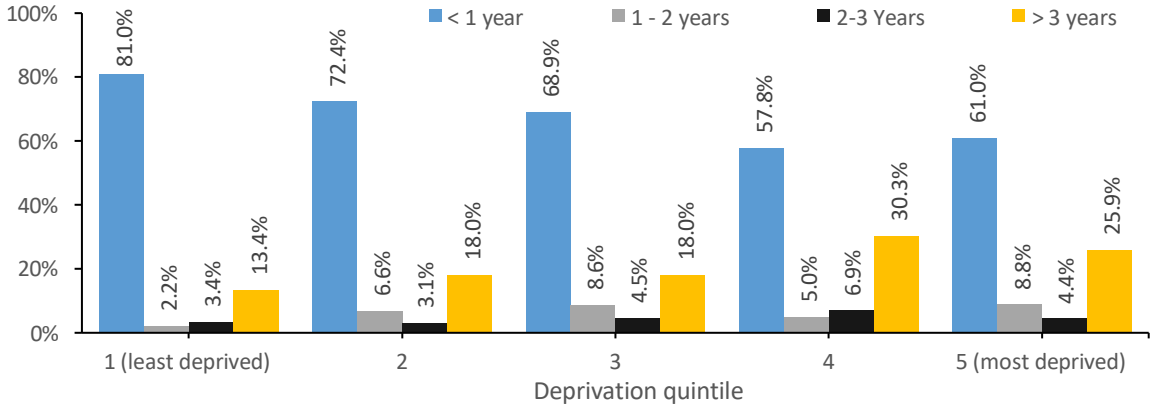


Figure 6: Frequency of routine dental check-ups by deprivation



6. Workforce challenges must be addressed to ensure sustainability of NHS Dentistry

Matching and forecasting the need, demand and supply of healthcare workers are complex activities in any context. It is even more complex following Brexit, the impact of COVID19 pandemic on the dental workforce, and the complexities of dental and wider primary care transformation in Wales. However, dental workforce situational

analysis is needed to 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 impacts of Brexit, the pandemic, ongoing changes in NHS dentistry and career aspirations of current and future workforce.

Implementing workforce strategies in a flexible manner, based on careful monitoring, is key to responding to changing needs and dynamic context. Any dental workforce plan that is linked to oral health and dental service improvement should not be regarded as a "one-off" creation that is not open to adaption and change; rather, it must be tested and revised as and when necessary. Ongoing monitoring of workforce situation is essential to adjust interventions to changing contextual factors.

Oral health of the population has been improving over many decades. Despite this, there remains substantive areas of oral health inequality as highlighted in the previous section. This suggests that developing a needs-based workforce planning model is essential, particularly if the objectives of the Future Generations Act were to be delivered. Innovative incentives and service models may need to be tested to attract different dental team members to work in different areas in Wales.

A recent study suggests that many patients who attended NHS dental practices prior to COVID19 pandemic were assessed as having low risk with no need for dental care.[40] Given this and the lag between the start of training and the provision of supply in the dental profession, it is important to take a needs-based approach to workforce planning in order to increase the level of prevention, provide appropriate service provision and reduce future health inequalities.

Prudent Healthcare argues for the greater use of 'skill-mix'. In NHS Dentistry, this is limited by the legal confines of the current contract, as Dental Therapists and Dental Hygienists are not allowed to open an NHS treatment plan. This is in contrast to the position taken by their regulator (General Dental Council), who allows them to provide examinations and undertake treatment (e.g. Dental Therapists can provide fillings) within their scope of practice. Equally, their current supply is limited.

Future workforce planning that places a focus on prevention, increasing access and the reduction of inequality must account for the potential for expansion of these roles. In 2021, a study showed no difference between dental therapists and dentists in the care of patients within an NHS service context over a 15 month period.[41] This adds to the evidence base for their use.[42], [43] Dental Therapists are also now integrated into the Dental Epidemiological Programme for Wales, where they undertake examinations as part of the oral health surveillance function within Public Health Wales. Their training

time of three years as opposed to five years for a dentist, could dramatically increase supply of workforce in shorter timeframe, increase both the level of prevention and service provision, whilst concomitantly addressing the call from the World Health Organisation.[30]

Overall there is good public support for greater use of skill mix in NHS dentistry in Wales.[33] However, further work is needed because there seems to be a still significant proportion of public who would want their dental care to be exclusively delivered by a dentist.

Table2: NHS (and mixed) dental service users' response to being seen and treated by a trained member of the dental team other than a dentist

	Percentage in agreement
Yes, happy to be seen and treated by a trained dental team member other than a dentist	48%
Yes, happy to be seen and treated by a trained dental team member other than a dentist if they could rebook with a dentist if they were unhappy	20%
No, I would want everything I need to be done by a dentist or Not sure	32%

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Yr Pwyllgor Iechyd a Gofal Cymdeithasol – Health and Social Care Committee

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Baroness Buscombe
Chair
Joint Committee on the Draft Mental Health Bill
UK Parliament

11 October 2022

Dear Peta

Draft Mental Health Bill

Thank you for your letter of 23 September about your Committee's scrutiny of the draft Mental Health Bill ("the draft Bill").

Legislative and policy contexts in Wales and England

Many of the legislative changes proposed in the draft Bill will apply in Wales and in England. The different legislative and policy contexts in respect of mental health in Wales and England will therefore need to be taken into account in the development and scrutiny of the legislation, and in its implementation, to ensure that any changes complement rather than complicate the current legislative and policy framework in Wales. You may be aware, for example, that the Mental Health (Wales) Measure 2010 already makes provision in Wales for some of the proposals set out in the draft Bill, such as advocacy services for people receiving voluntary inpatient treatment and the right to a Care and Treatment Plan.

Ensuring that the legislative and policy contexts in both Wales and England are fully considered and reflected in the Bill and its implementation is particularly important as people who are resident in Wales may receive treatment in England, and vice versa.

Mental health inequalities

One of the aims of the draft Bill is to reduce inequalities experienced under the 1983 Act, including the disproportionate numbers of people from ethnic minority or racialised communities,

neurodivergent people, or people with a learning disability who are detained (or inappropriately detained) under the 1983 Act.

As you note in your letter, we are currently holding an inquiry into mental health inequalities. We expect to report on our inquiry later this year, and will share a copy of our report with you in due course. In the meantime, the annex to this letter highlights some of the issues emerging from our work that may be relevant to your scrutiny of the draft Bill.

Legislative consent

As set out in the Explanatory Notes to the draft Bill, many of the provisions would trigger the legislative consent process as and when any Bill is introduced. It is likely that the subsequent legislative consent memorandum would be referred to us for scrutiny. We will therefore follow your work and the evidence you receive with interest, and would be grateful to receive a copy of your report in due course.

If you would like any further information, please contact the clerk to the Health and Social Care Committee, Helen Finlayson, at seneddhealth@senedd.wales or on 0300 200 6341.

Yours sincerely

Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annex: Mental health inequalities: emerging issues

Our inquiry

Information about our inquiry into mental health inequalities is available on our website at www.senedd.wales/seneddhealth. To inform our work, we have:

- Issued a written call for evidence between 10 January and 24 February 2022.
- Held a series of focus groups during February and March 2022 with people who have lived experience of mental health inequalities.
- Held an informal stakeholder discussion with people with lived experience of neurodiversity on 8 June 2022.
- Visited EYST Cymru and Barnardo's Cymru on 23 June 2022.
- Held a series of focus groups during August 2022 with relevant workforce groups.
- Held oral evidence sessions with key stakeholders on 24 March, 4 May, 19 May, 8 June and 6 July 2022, and with the Deputy Minister for Mental Health and Wellbeing and the Deputy Minister for Social Services on 28 September 2022.
- Established an online advisory group, comprising people with lived experience of mental health inequalities, to provide advice during the final stages of the Committee's inquiry.

Trust in mental health services

Our online advisory group told us that one of the key barriers to improving mental health and tackling mental health inequalities was that people in need of mental health support in an urgent or emergency situation were often dealt with by the police, and might risk being detained under the 1983 Act.

This echoed views raised in focus groups with people with lived experience of mental health inequalities; for example one participant described their fears about the implications of the 1983 Act for Autistic people, noting that it was a barrier that deterred them from seeking mental health support from their GP:

> "Autism is still classed as grounds to be able to section people—when you have a GP who doesn't understand autism and they have that power it's really scary."[1]

[1] Health and Social Care Committee, Mental health inequalities: engagement findings, March 2022

Similarly, the Centre for Mental Health told us that some marginalised or racialised communities may be concerned that seeking mental health support could result in detention:

> "Marginalised young people express fears that health professionals are no different to the police and they won't be safe if they engage. Mental health services need to be actively anti-racist – taking proactive steps to combat and reverse ingrained patterns of oppression and injustice towards racialised communities."[2]

Policing

The Centre for Mental Health told us that people from racialised communities are:

> "…less likely to be referred for mental health support by their GP but more likely to come into contact with services through the police, four times as likely as white people to be sectioned under the Mental Health Act, and ten times more likely be given a community treatment order after they leave hospital".[3]

In oral evidence, the Centre for Mental Health's representative added that different approaches may be taken to policing different groups or communities on the basis of their age or ethnic background. He noted that that detentions under the 1983 Act were increasing, which could exacerbate existing trauma and inequality:

> "…the more we see the use of coercion in the mental health system, the more people are detained under the Mental Health Act 1983, which sadly is rising year after year after year, we know that can do harm long term. It may be necessary to save a life, but potentially those experiences of coercion can reinforce some of those traumatic experiences people have been through, and we know that's used unequally. So, if you are from an African or Caribbean background, you're something like four times more likely than a white person to be subject to the mental health Act, and there's something deeply, deeply wrong about that".[4]

Llamau described an incident in which a number of police officers and several vehicles had responded to a young person who was suicidal, which they said "frightened the young person and didn't help with their mental health crisis".[5] Similarly, Life Warriors, a peer-led therapeutic support group for people with a diagnosis of (or who identify with the characteristics of) 'personality disorder', told us:

[2] MHI 80 Centre for Mental Health

[3] MHI 80 Centre for Mental Health

[4] Health and Social Care Committee, Record of Proceedings [paragraphs 162 and 176], 24 March 2022

[5] MHI 56 Llamau

> "[The police] are most often first responders to someone in mental health crisis, so do need those specialist skills to remain person centred at times where people need help the most. "In moments of crisis, I am vulnerable and frightened, yet I am thrown in the back of a van and treated like a criminal, not explaining where we are or where we are going". "If they understood us, they would be much kinder than they are"."[6]

Other stakeholders also highlighted the need for police forces to have the right training to deal appropriately with people (including children and young people) experiencing mental health issues or crises, including training in mental health awareness and suicide prevention.[7]

Service accessibility and capacity

Professor Keith Lloyd of the Royal College of Psychiatrists outlined the potential consequences if mental health services were not sufficiently accessible or welcoming to people from all communities according to their needs. He also highlighted the interaction between accessibility and broader systemic and structural racism and discrimination:

> "Services are less friendly and welcoming, or appear less friendly and welcoming, to people from some communities than others. Black people of Caribbean and African heritage are all significantly more likely to be compulsorily admitted under the mental health Act than their white British counterparts. And that's multifactorial. It's about when people seek help, it's about whether the services are accessible, it's about perception of risk—there's a whole range of things. There's also a growing body of research to suggest that those who are exposed consistently to systemic racism are more likely to experience mental health problems such as psychosis and depression".[8]

Ashra Khanom of the Neath Port Talbot Black Minority Ethnic Community Association spoke about the experience of people from ethnic minority communities. She highlighted a range of barriers to accessing services, including insufficient capacity or flexibility, a lack of cultural awareness and sensitivity, stigma, fears of medication, inadequate translation services, and a workforce that does not reflect the diversity of Wales' communities, as well as financial barriers relating to travel or childcare.[9]

When asked about the availability of translation services, Professor Lloyd said that improved access to translation services for people in crisis situations would be "one simple measure that could be addressed to help quite a significantly disadvantaged sub-group of people who use our services."[10]

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[6] MHI 17 Life Warriors

[7] For example, MHI 75 DPJ Foundation, MHI35 Barnardo's Cymru

[8] Health and Social Care Committee, Record of Proceedings [paragraph 156], 6 July 2022

[9] Health and Social Care Committee, [Record of Proceedings [paragraphs 218, 233, 271, 311, 322 and 343], 19 May 2022

[10] Health and Social Care Committee, Record of Proceedings [paragraph 157], 6 July 2022

Other stakeholders have called for better mental health awareness and training across public services. For example, Cymorth Cymru said:

> "Someone experiencing homelessness and a mental health crisis may not access mental health services through traditional routes, such as calling their GP. Instead, this crisis may be encountered by other public services such as the police, social workers or housing officers, who may not be trained in how to deal with trauma or mental health crises. People might end up being dismissed due to their homelessness, or being taken into custody if there has been disruption in public places or homelessness services. This can delay or prevent access to the treatment and support that people need for their mental health"[11]

The Wallich described the impact of the pandemic on access to mental health crisis services, and explained that inadequate capacity to support people who are in severe mental distress, or at risk of harming themselves or others, could result situations deteriorating and the police being called. It said that in such circumstances "people in severe mental distress have ended up being detained in a police cell", which it described as "the punishment and criminalisation of people simply for having an acute episode of mental illness".[12]

Availability of data

Mind Cymru said that analysis of the 1983 Act section 135 and 136 dataset suggested that:

> "…in 2020 Black people in Wales were almost three times more likely than White people to be detained by police under section 135 and 136 of the Mental Health Act".[13]

Our predecessor Committee in the Fifth Senedd held an inquiry into mental health in policing and police custody in 2019, which, among other issues, identified concerns about the availability and robustness of equalities data on the operation of the 1983 Act. We recently wrote to the Deputy Minister for Mental Health and Wellbeing to request an update on the Fifth Senedd Committee's recommendations, in particular how the Welsh Government's work to implement the recommendations is contributing to tackling mental health inequalities. We will be happy to share the Deputy Minister's response with you when it is available.

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[11] MHI 89 Cymorth Cymru

[12] MHI 60 The Wallich

[13] MHI 47 Mind Cymru

professional standards authority

BY E-MAIL

Russell George MS
Chair, Health and Social Care Committee

7 October 2022

Dear Mr George,

We are writing to share with you the Professional Standards Authority's new report *Safer care for all – solutions from professional regulation and beyond*. The findings and recommendations within the report are very relevant to the ongoing work of the Health and Social Care Committee.

The report describes 'a fragmented and complex' patient and service user safety system. It highlights some of the biggest challenges affecting the quality and safety of health and social care across the UK today through the lens of professional regulation. It puts forward our recommendations, along with a call to action and commitment by the Authority to work together with all stakeholders on solutions towards safer care for all. The report covers four key themes:

1. Tackling inequalities
2. Regulating for new risks
3. Facing up to the workforce crisis
4. Accountability, fear and public safety.

The findings and recommendations of the report align with current areas of focus by the Committee, in particular the areas of health inequalities and the health and social care workforce. The report provides recommendations on how policy change can allow professional regulation to be part of the solution to these challenges.

The main recommendation in the report is the appointment of an independent Health and Social Care Safety Commissioner (or equivalent) for each UK country. These commissioners would identify current, emerging, and potential risks across the whole health and social care system, and bring about the necessary action across organisations. They would also coordinate public inquiries and reviews and monitor how recommendations are implemented. This would build on the recommendation from the Cumberlege Review for a Patient Safety Commissioner for medicines and medical devices. We are committed to working alongside the Committee and the Senedd should the decision be taken to bring forward legislation to create this role for Wales.

The Professional Standards Authority for Health and Social Care
157-197 Buckingham Palace Road, London SW1W 9SP
T 020 7389 8030 www.professionalstandards.org.uk

In its twentieth year, the Authority is publishing this report as a call to action for us all to work together to address some of the major outstanding safety concerns for health and social care. We know that not everyone will agree with our recommendations, but we want to work with patients and services users, regulators, registers, professional and representative organisations, governments, and all stakeholders across health and social care to tackle the big issues we describe in the report.

You can find all the resources related to the report on our dedicated *Safer care for all* web page.

We hope that you find our report of interest. We would very much welcome the opportunity to meet with you to discuss our recommendations and how these align with the work of the Committee and your own personal areas of interest.

Yours sincerely,

Alan Clamp
Chief Executive

Caroline Corby
Chair

cc. Sarah Beasley, Committee Clerk

Agenda Item 7

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Agenda Item 8

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