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

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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%.

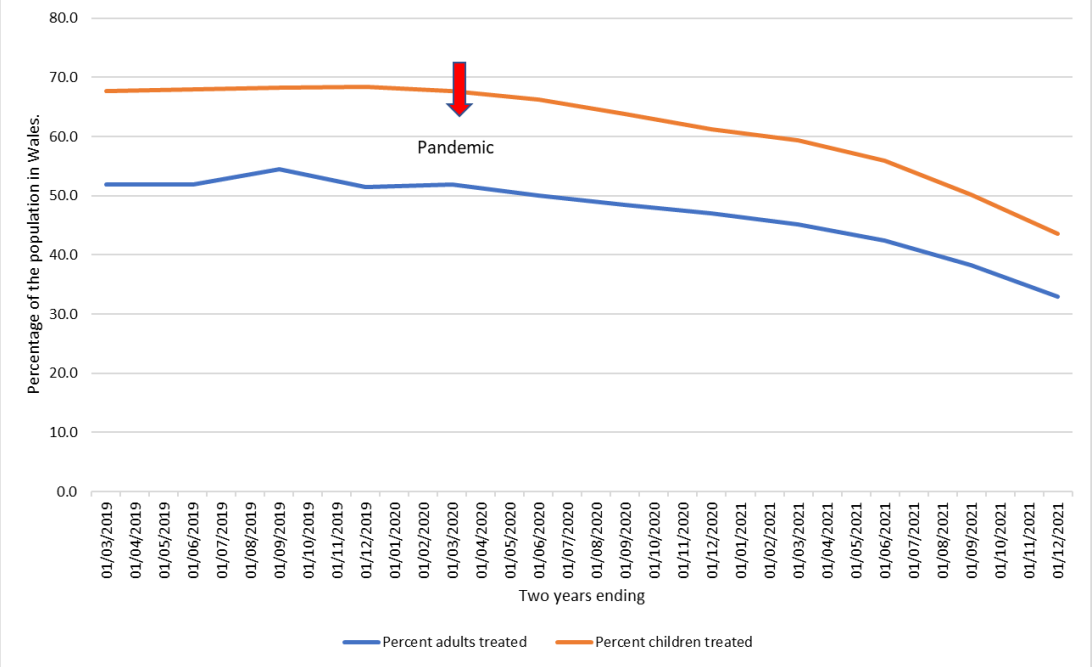

Figure 1 The percentage of adults and children treated under an NHS General Dental Service contract in the preceding two years (STATS Wales 2022).

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.

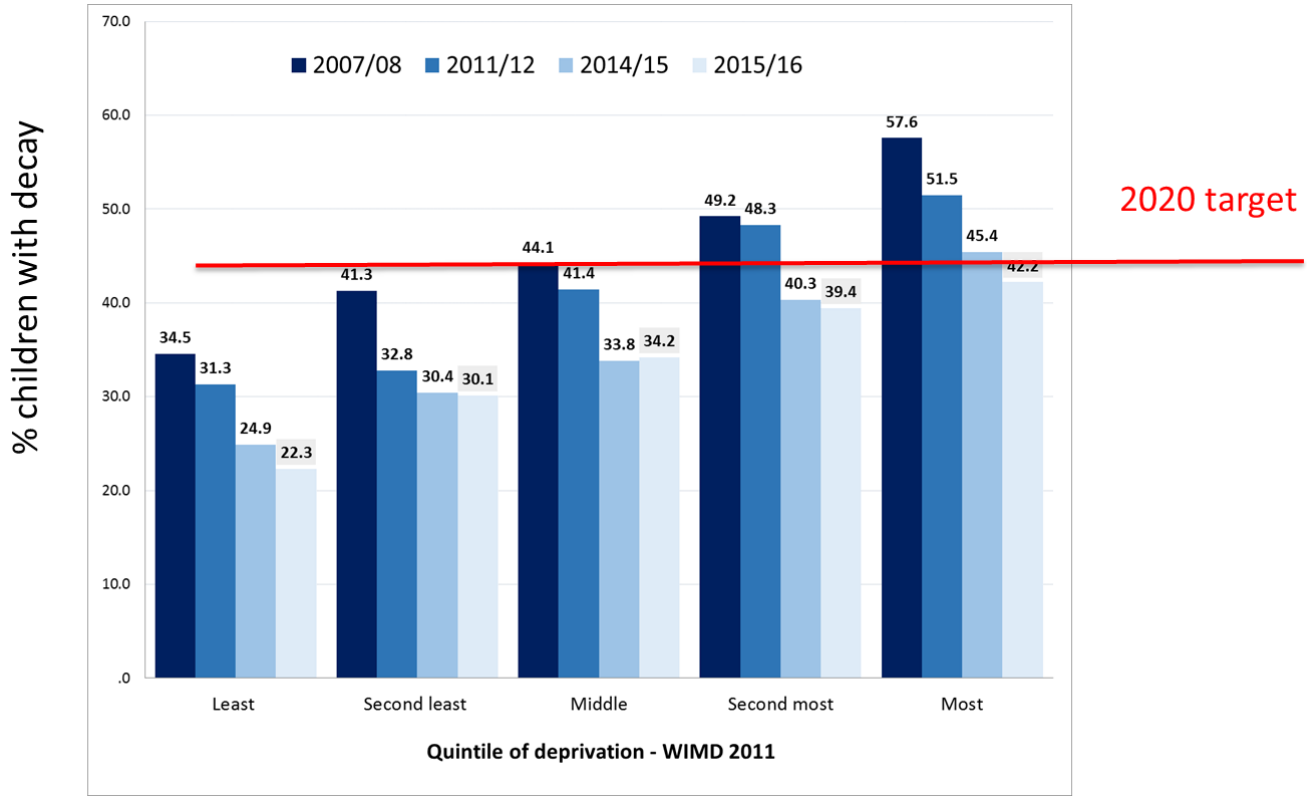

Figure 2 Changes in the prevalence of dental decay in 5 year olds in Wales 2007 – 2016 by quintile of deprivation.

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.