The British Association of Dental Therapists

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.

Access continues to be an issue, particularly in areas of dental manpower shortages. The backlog is due to the pandemic, and those patients we are now seeing have additional care needs. For example, patients that would have been seen routinely with very little need for treatment now require care for gum disease, treatment of new caries, repair of existing dental treatment etc. These are more complex due to the delay of treatment, meaning longer and more appointments than pre-pandemic.

There has been a change in the working pattern of dental hygienists and therapists, with more part-time working and a change in roles, some are doing less clinical work on the whole.

Dental Therapists can help address this issue; however, the pay and conditions need to be favourable in order to tempt them out of private practice….this is not necessarily a monetary reward e.g. indemnity, favourable working conditions, NHS benefits including pensions, study leave, etc.

There is a long waiting list for GA extractions, some of which could be addressed using inhalation sedation, a very simple and safe method of treating children and adults, however, there are not many contracts that are available to deliver this kind of treatment.

The use of "Hall Crowns" is an evidenced-based method of treating childhood dental disease in primary teeth, but the contract does not make this option financially viable, each crown costs approx. £5.50 but only attracts and band 2 payment (3 UDAs)

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.

Is there a sense that patients don't need reassurance, from experience, patients are generally happy to attend appointments, and access to care is the issue.

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

For DCPs in particular dental hygienists and dental therapists working in the NHS is less lucrative than that of private or independent practice, however dental therapists, in particular, are willing to work in the NHS. As they are sub-contractors, despite delivering NHS care they are not eligible for the same NHS benefits that NHS dentists are. Many would work in NHS practice earning less than a "private dental hygienist" if these benefits were available.

We have evidence of their willingness to work within the NHS.

The recruitment and retention of overseas dentists, at present the system is slow and involves multiple stakeholders.

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.

It is clear that prevention is the only way to be able to maintain an NHS dental service as health inequalities grow those that suffer from the dental disease have a greater amount of disease. Prevention of dental disease needs to be imbedded into every health care provider as oral health is part of general health (diabetes, cardiovascular disease, Alzheimer's disease, and poor pregnancy outcomes). Interprofessional education with all health professionals especially midwives, health visitors, and social services. GMP practices should also be aware of high-risk patients and provide advice and direction on dental health.

NHS dentistry should care for those in greatest need first (Prudent Healthcare) and low-risk patients should be made aware that the traditional 6-month appointments are not necessary. The system reform is addressing this, but patients need to understand this and that their oral health is their responsibility, and that dental disease is a preventable disease.

Allowing dental hygienists and dental therapists to open courses of treatment could enable the delivery of dental prevention as well as the use of dental nurses to provide fluoride application and preventative advice. Training and education need to be in place to allow this to happen and those using extended duties should be renumerated for it, it is not fair to expect DCPs to take on additional duties and responsibilities without it being reflected in their remuneration.

The exemption project for PoMs needs to be pushed forwards as has been a project since 2014

The scope for further expansion of the Community Dental Service.

The CDS has the same recruitment and retention issues as the GDS training more dental therapists in Wales can help address this issue, in 6 years to train one dentist you can train 2 dental therapists.

The suggestion of mobile dental units in schools using dental therapists to allow access to dental care for school children is favourable, but needs resources.

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

In general dental practices are owned dentists or corporate bodies and not dental hygienists and dental therapists and as such dental hygienists and dental therapists are not able to influence this or able to give an opinion.

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

The cost-of-living crisis may affect the ability to pay for private/independent treatment which will put more pressure on the NHS however this will be on an individual/location basis.