Evidence to the Sixth Senedd Health and Social Care Committee inquiry - Dentistry

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.

This evidence is submitted by Welsh Government at the request of the Health and Social Care Committee in advance of the oral hearing on 17th November 2022.

Key points

1. The burden of oral disease remains high in the population, despite being predominantly non-communicable and preventable. The primary oral diseases are tooth decay (caries) and gum disease (periodontitis).
2. Tooth decay has a considerable impact upon NHS health services, despite being largely preventable. It affects people at all stages of life and is the most common oral disease in children. Dental health surveys conducted across the UK have demonstrated a strong association between socio-economic deprivation and poor dental health[1].
3. Oral health can be prevented through a combination of dietary modification (reduction in sugar, alcohol, and tobacco consumption), regular toothbrushing with a fluoride-containing toothpaste, and guidance from dental professionals.
4. The oral health of the population cannot be improved through dental services alone, as prevention of oral diseases needs to be integral to population level prevention strategies and programmes, both at national and local level.
5. Evidence from observational and interventional studies shows that appropriate levels of supplemental fluoride can reduce the prevalence and severity of decay in both adults and children. Daily supervised tooth brushing schemes in early years and primary school settings are proving effective at reducing tooth decay and modifying health behaviour at a population level. Professional application of fluoride varnish to the teeth of high-risk child and adult patients can be of additional benefit. Population oral health improvement programmes (eg; Designed to Smile) are important to stop widening of oral health inequalities.
6. COVID19 impacted the delivery of dental care, which is still in a recovery phase. The impact is multi-factorial and far-reaching, affecting access to services, patient flow, workforce supply, health-seeking behaviour, increase in demand for urgent and emergency services and staff well-being. Long-term concerns regarding business sustainability and system resilience are emerging.
7. System reform in dentistry is the medium-term vision to transformation oral health services by delivering prevention and scaled up population health improvement. The Reform Programme acknowledges the need to implement a new dental contract for the contracted General Dental Services (GDS) that moves away from measuring treatment provided (the basis of the Unit of Dental Activity) towards a needs- and risk-based population outcome[2].
8. Contract reform underpins the wider ambition of system reform. Expansion and support for the Community Dental Services (CDS) is essential to address the oral health need of vulnerable and marginalised groups.
9. System reform aims to remove barriers to skill mix use within NHS dental teams, which includes expansion of access to training, enhanced skill acquisition and career development.

Evidence

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.**

   1.1. NHS dental services were probably the most impacted primary care service during the pandemic because a high proportion of operative dentistry involves aerosol generating procedures. Strict infection prevention and control measures were implemented to reduce the risk of transmission within dental settings, both to protect patients and staff.

   1.2. Dental practices did not close during the pandemic, but the enhanced infection control requirements, physical distancing, and enhanced PPE resulted in fewer people being able to access care.

   1.3. Dental services were provided with a £3m investment in 2021/22 and an additional recurrent £2m funding from 2022, targeted at GDS and CDS.

   1.4. 2021/22 was viewed as a reset and recovery year where dental teams were asked to focus on prioritising urgent care, dealing with the needs of vulnerable groups, addressing the backlog of treatment resulting from the scaling back of dental services, interspersed with the reintroduction of routine with routine care.

   1.5. Between 2020/2, 980,201 patients (30.9% of the total population) received dental care, representing 732,000 adults (28.8% of the adult population) and 250,000 children (39.4% of the child population). However. in 2021-22, 1.1 million courses of treatment were recorded, which is an increase of 92.5% from 2020/21[3].

   1.6. Band 1 treatments were the most common treatment band, accounting for just under half (461,494) of all courses of treatment. Just over a fifth of all treatments (or 230,106 treatments) were urgent/emergency cases.

   1.7. Just under 624,000 examinations were recorded in 2021/22, which was more than double (up 114.4%) than in 2020-21 but 59.6% lower than pre-pandemic levels.

   1.8. A larger than usual proportion of Band 2 claims (and lower than usual proportion of Band 1 claims) during 2021/22, indicating a prioritisation of high needs patients.

   1.9. The number of orthodontic treatments, radiographs and 'other treatments' for children have returned to pre-pandemic levels

   1.10. Comparison of activity data during 20/21 and 21/22 to pre-pandemic year 19/20 highlights the significant 'treatment back log' in GDS. A similar situation exists in other UK countries. Activity data predicts that the GDS will continue to recover and deliver additional capacity in 2022/23. However, the residual treatment back log as a direct result of the pandemic, indicates a need to continue prioritisation of dental access and care to the most vulnerable, high risk, urgent case, and children over those with no dental disease and low risk, but seek a regular 'check-up'.

   1.11. Additional capacity will need to be created within primary care to meet the oral health and dental needs of the population, as well as using the reform programme changes to allow primary care dental services to work with other health and care services locally to ensure proactive, preventive, and co-ordinated care. It is an

ambition of the reform programme to align dentistry within the Accelerated Cluster Development system.

1.12. The reform programme aligns to the Welsh Government document 'Oral Health and Dental Services response to A Healthier Wales' (2018), delivering a needs-based approach to the provision of NHS dentistry across Wales, which will:

- Increase access to new patients with higher needs
- Adopt a preventive approach to care for all
- Extend the use of 'skill-mix' as part of the Prudent Health agenda
- Prompt patients to attend according to need.

1.13. Previous dental contracts (1990 and 2006) did not address variations in population oral health needs. The contracts did not enable local innovation within service commissioning, which is being addressed within the reform programme. It is proposed to replace the current Units of Dental Activity (UDA) activity model with a needs-based funding system. A prototype was trialled during the pandemic and being adapted within the current contract variation, pending necessary legislative changes.

1.14. The impact of the pandemic on access to primary care dentistry is illustrated in Figure 1 (children) and Figure 2 (adults) with signs of recovery in the latter months.

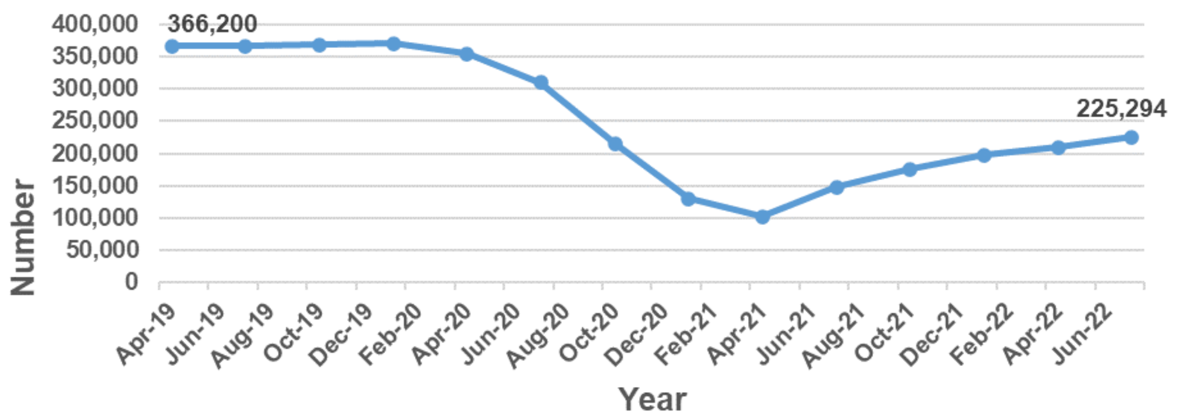

Figure 1: Number of children who received NHS dental care in the previous 12 months up to and including the month shown

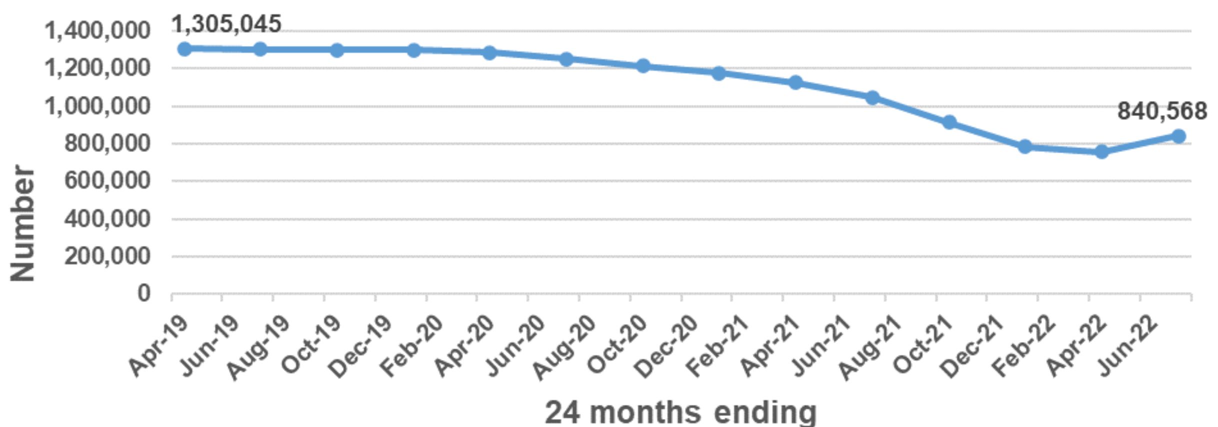

Figure 2: Number of adults who received NHS dental care in the previous 24 months up to and including the month shown

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.**

    2.1. Welsh Government works collaboratively with other agencies such as Healthcare Inspectorate Wales (HIW), NHS Wales Shared Services Partnership (NWSSP) Primary Care Services, General Dental Council (GDC), NHS Business Services Authority (NHSBSA), Community Health Councils (CHC) and Health Education and Improvement Wales (HEIW) to share information relating to quality and safety assurance in dentistry.

    2.2. Dental practices are inspected by HIW. HIW provides the public with independent and objective assurance of the quality, safety and effectiveness of healthcare services and makes recommendations to healthcare organisations to promote improvements.

    2.3. Practices have adapted the clinical environment to ensure patient and staff safety.

    2.4. Activity evidence indicates patients have returned to dental practices, although at the current time the on-going restrictions have reduced capacity and patients are having to wait for an appointment.

    2.5. Guidance has been offered to practices, included within the GDS contract variation 2022/23, and promoted through a public media campaign in July 2022, that is aimed to discontinue unnecessary and ineffective treatments. This has been targeted at three areas:

    - Extension of the recall interval for healthy, low risk patients. The practice of standardised six-month recall 'check-ups' was disputed NICE in 2004. A Cochrane Systematic Review concluded that "there is no evidence to support or refute the practice of encouraging patients to attend for dental check-ups at six-monthly intervals"[4]. Other well-designed studies have indicated that "the evidence for using a one-recall-interval-fits-all protocol to reduce caries incidence was weak. Studies that addressed the impact of recall interval on caries incidence were methodologically weak. The evidence was not strong enough to support using any specific one-recall-interval-fits-all protocol for all patients"[5]. This message has been used in public media communications.
    - A UK trial showed overall no clinical benefit of regular 6 monthly or 12 monthly scale and polish (teeth cleaning).
    - The UK National Screening Committee has reviewed screening for oral cancer and oral cancer screening of UK population is not recommended. Oral cancer screening cannot be used to justify 6 monthly check-up in low-risk patients. Dentists are encouraged to provide focussed interventional advice regarding the health risks of smoking and excessive alcohol usage, with signposting to prevention programmes.

    2.6. It is acknowledged that some patients appreciate the recall appointments, even when not indicated. Further changes in policy and clinical practices will require continuous engagement between patients and dental professionals.

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

   3.1. The number of dentists with NHS activity has increased slightly every year since comparable data was collected in 2006-07 until 2018-19. Small decreases occurred in 2019-20 and 2020-21 but the number increased in 2021-22.

   3.2. 1,420 dentists with NHS activity were recorded in Wales in 2021-22. This equates to 2,232 people per dentist with NHS activity.

   3.3. In 2020-21, 132 dentists (9.5% of all dentists) stopped performing NHS work, compared to 123 dentists (8.9%) newly performing NHS work.

   3.4. Implementing workforce strategies in a flexible manner, based on careful monitoring, is key to responding to changing population needs. Dental workforce planning that links oral health and service improvement should not be regarded as a "one-off" creation, but capable of adaption and change. This is the basis of the current reform programme.

   3.5. The dental reform programme has outlined the intention to develop skill mix within dental teams, reflecting the valuable contribution made by dental nurses, hygienists, and therapists. Workforce planning must be more ambitious than expansion of dentist numbers.

   3.6. International recruitment has been impacted by Brexit and the pandemic. The imminent Section 60 Order changes within the General Dental Council international registration proposal (*The Dentists, Dental Care Professionals, Nurses, Nursing Associates and Midwives (International Registrations) Order 2022*) could support the recruitment of international graduates into rural areas of dental access need. The draft Order will provide the GDC with flexibility to apply a range of assessment options in determining whether an international DCP applicant has the necessary knowledge, skills, and experience for practice in the UK.

   3.7. Salaried primary care posts are being developed in GDS. This has been launched in BCUHB and offers an innovative job plan, comprising GDS in high needs area combined with upskilling opportunities in CDS or secondary care.

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:

   4.1. Designed to Smile (D2S) is a national programme, which follows public health principles of proportionate universalism[6]. It is based on delivering approaches recommended in NICE guidance[7]

   4.2. D2S comprises a universal preventative programme for children from birth, integrated within the Healthy Child Wales Programme and a targeted 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.

4.3. The aims are to start good habits early, by giving advice to families with young children and encouraging regular attendance to a dental practice. This element of D2S is aligned to the Healthy Child Wales programme and its approach to provision of universal and enhanced support. Children requiring enhanced support are supplied with toothbrushing home packs and feeder cups. All primary schools in Wales are encouraged to participate in the Welsh Network of Healthy Schools, and within that, incorporate good practice for healthy behaviours as part of a 'whole-school' approach. This includes healthy eating for oral health and oral hygiene, and policies on food and drink provision within the setting. D2S works closely with Healthy Schools Co-ordinators and the Nutrition Skills for Life programme. D2S teaching resources are universally available on Hwb (https://hwb.gov.wales/) to support teaching professionals providing oral health education and raising awareness of the importance of oral health.

4.4. D2S delivers a targeted 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. Toothbrushing home packs are also supplied to encourage good habits at home. These aspects of D2S are targeted to more disadvantaged areas of Wales, with approximately 70% of nurseries and schools invited to participate. Children up to and including Year 2 (6–7-year-olds) are included. Additionally, all nurseries with Flying Start status, and all schools with Additional Learning Needs provision are invited to participate

4.5. The aim of D2S in academic year 2021-22 was to restart activity as much as possible following the pause during the Covid-19 pandemic. With substantial challenges and uncertainty, it was widely accepted that it would be very difficult to immediately return to the activity levels that had been reached over a 10-year period prior to the pandemic.

4.6. The year's activity was hampered by the continued re-deployment of staff and vehicles into 2022, and the challenges and disruptions posed by the Omicron variant of Covid-19 on educational settings, and staff and child absences. Additionally, there were a substantial number of staff vacancies accrued over the previous two years that required addressing amidst a reduced pool of applicants and NHS recruitment process backlogs. Demotivation and poor well-being because of repeated redeployment were substantial issues.

4.7. The programme also suffered from stock shortages also seen in other sectors, and particularly a national shortage of the licensed fluoride varnish in the Spring term. Aside from the pandemic, the consequences of the devastating floods of early 2020 which destroyed a work base and several D2S vehicles were still being overcome in Cardiff and Vale University Health Board.

4.8. The academic year 2021-2022 began with D2S staff training and updating of protocols and resources. Staff were very flexible, implementing smart working using skill mix where possible.

4.9. Prioritisation of settings was implemented. Relationships with settings had to begin afresh, and training and consent processes started anew in a more time-consuming way than the roll-over between academic years previously. This impacted the speed of restarting in settings. There was a mixed response from settings: some enthusiastically embraced the restart of D2S and recognised the value of oral health

improvement and the return to establishing routines to build on life skills. There was resistance in some settings, particularly to the toothbrushing programme. Most of these were positive about commencing toothbrushing during the 2022-2023 year.

4.10. Table 1 demonstrates the need for continued support to enable Designed to Smile to return to previous activity levels, and the size of the expansion possible, based on the coverage of the programme in 2018-2019.

	Academic year: 2018/19 (pre-pandemic)	**Academic year: 2021/22**
No. of nurseries and schools participating in toothbrushing	1,396	**317**
% of eligible nurseries/schools that are participating in toothbrushing	82%	**20%**
No. of children toothbrushing at nursery/school	90,602	**15,350**
No. of targeted settings refusing to participate in toothbrushing	137	**389**
No. of nursery/school staff receiving toothbrushing training	4,436	**2,142**
No. of toothbrushing home-packs distributed to nurseries and schools	188,709	**171,465**
No. of children receiving fluoride varnish at school	44,217	**17,744**
No. of toothbrushing home packs distributed by health visitors	16,390	**19,510**
No of feeder cups distributed by health visitors	8,286	**7,726**
Whole time equivalent workforce employed to deliver Designed to Smile within NHS Wales	82.5	**88.7**
Programme expenditure within NHS Wales	£3,767,416	**£3,265,155**

Table 1: Summary of D2S activity in 2021/22 and 2018/19

4.11. Settings participating in D2S are provided with toothbrushing home packs to distribute to their attending children, twice a year. This is to encourage healthy habits for brushing at home. Throughout the pandemic, efforts were made to continue this intervention, and in the 2021-2022 academic year, home packs were provided to eligible settings, even if they were not yet participating in either the supervised toothbrushing or fluoride varnish programmes. Table 2 details the distribution of home packs to 784 nurseries and 830 schools, and the total number of home packs distributed to these settings. The number of packs provided to each setting is based on the number of children attending, and so an estimate of number of children receiving home packs is reported.

	No. of nurseries receiving toothbrushing home packs	No. of schools receiving toothbrushing home packs	Total no. of home packs distributed to settings	Estimated no. of children receiving home packs from the setting
Wales Total	**784**	**830**	**171,465**	**95,623**
ABUHB	109	129	35,592	19,507
BCUHB	226	205	35,348	18,014
CAVUHB	75	87	22,237	13,054
CTMUHB	140	139	38,856	17,499
HDUHB	116	121	12,720	8,692
PTHB	44	37	5,008	2,503
SBUHB	74	112	21,704	16,354

Table 2: Number of toothbrushing home packs distributed to nurseries and schools

Gwên am Byth

4.12. Gwên Am Byth is the national oral health improvement programme delivered by the Community Dental Services in Wales with the primary aim of improving oral health and hygiene for older people living in care homes. It is underpinned by Welsh Health Circular 2015/001: https://gov.wales/sites/default/files/publications/2019-07/improving-oral-health-for-older-people-living-in-care-homes-in-wales.pdf

4.13. Gwên Am Byth was significantly impacted during the COVID19 pandemic as significant numbers of staff were redeployed to other roles to support the NHS. When Gwên Am Byth work has been possible, it has been apparent how changes within the care home environment have affected the ability to rebound from the pandemic. These changes include the considerable turnover of care home staff and care home management, as well as closures of care homes, which have meant restarting afresh in many circumstances, with a loss of organisational memory and established working relationships.

4.14. Covid-19 outbreaks and changing restrictions caused substantial cancellation and rescheduling of work. Whilst virtual engagement has been possible in some situations, it wasn't without challenges and for many, both teaching and learning, it was not a replacement to face-face oral healthcare education.

4.15. There has been very positive re-engagement and feedback from care home staff about restarting the Gwên Am Byth programme, as the teaching and the interventions are highly valued in importance. Activity data for this reporting period is provided in Table 3.

4.16. In December 2019, Welsh Government announced that Gwên Am Byth would receive a doubling of funding across the seven Local Health Boards. The funding was increased to £0.5 million a year to ensure the programme is rolled out fully to all care homes in Wales during 2020/21. This funding uplift has resulted in an increase in workforce allocated to support the programme.

Table 3 Participation of homes	1st April 2021 to 31st March 2022							
Health Board	BCUHB	CTMUHB	HDUHB	PTHB	SBUHB	ABUHB	CAVUHB	**All Wales total**
Total number of homes in HB	**185**	**67**	**93**	**30**	**83**	**89**	**63**	**610~**
Number of homes targeted for the programme	**137**	**67**	**93**	**25**	**83**	**89**	**63**	**557**
Number of care homes participating fully in the programme	77	32	26	1	78	71	14	299
Participating partly in the programme	50	32	31	6	5	10	36	170
Care Home has requested training only	1	0	28	0	0	0	0	29
Number of homes not participating	**57**	**3**	**8**	**23**	**0**	**8***	**13**	**112**
Number of homes with an up to date mouth care policy	73	54	35	14	78	89	38	381
Number of homes who can identify their local dental services	92	54	40	30	78	89	38	421
Number of homes that have had an external inspection highlighting good / excellent mouth care	0	0	4	0	2	1	0	7
Number of homes that have had an external inspection highlighting inadequate mouth care	0	0	0	0	2	0	0	2

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

5.1 The Community Dental Services (CDS) Welsh Health Circular [WHC(2022)022] has replaced WHC(2019)021. This provides updated guidance on the role of the community service, outlining an expected expansion of salaried dental officer posts to support local communities who have limited or no access to general dental services.

5.2 The requirements for CDS, laid out in the WHC, are:

- Expectation to develop a wider range of routine and specialist services (level 2 and 3), which shouldn't be limited to the existing special care and paediatric dentistry services.
- Expansion of salaried GDP roles
- Ensure a satisfactory infrastructure and range of equipment
- Continue to develop a robust IT infrastructure. Work currently being undertaken with the NHSBSA to identify the significant data collection issues that impact the quality of activity data.
- Become an exemplar of best practice in dental skill mixing, utilising the wide range of staff currently working within the CDS and share this learning with the GDS within the Dental Reform programme design
- Continue to expand the staffing level of Dental Therapists, including scoping opportunities for employing Foundation Therapists on the HEIW programme
- Maximise the skill use of dental nurses, including extended role
- Support the Public Health function at HB level
- Continue to work closely with HEIW to expand training with the community setting, scope opportunities to host undergraduate dental students on outreach programmes
- Maximum clinical chair capacity and utilisation.

5.3 Early planning for CDS to support schools-based oral health programmes for 12–17-year-old children

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

6.1 Funding for NHS dentistry has increased year on year as shown in the table below. Annual increases have been applied in line with recommendations from the Doctors' and Dentists' Review Body along with periodic additional allocations to target specific

challenges or to fund innovation projects. For example, recurrent funding of £2m has been provided from 2022-23 for health boards to support patient access initiatives. This funding has been used in a variety of ways by health boards including expanding CDS provision and to commission new GDS contracts.

Year	2018-19	2019-20	2020-21	2021-22	2022-23
Overall Dental Funding (£m)	140.278	142.184	146.282	150.947	158.538

6.1 During the Covid-19 pandemic Welsh Government supported dental practices in several ways:

- PPE was provided free of charge to NHS dental practices throughout the pandemic and will continue until March 2023.
- £450,000 was provided to enable practices to install ventilation systems that increased the number of air changes therefore enabling a greater throughput of patients.
- Practices were supported financially with 80% contract value paid during the red alert period, increasing to 90% during the amber phase of recovery and providing the practice was gradually increasing their levels of activity and range of services
- For all of 2020-21 and 2021-22 UDA targets were suspended though new activity metrics aligned to the principles of dental reform were introduced in 2021-22. This enabled practices to focus on treating patient needs rather than meeting targets and providing activity levels were appropriate contracts returned to 100% funding.
- Recognising the challenges practices and their staff faced during these two years financial sanctions were effectively removed, except for a very limited sanction in 2021-22 if fluoride varnish application levels were not achieved.

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

7.1. No data currently available. However, as financial health is a measurable social determinant of overall health, it is anticipated that asylum seekers, refugees and low-income families with children will experience the greatest impact[8].

7.2. Cost of living crises impacts on expendable income, which influences spending on healthcare. This impacts all socio-economic groups, leading to avoidance of dental care due to affordability issues. Evidence suggests this is greatest in people from lower socio-economic groups (D-E), ethnic minority communities, those over 55 and living in specific geographies. The Lancet Commission stressed ‘an absence of affordability is a major barrier to dental care’ and has recommended abolition of patients’ co-payments to access and receive dental care[9].

7.3. Financial hardship restricts spending on essential items, including toothbrushes and toothpaste, which are being made available through foodbanks. This underlines the value within the Designed To Smile programme, which distributed over 171000 toothbrush packs to children in 2021.

7.4. Economic decision factors, such as food price and income, influence people's food choices. Food costs are a barrier for low income-families to choose healthier foods, which have the potential to impact on oral health.

7.5. There is potential impact on dental practices and their teams, which will face amplified business costs due to rising energy prices and general costs of living.

Summary

1. The dental reform programme has identified three key areas for transformation of NHS services: a step-up in prevention; developing services that are fit for future generations; and developing dental teams and networks. The programme has adopted a continual improvement model, underpinned by evidence-based prevention and treatment.

2. Addressing common risk factors for oral health and non-communicable diseases through policy, professional engagement, and public messaging, is needed to improve oral health.

3. Population health programmes are critical to prevent further widening of oral health inequalities. This requires improving access to dental provision, both on an urgent and routine basis, monitored through population health improvement.

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

5. Despite the oral health of the population improving, the effect of the pandemic has impacted on this improvement and widened oral health inequality. Adopting a needs-based workforce planning model, based on local data, is necessary to meet the objectives within the Well-being of Future Generations Act. This is a medium-term ambition.

6. A programme of reform within primary care is addressing the issues raised in the 5th Senedd health, social care, and sport committee's report (2019). In particular, this aims to:

    - Replace the current Unit of Dental Activity targets with a new, more appropriate, and more flexible system for monitoring outcomes to include a focus on prevention and quality of treatment
    - Work with the profession and Health Boards to address the issue of money recovered through under-delivery of the contract value ('clawback')
    - Work with HEIW towards a range of strategies to increase the recruitment of Welsh domiciled and increase levels of retention of students training in Wales, as well as attracting qualified practitioners into Wales
    - Monitor the delivery of the Designed to Smile programme, which now includes up to Year 2. This is supporting the adoption of fluoride varnish applications to children over the age of 3 years when attending for their dental check.
    - Build on existing oral health improvement programmes to address and improve the oral health of older children and young teenagers in Wales.

7. The reform programme will support the further development of the CDS.

8. Prudent Healthcare argues for the greater use of 'skill-mix'. There is public support for greater use of skill mix in NHS dentistry in Wales[10].· In NHS Dentistry, this is restricted the legal confines of the current contract, as Dental Therapists and Dental Hygienists are not allowed to open a course of treatment without a dentist's approval. This contrasts with the GDC position, which permits Therapists to perform a wide range of procedures within scope of practice. Work is being undertaken to address this issue, expand the Therapist network and increase the number entering training[11].

9. Interventions aimed at reducing oral health interdisciplinary knowledge barriers should be implemented to improve holistic patient care[12].

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