Health & Social Care Committee

Date: Thursday 21 November 2013

Venue: National Assembly for Wales

Title: Access to NHS dentistry

Purpose

1. The Health and Social Care has been discussing its forward work plan for the Spring term and identified access to NHS dentistry as a possible area for conducting a future inquiry.

2. The Committee has requested an evidence paper on the issues for its general scrutiny session on 21 November, to be attended by the Chief Dental Officer David Thomas.

Background

3. In looking at the challenges regarding access and the changes made to the dental system, it is important to remember the level of change there has been in dental need and demand since the NHS dental service began in 1948. In the immediate post war years NHS dentistry served a nation with generally poor oral health, large amounts of untreated decay and therefore with extensive treatment requirements. A large proportion of the adult population were toothless (edentate). As recently as 1973, 40% of the population had no natural teeth.

4. The NHS dental system set up in 1948 reflected a world where those with teeth typically needed complex treatment for extensive decay and those without required full dentures. From the early 1970s onwards developments in dental care and particularly the spread in the use of fluoride toothpaste has meant that an ever-increasing proportion of adults retain their teeth into old age. The latest Adult Dental Health Survey (ADHS) published in 2011 found that only 10% of the adult population in Wales were edentate. The majority of these were aged 75 and over. Decay rates had fallen in all groups (although there remains a marked gap between socio economic groups – Annex 1 Table A).

5. Over the past two decades or so patients' focus has moved from simply ensuring their teeth are healthy and pain-free to an ever-stronger desire that they should also be cosmetically pleasing. This presents new challenges about where the boundaries should lie between clinically needed treatment—available for all who want it from the NHS - and purely cosmetic treatment, which most would agree need not necessarily be delivered by the NHS.

6. The system set up in 1948 was provider and treatment driven. Dentists decided on the level and location of services, and under payment per item of service the more treatment delivered and the more complex that treatment was, the more the dentist earned. NHS dental charges were introduced in 1951 for charge paying adults (those under 18, or in receipt of certain benefits or pregnant are exempt from all charges). Charges were based on individual items of service.

7. From the early 1990s, the inherent risks of a provider driven system that left dentists to decide where and what level of service should be available became apparent. As dentists drifted away from the NHS, service commissioners had no powers to seek alternative providers. The access difficulties that resulted, the legacy of which we are still dealing with today, are well known. The incentive to deliver complex restorative treatment was a good fit for a nation in poor oral health but an increasingly bad fit as decay rates declined. Dentists complained of being on a treadmill that allowed no time for preventive as well as restorative treatment.

8. In October 2004 the National Institute for Health and Social Care Excellence (NICE) introduced guidelines on the recall interval between routine dental examinations. Largely because the oral health of the nation has improved dramatically over the last few decades, routine visits to the dentist every six months are not necessary for everyone anymore. Everyone needs regular visits to the dentist but the interval between visits can vary depending upon the clinical need of the patient (up to a year between visits for children and up to two years for adults).

9. The April 2006 dental reforms created much greater stability in funding and access, with the local NHS for the first time having local control of dental resources. Local Health Boards (LHBs) use this money to agree local contracts with dentists and, if a dentist leaves the NHS, can use the released funds to bring in new services.

10. The main gains have been at local level. Some previously very hard-pressed areas have seen significant improvements in access for local people. Hywel Dda, Betsi Cadwaladr and Powys LHB areas have seen particular successes in addressing long standing access issues.

<u>Headline activity and need data</u>

11. In March 2006, immediately prior to the new contract, 50.7% of the population were registered with a dentist. Since 2006 access to 'high street' NHS dental services has remained broadly stable with some 54-55% of the population regularly accessing NHS dental care. However, the number of individual patients has increased by over 30,000 reflecting the rise in the population. There is still variation between LHB areas (Annex 1 – Table B) but this has reduced significantly from the position in the 1990s.

- 1.68 million patients were recorded as accessing NHS dental treatment in the 24 months to 31 March 2013. This amounts to 54.8 per cent of the population - 64.7 per cent of children (under 18 years) and 52.2 per cent of adults. This is an increase of some 8,500 over the same period in the previous year.
- In addition the Community Dental Service who work predominantly with young and vulnerable patients, had contact with 71,400 individual patients across Wales in 2011/12 (this figure is not included in the above totals of those accessing other NHS dental services).
- The latest workforce data for the year ending 31 March 2013 showed there were 1,392 dentists with NHS activity recorded, equating to 4.5 dentists per 10,000 population. This compares with 1,360 at 31 March 2012 and 1,087 at 31 March 2006.

- 89.9% of patients said they were satisfied with the dentistry they received. 84.2% of patients were satisfied with the time they had to wait for an appointment.
- Total dental spend (net) was £140.2m in 2012/13.

12. The ADHS found that 69% of dentate adults in Wales reported attending the dentists for regular check-ups; 7% reported attending occasionally; 23% reported attending only when they had trouble with their teeth; and 1% said they never attended. Overall 79% of dentate adults in Wales indicated that they attended the dentists at least every 2 years.

13. The oral health survey of 12 year olds carried out in 2008/09 found the percentage of 12 year old children affected by dental decay (i.e. those with at least one tooth decayed, missing due to decay or filled teeth) had fallen from 51% in 2001 to 42.5% in this latest survey.

14. Compared with 2007/08, the 2011/12 dental epidemiological survey of 5 year olds shows a 6% decrease in the proportion of children with experience of dental decay in Wales (47.6% falling to 41.4%). This is mirrored by statistically significant reductions in all Wales mean decay experience and active decay levels. Dental disease levels in children are improving in Wales across all social groups. There is no evidence of widening inequalities. This is in contrast with previous surveys when improved decay levels were normally associated with widening inequality.

15. The Welsh Citizen Survey of Dental Services 2009/10 asked why people had not contacted a dental practice in Wales in the last 2 years. The reasons given were:

No need	63%
Access services in England	9%
Difficult to get an NHS dentist	8%
Scared of/don't like dentists	7%
Could not obtain information to contact the practice	4%
Too expensive	3%

16. Overall 70% of dentate adults received either paid for or free NHS dental care (37% paid; 33% free), and 29% received private dental care. Total income from NHS patient charges in 2012-13 totalled £28.5m.

<u>Government commitment to NHS dental services</u>

17. There is a Programme for Government commitment to continue to increase access to NHS dental services where there are localised problems. In order to provide additional income to LHBs, NHS dental patient charges were increased from 1 September 2012 and 1 April 2013 - the first rise for six years. This will generate revenue of some £0.8m p.a. specifically for LHBs to finance improved and additional dental services.

18. There is evidence that some patients are still being recalled more frequently than is necessary and officials are working with LHBs and dental contractors to promote the application of current NICE guidance on dental recall intervals. This will help

provide an increase in capacity and guidance has been issued to LHBs aimed at ensuring effective delivery of NHS dental services and the management of contracts.

Delivery of NHS Orthodontic services

19. Demand for orthodontic treatment has increased across the UK, and undoubtedly there are some social and cultural factors involved. Demand can be raised by 'cosmetic' requests and can also be driven up by the presence of Specialist (High Street) providers themselves.

20. With the spending pressures facing the NHS, orthodontic provision has to be placed in context with other dental health priorities. Total expenditure on orthodontics within primary care dentistry already makes up a significant percentage of the total funding of dental services. It is therefore vital that continued funding is based upon sound needs assessment, prioritisation and an integrated approach between the orthodontic dental service providers.

21. Difficulties remain for patients seeking orthodontic treatment in some parts of Wales and there have been reports of lengthy waiting times for treatment. There are a number of reasons for this and LHBs have been working to address on-going capacity issues in both the secondary and primary care orthodontic services. In some instances list sizes are inflated through early, duplicate or inappropriate referrals and by other factors. Recruitment and retention has also been an issue for secondary care and specialist services in some rural areas.

22. In September 2009 an independent expert group, chaired by Professor Stephen Richmond, Professor of Orthodontics at Cardiff University School of Dentistry examined the provision of orthodontics in Wales. The review report reached some interesting and challenging conclusions.

23. In such difficult economic times it was encouraging that the report found current spending on orthodontics in Wales – over £13 million annually – is capable of largely meeting the orthodontic needs of Welsh patients. The review reported that the number of completed NHS orthodontic treatments for children was comprised of: 8,991 undertaken in general dental service; 1,620 in the Hospital Dental Service; and 420 in the Community Dental Service during the calendar year.

24. The report also made clear there is little unnecessary treatment undertaken, although there was a need for improved validation and further confirmation regarding the quality of services provided. The Health, Wellbeing and Local Government Committee reported in December 2010 on their own inquiry into orthodontic services in Wales. The Committee's recommendations supported our current policy direction and also mirrored the findings and recommendations of the expert group.

25. We have established a Strategic Advisory Group to produce an annual report on the provision of orthodontic services in Wales and to consider the recommendations of both the expert group and the Committee. We have issued guidance to help support LHBs and orthodontic providers to deliver more effective orthodontic services with Managed Clinical Networks (MCNs) being established in South West, South East and North Wales.

26. The development of MCNs is helping create a more efficient referral management process to reduce early, multiple and inappropriate referrals. LHBs are now using MCNs to identify patients who have been referred to more than one orthodontist or referred ahead of need to free up capacity; both of which have contributed in the past to the length of waiting lists.

Welsh Dental Pilot Programme

27. A previous Minister for Health and Social Services established a Task and Finish Group to review the dental contract introduced in 2006 and look at a range of issues to improve the way in which the contract works. A number of issues were of concern to the Task and Finish Group including the need to review and analyse the contract currency. It was concluded there was a need to pilot a number of new models which would look at alternative ways of working, improved quality, and changes to payment relating to the dental contract.

28. The Welsh Pilot programme has been established to test new systems of payment and delivery and to find a structure that will work for providers, LHBs and patients alike. We are piloting systems which move away from Units of Dental Activity as a means of specifying treatment categories and paying dentists, toward one which focuses on tailored patient care based on risk assessment and quality. Pilot providers are paid per patient on a weighted capitation basis, and practice performance is measured using a number of access and treatment-quality key performance indicators. The process has now been extended to run until March 2015.

29. Qualitative findings show practice staff and patients value the changes. In terms of evaluation this has been an on-going process. Miller Research Ltd is providing qualitative monitoring and evaluation. The quantitative monitoring and evaluation is being undertaken by Public Health Wales. A final evaluation report on the Pilots will be published in 2015.

Use of Direct Access to DCPs

30. Dental Care Professionals (DCPs) include dental therapists, hygienists and dental nurses. Until April 2013, treatment could only be carried out by a DCP on the prescription of a dentist. In May 2013 the General Dental Council (GDC) approved guidance which removed the necessity for patients to see a dentist before accessing certain treatments from DCPs. The GDC's 'Scope of Practice' guidance was reviewed and approved by the GDC in September 2013. The 2013 review allowed some additional scope of practice for all DCPs and clarifies the previous guidance. The GDC based their decision on a comprehensive literature review of over 100 research dental and other health-related papers. The review highlighted that there was no evidence of significant issues of patient safety resulting from the clinical activity of DCPs, and, that there was strong evidence that access to dental care improved as a result of direct access arrangements, of cost benefits to patients, and of high levels of patent satisfaction.

31. There is now a real opportunity for DCPs to carry out treatments without the prescription of a dentist. Many patients who are treated in CDS settings have high decay rates. These patients needs represent a significant portion of dentists' clinical time. Often recall intervals slip because of other patient priorities. A significant amount of time is spent monitoring oral hygiene, giving tooth-brushing instruction, discussing diet and applying topical fluoride, all of which are within the scope of practice of many DCPs.

32. In October 2013 the Minister for Health and Social Services approved a pilot study which will test direct access to dental care professionals in a CDS setting in Betsi Cadwaldwr and in Hywel Dda LHB areas.

Key priorities for future delivery of dental services in Wales

33. Dental services continue to be highly valued highly by patients and the imminent publication of Delivering Better Oral Health (our evidence based guidance developed jointly with Public Health England) will enable clinicians to adopt a more preventive approach to tackling dental disease within their practices. In addition we are working to develop a new contract for NHS primary care dental services. The engagement and enthusiasm we have seen from clinicians involved in the pilot process has been extremely encouraging and we need to continue this.

34. We are working with clinicians and commissioners to develop care pathways for patients in need of an element of advanced care. We need to ensure that we utilise the skills of the whole dental team within a specialist led, but not necessarily delivered, service that provides high quality care regardless of setting. Everyone understands the current financial climate is tight but we are committed to develop a system which produces dental services for patients, based on improving health outcomes, which are both cost effective and clinically effective and offering patients a positive experience of care in a safe environment.

35. The National Oral Health Plan "Together for Health: A National Oral Health Plan for Wales" was launched in March 2013. The five year Plan outlines how the key priorities and Programme for Government commitments in relation to oral health and dentistry will be met, and focuses on:

- the inequalities in oral disease and who is particularly at risk;
- how we can improve the effectiveness and efficiency of services;
- how to improve the quality of dental services to promote access;
- improving the efficiency of the current dental contractual arrangements; and health outcomes, in addition to providing excellent treatment

36. A key requirement of the Plan is for LHBs to develop Local Oral Health Plans (LOHPs) to address the oral health needs of their residents, ensuring effective commissioning and delivery of all dental services. LOHPs need to be submitted to Welsh Government by 31 December 2013.

Annex 1

Table A
Characteristics of dentate adults by socio-economic classification

	Characteristics of dentate adult				
Socio-economic classification of household	No. of natural teeth (Mean)	Presence of bleeding (Yes %)	Frequency of brushing (>= Twice a day)	Smoking status (% who smoke)	Presence of plaque (Yes %)
Managerial & professional	25.3	47	79	14	67
Intermediate occupations	23.5	57	64	27	77
Routine & Manual	23.7	61	66	32	85

Source: Adult Dental Health Survey 2009

Table B
NHS patients treated: adults and children by Local Health Board – 2 years ending 31.3.13

	Number of patients treated	% of patients treated	Number of adults treated	% of adults treated	Number of children treated	% of children treated
Wales	1,684,427.00	54.8	1,276,175.00	52.2	408,252.00	64.7
Betsi Cadwaladr University Health Board	350,565.00	50.8	264,237.00	48	86,328.00	61.6
Powys Health Board	80,295.00	60.4	64,074.00	59.8	16,221.00	62.9
Hywel Dda Health Board	172,765.00	45.1	129,157.00	41.9	43,608.00	58
Abertawe Bro Morgannwg University Health Board	322,343.00	62.1	245,448.00	59	76,895.00	74.1
Cwm Taf Health Board	171,228.00	58.1	136,133.00	58.7	35,095.00	56.2
Aneurin Bevan Health Board	325,579.00	56.3	244,454.00	53.9	81,125.00	65
Cardiff and Vale University Health Board	261,652.00	55	192,672.00	51.2	68,980.00	69.8

Source: StatsWales