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Ymchwiliad i Ddeintyddiaeth yng Nghymru / Inquiry into Dentistry in Wales
Ymateb gan Fwrdd Iechyd Prifysgol Hywel Dda
Response from Hywel Dda University Health Board

Hywel Dda University Health Board

Social Care and Sports Committee Inquiry into Dental Services (Comments to be submitted by 22 August 2018)

The Welsh Government Dental Contract Reform

The Health Board has participated in Phase 1 of Dental Contract Reform and has plans in place to meet the target of 10% of practices participating in the programme from October 2018. The Practices participating in the programme to date have provided positive feedback. The Health Board has received some interesting data from Public Health Wales which was collected between January 2018 and March 2018. The All Wales data for Quarter 4 2017/18 only indicates that there is scope to change the focus of how often patients are seen based on their individual clinical and oral health needs. The level of risks on oral health from medical, social and past dental history at all Wales is that an average 87% of the patients have low risk from these categories with the average figure for Hywel Dda being at 78%. The proportion of patients categorised as Red, Amber and Green for tooth decay, gum health and other dental conditions at all Wales average was 19%, 20% and 61% respectively. For Hywel Dda the figures were 8%, 12% and 80%. However, more data over a longer period of time is required in order to open discussions with Practices in order to inform transformation.

These conversations will be clinically led through leadership provided by the Health Boards Associate Medical Director for Dental Services, which was considered to be a key role for investment by the Health Board to support the strategic development of dental services.

Engaging with patients will be key to their understanding of Dental Contract Reform in Wales and what it means for them as individuals. It is imperative that there is a national publicity campaign or national communications strategy to address this, giving consistent messages across Wales. The Assessment of Clinical Orals Risks and Need (ACORN) is an important driver for informing the dialogue between dental professionals and patients. The care pathway will be based on the patients' oral health needs and patients will be informed of their individual responsibilities in terms of their own oral health. If ACORN is carried out consistently it shouldn't then matter who the patient sees within a dental practice as long as the patient understands the appropriateness of being treated by a multi-disciplinary team, then the same messages should be delivered around making every contact count. The culture needs to be developed and embedded in practice so that the patient understands why they are visiting a dental team rather than a named dentist. There is no reason why all Dental Practices couldn't undertake Phase 1 of the programme to inform the oral health needs of the population for Wales and to change the behaviour regarding recall intervals to create capacity to see more patients; however this will need consistent messaging to patients and the profession as the historical NICE Guidance on recall intervals has been challenging to implement.

Phase 2 of the scheme will be more challenging to roll out across all practices. Contract reform is heavily dependent on increasing the skills mix in general practice however the current General Dental Services (GDS) contract has not been supportive in this way of working, necessitating significant remodelling of the workforce which will require an investment of time and resources to upskill existing staff, as well as supporting the increase in training numbers for the wider dental team as well as the re-education of patients.

Many Practices will be constrained in their participation of Phase 2 by their infrastructure not enabling an increase chair capacity. For those Practices who are ready and able to work at Phase 2, the development of the scheme is not happening quickly enough. We need to be careful that the commitment and drive from practices involved in the current contract reform programme is not lost by a decrease in momentum for rolling out Phase 2 and subsequent development of the Contract Reform programme. This is the area where Cluster working could provide the opportunity for collaboration across Dental practices in providing collaboration in terms of training and upskilling staff, sharing key posts across a group of practices, and the leadership for the delivery of strategy and planning. Consideration as to how this could be incentivised needs to be included in reform discussions.

As Dental Contract reform expands consideration also needs to be given to the governance around the monitoring process, with key parameters being set nationally to provide a consistent approach for all participating Dental Practices and Health Boards.

How 'clawback money' from Health Boards is being used

For all new dental activity (regardless of where the funding has been identified) the Health Board is required to go out to use formal procurement processes to invite expressions of interest from parties who may be interested in providing Dental Services. This is done in accordance with the Health Board Standing Orders and Standing Financial Instructions, and EU procurement legislation and the national dental contact. As a result of this process Dental Contractors submit bids to the Health Board setting out the levels at which they feel able to deliver under a contract with the Health Board. The end result of this process is that the Health Board will contract with the tender winners to provide levels of activity that the Dental Contractors have set out in their bid.

The Health Board will expect the Dental Contractor to provide patient activity at the levels to which they have agreed when they sign the Contract; based on this the Dental Contractor is paid in monthly instalments to provide a dental service at the Contract level. The Health Board monitors activity on a monthly basis to ensure that the Dental Contractors meet the activity targets as per the Regulations. If a Dental Contractor is unable to meet 95% or more of the activity that they have been contracted to provide then the Health Board has a fiduciary duty to recover on over payments that have been made to them. Whilst the Health Board wants to support the investment into dental services and the development of service provision it has a duty to ensure that public money is spent prudently particularly given the current climate of financial austerity.

The term 'clawback money' is an unfortunate description for Health Boards enacting clearly defined national contractual management arrangements in line with Regulations to ensure correct governance

for the management of Public Funds. In year funding being returned to the Health Board can derive from the following three areas:-

- Financial recovery due to a Dental Practice not delivering 95% of their contracted Units of Dental Activity (UDAs). This funding is non-recurrent and usually not identified until the end of the financial year and therefore accounted within the Health Board Accounts;
- GDPs who have had 2 remedial notices and as a result have their contracts permanently rebased;
- The GDPs request a rebase due to circumstances within the business and this can be on either a recurrent or non-recurrent basis.

The way in which the Health Board deals with financial recovery from Dental Contractors will depend upon the nature of the recovery and whether it is a one-off event or represents a permanent reduction in the funding within a Dental Contract. In the case of a permanent Contract reduction the Health Board makes every effort to re-provide the activity for patients by going out to Tender for replacement dental services. This is not always an easy process as it is not always possible to find Contractors to redeliver the service due to recruitment issues in rural West Wales. Furthermore, established Practices often cannot cope with significant increases in activity without additional infrastructure investment. The 2006 Contract removed the Health Board's ability to invest in Dental infrastructure and pump prime the expansion of local practices.

The level of financial recovery in relation to performance that can be reinvested is further restricted by the following issues:-

- The final performance outturn against contracted activity is not fully understood until June of the following Financial year once all FP17's have been submitted for payment;
- The Health Board is required to go out to tender for the provision of any services in excess of £25k as set in the Health Board's Standing Orders and Standing Financial Instructions which are based on the standard model set out by Welsh Government;
- Resource accounting rules issued by Welsh Government require Health Boards to estimate Contract under performance and account for this in the financial year to which it applies. As a result, if Health Boards invest under performance in subsequent financial years, when we have established the true level and recovered the cash from contractors there is a potential to spend more that our resource limit so breaching Welsh Government resource accounting rules.

Greater than expected levels of financial recovery of dental contracts has occurred in both 2015/16 and 2016/17. The vast majority of this relates to underperformance by one corporate provider accounting for in excess of 94% of the total recovery in these 2 financial years. The business model which the Corporate Company has developed to provide services does not appear to be stable in the Hywel Dda area where they have experienced problems with recruitment and retention of qualified dentists despite offering higher associate rates and Golden Hello's. In Hywel Dda, the National Corporate Dental Company holds 11 General Dental Contracts representing 19% of the total contracts and 45% of the Health Board total expenditure on Dental Contracts. This deterioration in the provision of general dental services may be a

legacy prior to the introduction of the new contract when significant numbers of dental practices surrendered their NHS commitment in favour of private dental services.

Issues with training recruitment and retention of Dentists in Wales

The Health Board has provided comments on this point in the context of the whole dental team as key to delivering the Contract Reform model will necessitate practices working as a multi-disciplinary team.

Health Boards need to undertake regular dental workforce analysis in order to create a baseline database to inform service planning, training at a national and local level, and to identify potential service continuity issues from retirements. There is an all Wales analysis of the dental workforce from 2011 available however this now needs reviewing as it is considerably out of date. It would be advantageous if this could be carried out nationally.

Dentists - In order to improve recruitment and retention Health Boards need to consider training Dentists with Enhanced Skills (DES). Hywel Dda has issues with attracting Specialists into the area and is considering funding post foundation core training posts in primary care supported by the Deanery. Dentists who have just finished Dental Foundation Training often want to develop specialist expertise and build confidence in practice. The approved training practices could be the current training practices or consideration could be given to larger practices who are high performers who may have capacity/need for another dentist. The Health Board has considered the potential to introduce training pathways where the dentist works chairside for four days in practice and one day working alongside a specialist to support DES accreditation. The challenge in Hywel Dda will be finding Practices with the appropriate level of mentorship and training skills to take this forward.

15% of dentists currently are from the EEA and 5% are from outside the EEA. There is a significant fall off in EEA dentists coming to work in the area and this is potentially as a result of the uncertainty regarding Brexit and the current poor exchange rate. Without this workforce there needs to be an assurance that there are sufficient training places available within the UK and a commitment national that the Train Work Live programme is expanded to include Dentist and other dental care professionals.

Whilst there is national recognition of the sustainability of general medical services much less focus is given to the potential recruitment and retention issues of dentists and the impact that this can have on service provision and service development.

Dental therapists - The service will require an increase in the number of therapists being trained in the future in order to deliver a multi skilled approach to the delivery of care under Contract Reform or support the sustainability of services where there are issues due to dentist recruitment. In Wales currently, there are not enough therapists graduating to meet the potential demand or the pace of change needed to deliver contract reform. If training is funded from the NHS resources then Wales needs a way of securing the commitment of the individual to the NHS for a period of time. The current restrictions on claiming funding for services provided by therapists under the NHS contract need to be reviewed as multi skilled working will be difficult without this. We understand that this may be being reviewed as part of introducing the electronic FP 17 (Services claim form) and would welcome this change.

Dental Nurses - Dental Nurses can be trained to undertake a range of extended duties and a proportion of the workforce will already have the qualifications but are not fully utilising their skills to the maximum benefit. Additional skills in signposting to other healthcare services (smoking cessation, diabetic services) can be gained quite easily as the baseline knowledge is often there as a result of individuals having undertaken an oral healthcare qualification. Access to training needs to be improved by Health Board area; one of the reported barriers to Dental Practice training is the location and availability of the training. Staff often fund their own courses and the cost of travelling expenses is often one cost too much.

Integrated learning - Cluster projects across could encompass areas such as prescribing, 111/telephone triage training, Health Care Advice and sign posting, smoking cessation, Lift the lip, 1000 Lives +, frail and elderly care etc. could all be delivered to integrated professional groups within Clusters. The Health Board is supporting appropriate dental engagement at a Cluster level and currently has just below 50% representation across our Clusters.

Genera Dental Services engagement events - The Health Board has raised the issue of how new Practices can be developed in the area and already supports Practices with recruitment options, however feedback from current service providers has highlighted:

- There was a view that the service could lose considerable expertise over the next few years due to retirements. One of the main barriers to dentists returning to work part time is that of the cost of indemnity cover so a suggestion is a scheme to support this that may encourage retention of skills through affordable part time working. This is currently being considered as part of the GMS contract discussions and therefore consideration should be given nationally as to whether or not this could be expanded to include the dental profession;
- Providing pump priming to assist with setting up either new or additional infrastructure to enable service development and modernisation;
- Increased financial recognition in areas of unmet need to support the dental resources needed to get patients orally fit (we fully recognise that this would need to be based on robust data);
- Introduce Golden Hello's, particularly for newly qualified Dentists who have incurred student debt;
- The Oral Health Promotion lead has been invited to attend a meeting with a group of dentists to provide information on the Local Oral Health Plan and to support practice audit around the use of Fluoride Varnish, it is hoped that this type of integration will be further developed;
- Cluster working to provide peer engagement and leadership and sub cluster working for Dental Practices.

In order to consider any of the above, careful thought would need to be given to the criteria used for the schemes and the governance structure supporting them. In addition to this whilst Health Boards can consider schemes on a local basis consideration would need to be given to any impact such schemes could have across Wales.

Community Dental Services also experience recruitment issues due to the NHS pay scales for Dentists being relatively poor compared to those offered in the Private Sector. There is a lack of career development due the restrictions placed on posts by funding constraints.

The provision of Orthodontic Services

The Health Board has recently reviewed its provision of Orthodontic Services based on population need compared to its current contracting levels. The population needs have changed since this exercise was last undertaken in 2011 and this has resulted in the Health Board commencing a tendering process for a new orthodontic contract with increased activity levels which will require a considerable investment from the Health Board.

The tendering process will afford the Health Board an opportunity to consider the value of Unit of Orthodontic Activity (UoA) rate and align the rate to a level similar to those set in England and in other parts of Wales where similar work has been undertaken. The challenge will be whether interested providers will be able to attract Orthodontic Specialists prepared to work in West Wales.

Since 2015 the Health Board has been experiencing growing waiting times for access to Orthodontic Services and the increased contract activity from April 2019 will start to address this. In addition to this the Health Board will review the opportunity to undertake waiting list initiatives with non-recurrent in year funding to remove the waiting list backlog. The Health Board is currently out to tender for a waiting list initiative which will remove up to 300 patients from the waiting list.

The Wales Strategic Advisory Forum for Orthodontics (SAFO) has issued guidance on the management of Orthodontic Services and the Health Board has found this guidance very useful. It would be useful if there was guidance issued centrally regarding the appropriate length of wait to access orthodontic services.

The issue for the Health Board is that investment of funds into Orthodontic services means that the Health Board has less investment available to improve access into General Dental Services to improve the Oral Health of the population.

The clinical threshold used in order to assess patients for eligibility to NHS care could be reviewed and limited to Index of Orthodontic Treatment Need (IOTN) scores of grade 4 and above.

The introduction of E-referrals will greatly support the understanding the actual demand for orthodontic services compared to need based on population demographics. E-referrals will assist the management and validation of waiting lists for Orthodontic Services going forward. The Health Board would welcome a national statement on General Dental Practices being trained on using the IOTN and support in telling parents/carers when their child does not meet the criteria and cannot be referred.

The effectiveness of local and national oral health improvement programmes for children and young people

The Designed to Smile (D2S) team were provided with a new Welsh Index of Multiple Deprivation list in July 2017, this dictated a further expansion into the third quintile of deprivation. In numbers this meant an additional 80+ schools and pre schools were to be approached and taken on from September 2017, and it is expected that by December 2018 all targeted settings will be tooth brushing daily.

The Welsh Government return for 2017 to 2018 records a total of 275 schools and pre schools participating with a total of 11000 children tooth brushing every day. Last year Hywel Dda recorded a decrease in caries of 21%, this was the highest recorded in Wales.

A new fluoride varnish protocol has been developed by the Oral Health Promotion Manager and this is going to be piloted in September 2018. This will ensure that all school pupils within the D2S programme will have fluoride varnish applied twice a year.

The Oral Health Promotion (OHP) team attended the first Designed to Smile symposium learning event which provided the opportunity to meet other D2S teams across Wales and share best practice and feedback.

The team in Hywel Dda have developed a training presentation for use across Wales to deliver a one hour continuing professional development sessions to local General Dental Practices engaged in the Dental Foundation Training programme.

The national D2S lead recognised that whilst the emphasis of D2S targets those children in the foundation phase, there needs to be something in place to support those pupils around Year 6 before they make the transition to secondary school. It is around this time that pupils start to make choices around diet and unfortunately can “undo” the good work of the fluoride intervention in previous years. A resource has been produced which is presently under consultation with the local Education Department; if approved it will provide teaching staff with two lessons as power points to deliver to Year 6 pupils and will cover all key messages as advised in Delivering Better Oral Health Version 3 inclusive of smoking.

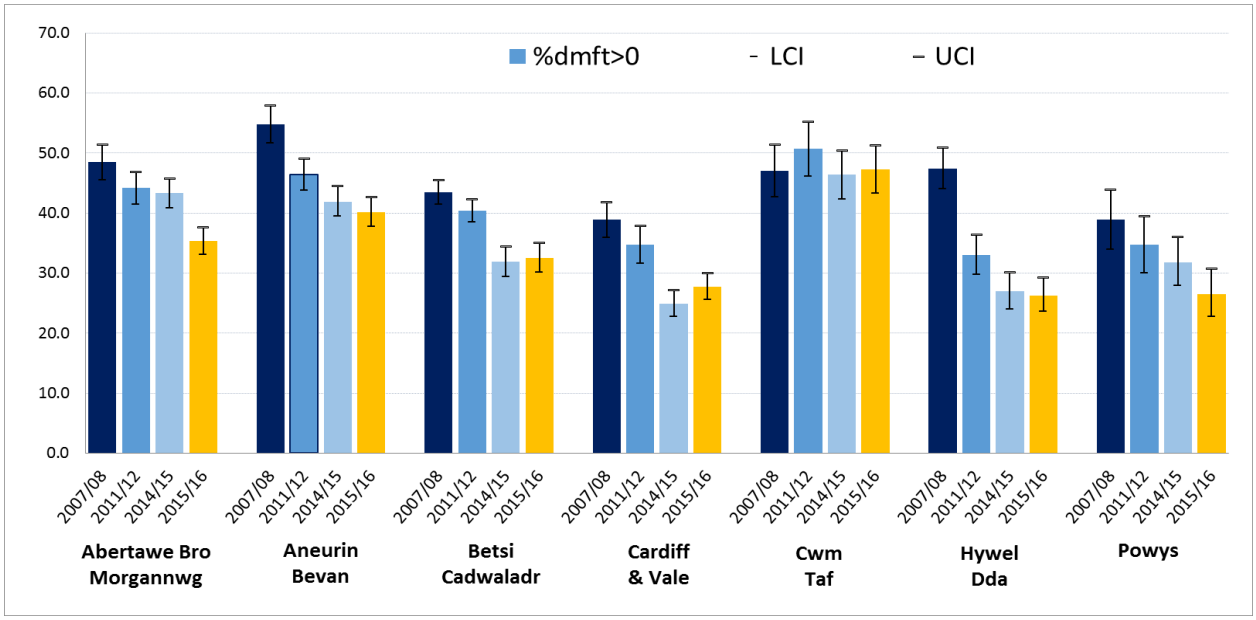
The team continue to collaborate with the wider health and education departments to include training with school nurses, health visitors, flying start, Public Health Wales, local colleges, drug and alcohol services and the All Wales Healthy School Scheme etc.

0-3 year olds

The Oral Health Promotion team deliver standardised training to Health Visiting teams to include Flying Start clusters. The Welsh Government return 2017 to 2018 evidenced that 1875 home packs were given to children aged 0-2 via the Health Visitors along with 900 Tommee Tippee cups. The links between the D2S team and the Health Visiting teams are well established ensuring key messages are delivered at source to the parent and the family.

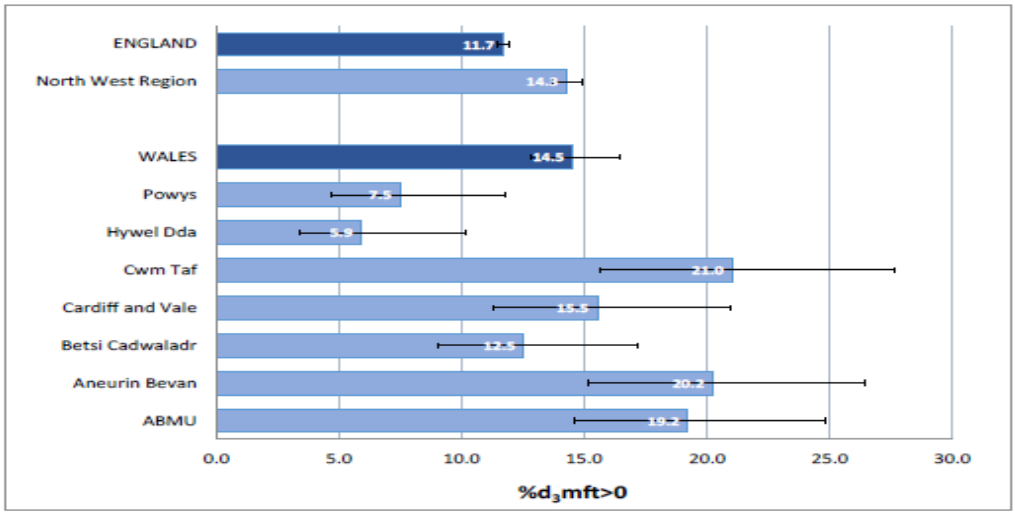
A plan is also in place to support the mouth care needs of women in early stages of pregnancy. This will see the Oral Health Promotion team delivering training to community midwifery teams along with resources to be able to provide items to pregnant mothers to ensure that they are informed of the importance of maintaining oral hygiene during pregnancy; it is anticipated that this will help to prevent pregnancy gingivitis due to hormonal changes, thus improving overall health and wellbeing. The team will attend antenatal clinics for women who are in the second and third trimester to provide advice to the mother about how to look after both their own and their child's teeth in early infancy. This piece of work will compliment the D2S programme and also Public Health Wales's First 1000 Days initiative.

Needs data



The above graph shows that unfortunately the decrease in prevalence of children with caries hasn't been seen across all Health Boards in Wales. Pockets of high need and high caries rates persist, and whilst Hywel Dda has seen a significant improvement, work needs to continue with early years to improve intervention.

Figure 1 Proportion of 3 year olds with at least one tooth affected by decay (% with $d_3mft>0$*)



The graph above shows that 14.3% of 3 year olds in Wales presented with dental caries. Whilst Hywel Dda presents below the national average we can't become complacent, the work needs to continue to ensure that a consistent drop in caries is achieved across all areas of deprivation.

Conclusion

Whilst there is considerable work ongoing to improve the oral health of the Hywel Dda resident population. There is further work that needs to be done locally and nationally to continue to improve how services are developed, to deliver prudent healthcare whilst harnessing the need for a changing skill set and workforce to ensure that residents have access to the best care possible. Hywel Dda Health Board has welcomed the change that the Dental Contract Reform programme has brought and is keen to ensure that this maintains the momentum that is imperative to enable service change and improved oral health for its population.