



**Cynulliad Cenedlaethol Cymru
The National Assembly for Wales**

**Y Pwyllgor Iechyd a Gofal Cymdeithasol
The Health and Social Care Committee**

**Dydd Iau, 21 Tachwedd 2013
Thursday, 21 November 2013**

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the Meeting

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir
trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In
addition, a transcription of the simultaneous interpretation is included.

**Aelodau'r pwyllgor yn bresennol
Committee members in attendance**

Leighton Andrews	Llafur Labour
Mohammad Asghar	Ceidwadwyr Cymreig (yn dirprwyo ar ran Darren Millar) Welsh Conservatives (substituting for Darren Millar)
Rebecca Evans	Llafur Labour

William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Lisa Howells	Uwch Swyddog Deintyddol Senior Dental Officer
David Thomas	Prif Swyddog Deintyddol Chief Dental Officer

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Llinos Madeley	Clerc Clerk
Victoria Paris	Y Gwasanaeth Ymchwil Research Service
Sarah Sargent	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 09:31.
The meeting began at 09:31.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. I welcome Members to this morning's meeting of the Health and Social Care Committee. The meeting is bilingual and headphones can be used for simultaneous translation from Welsh to English on channel 1, or for amplification of the sound on channel 0. I remind people to turn off their mobile phones or any other equipment that may interfere with the broadcasting equipment. There is no scheduled fire alarm today, so in the event of the fire alarm sounding, please follow the directions of the ushers. We have received apologies for absence from Darren Millar. Mohammad Asghar is attending as a substitute. Welcome, Mohammad.

Sesiwn Graffu Gyffredinol gyda Phrif Swyddog Deintyddol Cymru
General Scrutiny Session with the Chief Dental Officer for Wales

[2] **David Rees:** This morning's session is a scrutiny session with the Chief Dental Officer for Wales. I welcome David Thomas, the chief dental officer, and Lisa Howells, the senior dental officer, to the meeting. Thank you for your written evidence to the committee.

Just to give you an indication, part of our scrutiny will be about whether it is worth us looking at an inquiry into NHS dentistry further down the line. Perhaps the discussions and responses that we have this morning will help us in that decision-making process.

[3] Before I ask Members to start with their questions, I have one question. The two pilot schemes that were established, one for children and one for quality and outcomes, have been operated. The children's one was stopped and completed its two-year term, but the other is being progressed until March 2015.

[4] **Mr Thomas:** That is correct.

[5] **David Rees:** Perhaps you could confirm what the thinking was behind one being stopped and the other being continued.

[6] **Mr Thomas:** The quality and outcome pilot scheme is working extremely well. We are very pleased with the outcome. Although the children's pilot scheme was also working well—we saw an increase in the number of children being accepted by dentists as patients—the key issue for us was that there was a conflict between the children's pilot scheme, which was a patient-only pilot that did not use the unit to dental activity contract currency, and all of the other patients in the surgery. So, there was a real practical issue. Something that the pilot providers fed back to us was that there was a real issue trying to run two contracts simultaneously alongside each other. So, we have taken all of the things that we have learned from the children's pilot scheme and incorporated them into a whole-systems pilot scheme.

[7] **David Rees:** What evaluation will be available to the public of that first pilot scheme?

[8] **Mr Thomas:** Yes, evaluation is available; it is on my website. Two sorts of evaluation have been carried out: a quantitative evaluation by Public Health Wales, and also a qualitative evaluation by a research company called Miller Research (UK) Ltd, based in Monmouthshire. I think that those evaluations are available on my website. If they are not, I can supply the committee with the evaluation reports.

[9] **David Rees:** Thank you very much for that. We will now move on to questions from William.

[10] **William Graham:** Thank you for the evidence that you have submitted. In terms of the new contract model, you suggest that it will improve timely access, which is clearly good. Why is it that, within those terms, visiting the dentist is not a popular experience for most people? We know, from statistics, that over half of the population of Wales does not go to the dentist—54% had not been to the dentist for two years, and a third of children are not going to the dentist. I think that we all have not very pleasant personal experiences of going to the dentist. For those of us of a certain age it was a very unpleasant experience going to the dentist years ago. It has improved dramatically. So, timely access is good, but why is it not attractive for a patient to go to get early intervention so that they are not waiting when they are in pain?

[11] **Mr Thomas:** Could I just make a comment about the statistics? Over two-year periods, 54% of the population is going to the dentist; that is for the NHS. That does not, obviously, include the 10% of the population, usually deprived children and vulnerable adults, who are seen by the community dental service. Approximately 20% of the population also go to the dentist, but under private contract. So, we are up to nearly 85% of the population, and 9% of the population access services in England. So, a bigger percentage of the population is going to the dentist than is reflected in the NHS figures. In fact, the adult dental health survey in 2009 indicated that nearly 70% of the adult population had attended a dentist for a check-

up during that year.

[12] In terms of popularity, it is difficult for me as a dentist to say that we are not popular. I think that the dental profession has made great strides in improving the experience. All of us who are above the magic age of 40 or, personally, above the magic age of 60 as of last week will remember the horrors, sometimes, of going to the dentist and not receiving proper anaesthesia for treatment. I think that those days have gone. I think that we, through our offices, and Lisa may want to say a bit about quality, really strive to improve the quality of the service that is now delivered. By the way, Lisa is a bit croaky this morning.

[13] **Ms Howells:** I am sorry, I do not usually sound this strange. One of the things that we have tried to do is, as a profession, acknowledge that it is not actually, as you said, that dentists are not popular, but dentistry. You often find patients who will say, 'I like you, Lisa; it's what you do to me that I'm always worried about.' Certainly, great strides have been made in helping people who are anxious and nervous. If we can see young children at a very early age and get them used to going and put the emphasis on prevention so that they do not need a lot of treatment, then that is far better than the experiences that we might have had as children.

[14] **William Graham:** Could I ask you about the pilot scheme? Do you think that there are enough practices taking part in it so that the evidence that is produced at the end will be robust?

[15] **Mr Thomas:** I think that there are. We have 507 NHS practices working in Wales and we have six pilot practices. The practices have been chosen to reflect the composition of the types of practice that we have, for example we have a practice in Aberdare that is a Valleys practice and we have a practice in north Wales that is a corporate body practice. We have small practices and large practices. We are also working very closely with the Department of Health in England. Its pilot scheme is similar to ours, but not the same; it has 70 practices in its pilot scheme. So, I think that there are enough practices there for us to make some informed decisions.

[16] **David Rees:** Oscar, do you want to come in on this question?

[17] **Mohammad Asghar:** Thank you very much, Chair. David, following William's questions, accessibility to the dentist is decaying these days. I have a typical case in my constituency where a lady was removed from the surgery list because she missed two appointments—once because of bereavement and the other was because the surgery itself changed the date. She was removed and they asked her to go private. Since then, I have been writing to the NHS in Newport. There are 12 surgeries listed, she tried everywhere and there was no accessibility. She is 67 years old and she cannot travel to the other side of the town to get registered. That is terrible. The one surgery that she was recommended to register with by the NHS sent her a letter—I wonder whether it was from the girl who looked after the surgery or the dentist—the day before yesterday, clearly saying that she was afraid that there was no room for NHS patients in their surgery. It was the same fate in all the surgeries in Newport. So, you are telling us that accessibility is there, but it is not. Each surgery is getting roughly £1 million from the NHS and it is not serving the people who have paid all their NHS contributions during their working life—they are not having the service from dentists. This is very strange. Personally, I am very grateful to my dentist, Mr Philip Evans, for being such a wonderful dentist for the last 40 years.

[18] **David Rees:** Can we have a question, please?

[19] **Mohammad Asghar:** My question is that accessibility is not possible. You come with me after this meeting and try all 12 of these surgeries; they will never put you on the

NHS.

[20] **David Rees:** I think that, with specific cases, it is not possible for you to answer. The question is more one of how accessibility to national health service dentistry is being addressed when patients no longer attend a particular surgery.

[21] **Mr Thomas:** Access to dental services now is based on the fee income that was received in 2006, when a new contract was issued. About 50% of the population were registered with a dentist in 2006. There has been no increase in the funding at all, apart from the uplifts for dental practices, since 2006. We are now seeing 1.68 million people on a two-year rolling period. That equates to about 54% to 55% of the population. Access is stable. We accept, I think, that there are places where accessibility for patients who have not been to the dentist for a while is patchy. We continue to work with local health boards on this issue. Since a low point in March 2008, we have seen an increase of 80,000 patients across Wales gaining access to services. Certainly, the one thing that we are sure of is that if a patient is in pain, all local health boards in Wales—and I can say this with confidence—offer in-hours emergency dental services through the week, and all local health boards have services available for patients, whether they go to the dentist on a regular basis or not, on Saturdays, Sundays and bank holidays. I know this myself, because I have worked on Christmas Day before now in a dental surgery—not in Wales, but when I was working in Oxford.

[22] I understand your constituent's problem, and I can assure you that we are working with local health boards to ensure that when practices have spaces, they advertise them. To give you an example, Cardiff and Vale University Local Health Board has on its website—and you can go on the website and look, because I looked this morning before coming to this meeting—nine practices that are available, and the dentists have access to that website and can choose to say that they are accepting patients or not.

[23] Today, as Mr Asghar has pointed out, there does not appear to be access in Newport. This does change on a daily basis, and I would be happy, Mr Asghar, to check with Aneurin Bevan Local Health Board about Newport and report back separately to you if that is so.

[24] **David Rees:** I have three supplementary questions now. I will start with Leighton, then Lynne and then Elin.

[25] **Leighton Andrews:** I want to ask about the transparency of NHS funding to dental practices. Do you publish the amount of money that goes to each dental practice from the NHS?

[26] **Mr Thomas:** Each provider contract has been published in the past by the shared services partnership. For some reason—I have to hold up my hands and say that I do not know why—this has recently stopped.

[27] **Leighton Andrews:** So, could it start again?

[28] **Mr Thomas:** I would have to find out for you, Mr Andrews.

[29] **Lynne Neagle:** This is on the point that you made about emergency dental treatment. You said that you are very confident that people have this ready access to emergency dental treatment, but I have certainly dealt with cases where people in terrible pain have struggled to get an appointment. That seems to have been partly an issue of administration locally, so I want to ask: if you are very confident that that access is there, how can you reassure us that the health boards have strategies in place to make sure that people are aware of where to go if they are in desperate need of an appointment?

[30] **Mr Thomas:** We published the national oral health plan in 2013. One of the key priorities that we have charged local health boards with is to produce a local oral health board plan, within which we have set as one of the priorities ensuring that emergency dental service provision is as I have described it.

[31] **David Rees:** I think that the question was not so much whether it is in the plan, but whether it is communicated to the public.

[32] **Lynne Neagle:** Is it monitored? How is it actually monitored at Welsh Government level?

09:45

[33] **Mr Thomas:** I personally, with Lisa and my officials, hold one meeting at local health board headquarters with the dental teams of local health boards and review what they are doing every year. We also do mystery-shopper exercises, where one of my team rings up local health board dentists who appear to be accepting NHS patients or are providing the emergency dental services. I personally rang the Aneurin Bevan emergency dental services line last week to see what the issue was, and that was working fine at the time.

[34] **Elin Jones:** I would like to go back to the issue of access. I have certainly seen it improve in my area. In fact, I saw an advert in the local paper yesterday for one practice in Lampeter that was advertising for NHS patients. Lampeter, five, six or seven years ago, was a particular area of concern and there were queues on the high street for dental practice registration. So, it has certainly improved. However, on the point that Oscar made about missed appointments—and I believe that your constituent, Oscar, had missed two appointments and had therefore been struck off that register—what is your policy in terms of missed appointments and what guidance do you issue to NHS practices on missed appointments? We talk about it quite a bit in terms of GP surgeries, as it is a particular problem there. My own experience is that NHS dentists are much better at reminding people about their appointments than the GP surgeries are. However, is two missed appointments the strike-off level across Wales?

[35] **Ms Howells:** There is not a single policy for saying that, if you have just missed your appointments, you are out of the system. As you say, first of all, dental teams do make great efforts, particularly if a patient has a long appointment for some quite complex treatment, to remind them beforehand by text, phone or e-mail, as the patient prefers. One of the things we do know is that missed appointments are a problem for the NHS. In 2006, Public Health Wales issued some guidance to health boards and dentists on how to deal with that particular issue and other issues where there had been a breakdown in communication between a clinician and a patient and it was felt that it was not in the best interests of the patient or the practice for the patient to come to the practice any more. We are updating that now, and the advice is that, first, dentists do all they can in partnership with patients to remind them to attend; they make it clear in the practice, together with the health board, what their policy is, using both leaflets and the websites, and we have been asked to provide a small poster to tell patients so that they are clear what the policy is; and for dentists to keep very clear records when patients cancel appointments at the very last minute or fail to attend. Quite often, there is a misunderstanding with patients as to how many times they might have missed appointments, and it is important that you get accurate information from both sides.

[36] **Elin Jones:** So, if the dentists are keeping these records, do you monitor the level of missed appointments in NHS dentistry in Wales?

[37] **Mr Thomas:** We carried out, a couple of years ago, a monitoring exercise, as a research exercise—Public Health Wales carried out a research exercise for us. You may

remember that there was a review into NHS dentistry a few years ago and one of the recommendations from that review related to whether the charge for missed appointments should be reintroduced. We took advice from our legal team and we were advised that that would be quite difficult to do under the current regulations because it would mean that we would have to possibly think about charging people for missing general practice appointments and other NHS appointments as well. So, that has not been pursued.

[38] In terms of the guidance, we are happy to provide you with a copy of the updated guidance when we finish it.

[39] **Mohammad Asghar:** It is a good idea to charge people rather than just remove them from the register, as they will have to look for somewhere else and there are no vacancies anywhere.

[40] **David Rees:** You do not have to answer that; it is a comment.

[41] **Mr Thomas:** All I can say is that the current general dental service regulations, as of 2006, do not permit charging patients for missed appointments.

[42] **David Rees:** Okay, thank you. I move on to a question now from Gwyn Price.

[43] **Gwyn R. Price:** Good morning. In your written evidence, you say that the publication of ‘Delivering Better Oral Health’ is imminent. Has that come out yet, or is it still imminent?

[44] **Mr Thomas:** It is still imminent. I am told by Public Health England that it will be published in January or February of next year. With this, we have a commitment to ensure that a hard copy of this document goes to every NHS practice in Wales.

[45] **Gwyn R. Price:** So, it is January or February of next year.

[46] **Mr Thomas:** Yes.

[47] **David Rees:** Lindsay has a question on the programme.

[48] **Lindsay Whittle:** Good morning. I am very fortunate that I went to school with my dentist—Caerphilly Boys Grammar School—although he was a few years below me. I am so pleased that I was never a bully at school, otherwise his revenge would be sweet. I wanted to ask you about the Designed to Smile programme. We know that it has been reasonably successful, but it is just a 6% drop in the number of children who experience dental decay over a five-year period. I understand that the budget of £3.7 million has been ring-fenced, and that is okay, but ring-fenced for the next two or three years means that it is actually going to decrease a little in value. Given that this is an inquiry, what sort of questions—and I am almost guessing the answer—can we put to the Minister if we were to bring the Minister here? How can we improve access for young people to dentistry? There is no need to be afraid now of dentists—I am over 60 as well—because it is a great experience. We need to encourage young people and also their parents. What can we do to encourage their parents to have access?

[49] **Mr Thomas:** If I deal with Designed to Smile first, you are right that the survey showed that the proportion of children with tooth decay reduced by 6%. The proportion of children with active decay also decreased by the same amount. The thing that is not in the paper—which I deliberately did not include because this is emerging evidence, and we have to be cautious about the results—was that there was a 17% reduction in the decay rates of children that are participating in Designed to Smile. We are very pleased with this. We need

to validate this evidence, and we have asked Public Health Wales to commission a dental survey of five-year-old children next year and the year after, because we want to make sure that this is working.

[50] Designed to Smile is a community brushing and fluoride varnish programme that is developed in schools. Some 83,000 children take part in this every day, so we are very pleased. There are 1,350 settings. It is a fantastic achievement by the community dental services in Wales.

[51] In terms of whether or not it is working, the surveys will tell us whether it is working. We believe that we have some initial evidence to show that it is working.

[52] You talked about parents. I do not have the exact figures with me, but these will be in the Designed to Smile evaluation report that will be on my website this week, which was produced by the Welsh oral health information unit. The community dental service teams offer one-to-one sessions and group sessions for parents. I cannot remember the number of group sessions that are performed, but it is part of the Designed to Smile proposition to deliver that service to parents. So, I am confident that Designed to Smile is on the right track.

[53] I will finish with one bit of evidence that was published just last week as part of an international dental conference. Designed to Smile is based on a similar scheme in Scotland called Childsmile. They run a scheme very similar to Designed to Smile for nursery children. They found that when they spent £1.8 million on nursery children—their scheme has been running for a lot longer than Designed to Smile—they saved £6 million in treatment costs. That is published evidence attributed to Childsmile. The children who access Designed to Smile are usually the most deprived children in Wales. We talk about 60% of children going to the dentist, but these are the children who do not get to go to the dentist. This is the way that we will reduce dental decay in young children. All of us around here brush our own children's teeth. When I first came to Wales—I will give you an example—we started a little pilot scheme up in Merthyr Tydfil. I went to the school with the people who were running the trial, and was told 'Come in and see the children'. I saw the children, who said, 'Oh, this tastes like Polo mints' and 'What is this? Oh, it is a toothbrush'. A lot of the children had never seen a toothbrush or toothpaste—these are three or four-year-old children—so we really need to be thinking about maintaining this programme, in my opinion.

[54] **Lindsay Whittle:** I have a quick supplementary question. What is the evidence for teenagers, as well? Again, it is so much more advanced today. When I was a teenager, the thought of wearing a brace would have horrified most teenagers. However, today, they are quite trendy and colourful, and they seem to wear them with no problem at all. Has there been any advance on teenagers? Is there any evidence that we can have to show the Minister?

[55] **Mr Thomas:** From what perspective? I am sorry, Mr Whittle; do you mean oral health?

[56] **Lindsay Whittle:** Yes; is there evidence that children clean their teeth up to a certain age, but when they hit the teenage years they become the Kevins of this world and they suddenly change?

[57] **David Rees:** That is no reflection on anybody named Kevin. *[Laughter.]*

[58] **Mr Thomas:** All I can tell you is that we carry out surveys on five, 12 and 15-year-old children in Wales. The 12 and 15-year-olds have shown massive improvements in their oral health. They now have, on average, one decayed missing or filled tooth, whereas 20 years ago it was four or five.

[59] **Lindsay Whittle:** That is positive.

[60] **Mr Thomas:** There are positive results. I see that Lisa wants to say something.

[61] **Ms Howells:** I would like to pick up one issue for teenagers, if I may. One of the biggest problems that we are seeing is a tremendous reduction in tooth decay, but an increase in what is called tooth erosion, and that is the wearing away of the teeth from drinking acidic drinks. It is an increasing problem, and we need to get the message of that risk across to teenagers and young people.

[62] **Lindsay Whittle:** Thank you.

[63] **David Rees:** Before I bring Kirsty in, I have one question. On the figures that you presented in your paper, in table b, is the number of children who are involved in Designed to Smile included in the number of children that you have put in there, treated by the national health service, or are they additional?

[64] **Mr Thomas:** Sorry, the number—

[65] **David Rees:** You have presented the table b figures, and you have put the number of children treated on the national health service in there. I wonder whether the number of children that you are talking about in Designed to Smile is included in that or not.

[66] **Mr Thomas:** Some of them will be seeing the dentist. That is the total number of children who are treated.

[67] **David Rees:** Is that specifically children seeing dentists?

[68] **Mr Thomas:** These are children seeing dentists. Designed to Smile is a community-based programme in nurseries, schools and Community First and Flying Start centres. Those children are not seen by the dentist. The dentists who treat the children are aware that these children are receiving fluoride supplements.

[69] **Kirsty Williams:** May I come onto the issue of orthodontics, which is one of the areas where lots of teenagers potentially end up in dental services? The Assembly has long been interested in problems accessing orthodontic services. In paragraph 21 of your evidence, you say that:

[70] ‘Difficulties remain for patients seeking orthodontic treatment in some parts of Wales’.

[71] Could you explain what parts of Wales those are? You refer to long waiting times. Could you tell us what the waiting times for orthodontic treatment are? Also, it is only young people under the age of 18 who have access to orthodontic treatment on the NHS; adults have to be assessed. So, for instance, if you wanted implants, you would have to be a facial trauma case or a cancer case. Do you have any analysis of people seeking orthodontic treatments, or treatment of that kind, going abroad for that treatment because it is cheaper and who then end up having to have remedial treatment in Wales because there is no follow up, or because things have gone wrong with the treatment that they have received overseas?

[72] **Mr Thomas:** I will turn to orthodontics first, because I think that there are two or three questions there. Implants and whatever else are a slightly different issue. I am in the middle of implant treatment with my wife at the moment, so she is—

[73] **Kirsty Williams:** It is not cheap.

[74] **Mr Thomas:** It is not. In terms of orthodontics, you asked about waiting times. We understand that there are some significant waiting times in west Wales, in the Hywel Dda Local Health Board area. Again, we are working with Hywel Dda Local Health Board and Abertawe Bro Morgannwg University Local Health Board to try to alleviate that issue. I understand that there are some issues in Powys, as well.

10:00

[75] Elsewhere, waiting times vary between 12 and 24 months for either review or treatment. I have to say, though, that there are a couple of issues. Two years ago, we asked Professor Stephen Richmond to carry out an in-depth review of orthodontic treatment, which he has done. The results of that review are on the website. As I say in paragraph 2 of my paper, the review reached some interesting and challenging conclusions. We spend £13 million a year on orthodontics, to start with, which is interesting when you think of some places in Wales, such as Merthyr Tydfil, where my father comes from, where 65% of young children have tooth decay, but we are still trying to straighten teeth. There needs to be a debate about how much we spend on orthodontics. How we deliver it is another issue.

[76] The main thing that I was going to say was that Professor Richmond said that there was enough money in the system to treat all those people who need treatment. On average, about 9,000 children receive and complete treatment in the GDS. There is a smaller number in the hospital dental service, who tend to have very specialised treatment from consultants. There is a very small number in the community dental service. Roughly, nearly 11,000 children receive treatment. One of the things that we should look at is the time that children are sent to the orthodontist for an assessment. I have some figures here that I printed off today, looking at the number of assessments and reviews. You know from experience that children usually start having orthodontic treatment around the age of 12. That is when they have all of their permanent teeth in place. We had over 4,000 children referred by dentists for assessment between the ages of nought and nine—so, they were around 9 years old. A very small proportion of those children will need treatment at that time. So, one of the issues about clogging up waiting times is trying to educate dentists not to send their patients to the orthodontist until they are ready to be assessed, reviewed and treated. One of the things that we are doing at the moment is trying to work our way through the waiting lists to make sure that only those people who are ready to begin treatment are on that waiting list. Otherwise, all that happens is that patients clog waiting times up, and orthodontists are forever just reviewing people and not treating them. What we want to do is to have a realistic balance between review and treatment. So, that is orthodontics.

[77] **Kirsty Williams:** Before you go on, could I ask—

[78] **David Rees:** I have a couple of people who want to come in on a supplementary, so please ask a quick one.

[79] **Kirsty Williams:** From a dental perspective, what are the consequences of a delay of 12 to 24 months? Is it significant, in terms of outcomes? Does it matter if people wait 12 to 24 months? It might be frustrating, but does it matter dentally if they wait that long?

[80] **Mr Thomas:** I would have to defer to my orthodontic colleagues. I am not an expert in orthodontics. I believe that there is some evidence that if treatment is very delayed, there could be some problems. Usually, what happens in terms of starting treatment is that the orthodontists will tell you that they want to start treatment just when the growth spurt occurs, because it will mean that the treatment is quicker. However, as you know, orthodontics can be carried out on patients of any age.

[81] **David Rees:** Before you answer the second part of Kirsty's question, I have a couple of people who want to ask supplementary questions. You mentioned Hywel Dda and, as a consequence, a couple of people want to come in. I will come back to your question, Kirsty. We will now have Rebecca and then Elin.

[82] **Rebecca Evans:** You said that you are working to alleviate waiting times in the Hywel Dda area. Could you describe to us what that work entails? Is it the prioritising of the waiting lists, which you described, or is there additional work?

[83] **Mr Thomas:** Basically, we have asked the local health boards for an action plan on how they intend to prioritise the waiting lists. As far as I understand—and I may need to send the committee a note on this—Hywel Dda board has also commissioned additional orthodontic time in both primary and secondary care in a number of locations. So, additional orthodontic places will be available in Aberystwyth. I will send you a note on this. I am pretty sure that there are some additional orthodontic units of activity being released by Hywel Dda on this issue. I will send you a note on that.

[84] **Rebecca Evans:** When do you expect to receive the plans?

[85] **Mr Thomas:** We are getting the local oral health plans, which are due on 31 December.

[86] **Rebecca Evans:** That is great; thank you.

[87] **Elin Jones:** It would be great if you could send us a note on the Hywel Dda area and the actions that are being taken, because the length of time is a particularly worrying issue. I praised access to general dentistry and improvements to that earlier, but I was going to come on to orthodontics and not offer any praise because no really significant inroads seem to have been undertaken in my area, in particular. The waiting time is the biggest issue, of course, but another issue is the distance to travel for treatment.

[88] You mentioned Aberystwyth. There has not been really a proper orthodontic service in Ceredigion at all for the last few years. What it means is that these are young people who are going through their education and they are probably sitting GCSEs, and they are taking full days out of their GCSE studies in order to travel to Llanelli or, sometimes, to Swansea. It is really quite important and key that the services, if possible, are delivered locally. So, I am glad to hear that. However, what I wanted to ask is, when you were saying about the particular problems in the Hywel Dda area, you seemed to have lots of tables on waiting times in front of you—

[89] **Mr Thomas:** They are just the national statistics. They are not waiting times. It is the orthodontic activity for Wales 2008-09. I am happy to send these through.

[90] **Elin Jones:** That would be great.

[91] **Mr Thomas:** It is just a number. It is not waiting times.

[92] **Elin Jones:** Right, okay. Therefore, there is not anything broken down for us to see the differences in waiting times between the different health boards.

[93] **Mr Thomas:** No, there is not. I have not got that.

[94] **Elin Jones:** You just know that that is the case.

[95] **Mr Thomas:** I only know it anecdotally, from being a dentist and talking to

orthodontists. I should say a couple of other things to amplify this. One thing that we have introduced is a strategic group looking at orthodontics, which advises me. We have managed clinical networks in three areas now: south-east Wales, a bit of which covers Powys, north Wales, which covers the north of Powys, and south-west Wales. They are working very closely to improve the quality of the service that is being delivered. Orthodontics is now almost exclusively delivered by specialists. Before, it was allowable under general dental services, but we found that there were a lot of people just doing the reviews and assessments, claiming the orthodontic money and then referring people. That was really not good value for money. So, what we have tried to do is concentrate the numbers of people who are delivering this service. Coming back to the Hywel Dda area, I will certainly bring you that note. I would like to just return to the £13 million. We have to, at some time, have a debate about how much money we spend on orthodontics compared to other things. It is half the child dental health budget. Is it a cosmetic service or is it not? The NHS does not pay for cosmetic treatment in general terms. We need, I think, to have a debate about how much money we spend and what we would allow as orthodontic treatment.

[96] **David Rees:** I am sure that you have given us some thought to have such a discussion in the future. You mentioned that you did not have some data on waiting times, for example. Are the data sets that you have robust enough to provide sufficient data and information to have a comparison across health boards, or is there still a need to look at what data you are collecting and can you collect more?

[97] **Mr Thomas:** Health boards collect data that relate to referral-to-treatment times, so, in-patient data and out-patients attending hospital. We have data on orthodontics, for example, on hospital dental services. What local health boards do not tend to collect routinely is the information relating to the primary care specialists under the general dental services. They have to ask for that specifically.

[98] **David Rees:** I would like to go back to Kirsty's original question.

[99] **Kirsty Williams:** Yes. All I would say about orthodontics is that if we were to take a decision not to provide orthodontics anymore, it would just further drive the divide between those who can pay for their children to have orthodontics and those who cannot.

[100] **Mr Thomas:** Sure. I agree with you.

[101] **Kirsty Williams:** As someone who never had orthodontic work, I am aware of the impact that that has on you and the self-esteem issues that arise if you do not have good teeth or teeth that look good. I just think that we should urge caution, because it will be the poorest in society who will end up not having the service and middle-class parents who will pay for it. However, what about restorative treatment?

[102] **Ms Howells:** Yes, you asked about implants in particular and the issue of people going abroad. People sometimes choose to go abroad to have implants. That is not free of charge, of course. It costs quite a lot of money to go abroad to have the treatment. It is a problem for the NHS as a result of some patients returning from having had implants done abroad who perhaps have infections or problems. How is that picked up when they come back here? It is the same for a lot of other surgery as well. We have recently had correspondence with colleagues in the Cardiff health board about how to deal with this issue, because it is not an easy one to solve.

[103] **Mr Thomas:** We can solve it if the patient goes to a European Union country, because there are reciprocal arrangements in terms of what we can provide for that patient. Did you mention the availability of implants?

[104] **Kirsty Williams:** Yes, I am interested in the availability criteria here that may be driving people somewhere else.

[105] **Mr Thomas:** Generally, the eligibility criteria are based on the Royal College of Surgeons' guidance, which are, as you articulated, based on trauma, oncology—cancer—and congenital abnormality. For example, a patient may have a denture or whatever and is completely unable to wear that denture because they have lost a lot of teeth and lost a lot of bone and so the denture cannot be retained in their mouth. Those are the more exceptional cases. Those are the four areas where the implants would generally be delivered within the hospital dental service. Implants have never been part of the general dental services. As you say, they are very expensive. For one implant, we are talking between £1,500 and £2,500 for just the implant. There is then the restorative treatment on top of that. It can soon get into a large sum of money. Most hospital dental services have specific budgets for implants and they apply the criteria very strictly.

[106] **Mohammad Asghar:** You are talking about children but I think that people with diabetes and senior citizens have to have treatment within three months. Could you provide me with data about services being provided to these people?

[107] **Mr Thomas:** Orthodontic treatment?

[108] **Mohammad Asghar:** Yes, orthodontic treatment for those people who have diabetes. They should have treatment within a short period of time otherwise they lose their teeth.

[109] **Mr Thomas:** We do not collect that data routinely. I would not have a list of the people who have diabetes.

[110] **Mohammad Asghar:** Those patients go to the dentist for orthodontic treatment, I know that. Basically, if they do not get the treatment, their gums will suffer.

[111] **Mr Thomas:** Yes, there is a link between diabetes and periodontal or gum disease and I agree with you that patients who have a medical compromise should be able to access a service to deal with that.

[112] **Rebecca Evans:** I wanted to ask you about the dental workforce. The British Dental Association has highlighted some concerns about the longevity of the workforce that we have, given that 10% of dentists are currently actively considering retirement. What action is being taken to ensure the short, medium and long-term availability of dentistry for people in Wales?

[113] **Mr Thomas:** Sorry, I am just checking the paper to see whether I included a graph noting the number of dentists that we have working in Wales. I can say that over the last six years, the number of dentists working in Wales has increased. We have approximately 1,800 dentists working in Wales, of which 1,400 are working within the general dental services. The National Leadership and Innovation Agency for Healthcare carried out an analysis of the dental workforce for us. That analysis indicated that there would be a broad balance between supply and demand. I am aware of what the BDA has said. When you look at the demographic profile, you will see that we have quite a lot of dentists working in Wales who are under 40. However, that is not the whole picture. I would like to ask Lisa to describe a new initiative that the General Dental Council has just developed regarding dental hygienists, therapists and dental nurses.

10:15

[114] **Ms Howells:** Until relatively recently, patients could not access dental therapists and hygienists directly; they would be referred to them by a dentist. I cannot remember the exact

date, but earlier this year the General Dental Council changed those regulations—

[115] **Mr Thomas:** It was in May.

[116] **Ms Howells:** It was in May. That means that patients can now directly access a therapist or hygienist without seeing a dentist first. There are lots of systems in place around the NHS regulations and so on, so we cannot make it happen just like that, but we are going to pilot it in two community dental services—one in the Hywel Dda health board area and the other in the Betsi Cadwaladr health board area—to see whether having direct access to other forms of dental team members will help with access difficulties, and help widen and make greater use of the skills that the dental workforce has. So, those pilot schemes will start fairly shortly. We have their proposals. It will be interesting to see how that improves dental team working and the workforce issues.

[117] **Rebecca Evans:** How could we follow the work of those pilot schemes? Will there be regular reports, perhaps, on the website?

[118] **Mr Thomas:** Yes, there will be. All of the evidence suggests that if you include dental care professionals, so that you have a broad skill mix, access to dental services improves. For example, dental therapists and hygienists have been used in New Zealand, Canada and many European countries for many years on a direct access basis. We believe that this will help dental services to become much more efficient and effective than they were in the past. What we have seen with the pilot practices, coming back to your question on pilot schemes, Mr Rees, is that we are moving towards a situation where a number of pilot practices have included dental therapists as part of their teams and are using them effectively as another pair of hands to deliver dental services.

[119] **Rebecca Evans:** Do you recognise the BDA's concerns that recruitment is more difficult in Wales? I understand that we have around half of the applications for each post in Wales. Is it difficult to recruit to Wales or not?

[120] **Mr Thomas:** I think that the BDA is correct. It used to be difficult, but, generally, it is not so difficult now. There are still some difficulties. It is quite difficult to get people to go to work in lovely Haverfordwest and Aberystwyth. I have an anecdote: I was telephoned by a Portuguese radio station asking me why Portuguese dentists liked Aberystwyth. I do not know why. *[Laughter.]* Generally, the answer is that I think that recruitment is easier now than it was.

[121] **Rebecca Evans:** Is income level across the border in England an issue for dentists? Would it be more attractive for them to work in England for that reason?

[122] **Mr Thomas:** The figures that were produced by the dental rates study group show that if you are a dentist who owns a practice in Wales, you earn less money for the same amount of activity in England, but if you are employed by a dentist in Wales, you will actually earn more. So, it is swings and roundabouts.

[123] **Rebecca Evans:** Okay. Finally, I do not know whether you are aware of the work that the Welsh Government is doing to try to attract doctors from some difficult-to-recruit specialisms to Wales, but would there be anything that we could learn from that with regard to recruiting dentists, or vice versa?

[124] **Mr Thomas:** Fifteen per cent of our dentists working in Wales are from the EEA and about 3% are from countries outside of the EEA. The biggest number of dentists that we have come across the Severn bridge from England. We do not really have a problem in terms of recruiting dentists to specialist posts in Wales.

[125] **David Rees:** Could I take it back to the GDC's decision to allow dental therapists to undertake work without the need to be supervised by a dentist? For the pilot schemes that you are proposing, I assume that all of the professionals will be based in a single practice, rather than in individual ones.

[126] **Mr Thomas:** Yes.

[127] **David Rees:** I just wanted confirmation, because people out in the wider world know about going to a dentist, but perhaps they do not understand about going to a dental therapist and what the differences would be. It is important that that information is clear.

[128] **Mr Thomas:** As Lisa has intimated, there is no impediment for a dental therapist or hygienist to open a dental practice in Wales and providing private dentistry. However, I think that it would be a retrograde step in that it really would not be all that efficient. The best use of the skill mix would be within a bigger practice environment.

[129] **David Rees:** Okay, thank you. Lynne?

[130] **Lynne Neagle:** I have three questions and the first is on children's oral health. Rebecca and I sat on the Children and Young People Committee's review into children's oral health in Wales, and we heard some pretty hair-raising evidence about the state of some children's teeth at a very young age. We also heard a lot of evidence that one of the main benefits of Designed to Smile is not really the brushing—that is something that you get with it—but it is actually getting fluoride in contact with the teeth; that is what it is really about. I wondered whether the issue of water fluoridation, or other means of getting more fluoride into children, is something that the Welsh Government is still keeping under review or whether it is something that has completely been put to one side.

[131] **Mr Thomas:** You are right to highlight the big variation in child oral health in Wales. It is something that I have tried to highlight through the years that I have been chief dental officer, and before when I was working in Public Health Wales. Brushing with fluoride toothpaste—putting fluoride on teeth—is the most effective way that we have at the moment of improving oral health. In fact, if we were to look at the evidence across the whole of the world, we would see that brushing with fluoride toothpaste is the main reason why oral health is so good in the countries where we do see brushing with fluoride toothpaste.

[132] In terms of fluoridation, the Welsh Government policy line at the moment is that there are no plans to fluoridate the water supply. I have discussed the issue of fluoridation with the Minister. There are some particular political and financial issues that would make fluoridation difficult at the moment, I have to say. It is something that we are reviewing and we will continue to keep it under review, because there is incontrovertible evidence that oral health for the whole community has improved with fluoridation. I am from Birmingham, where fluoride has been provided in the water since 1963, so I should know.

[133] **Lynne Neagle:** Again in relation to children's oral health, can I ask about the dental fissure sealant programme? We used to hear a lot about that in the early days of the Assembly, but we do not seem to hear so much about it now. Is this something that is still being actively taken forward? What evidence is there that it is actually benefiting children in deprived communities in terms of their oral health?

[134] **Ms Howells:** It is now an integral part of the Designed to Smile programme, rather than a stand-alone programme. So, it is happening. Clearly, fissure sealant is a means to prevent tooth decay in the back adult teeth when they first come through, so it is for slightly older children—six or seven-year-olds, that sort of age group. They are screened beforehand

to check that they are suitable and that the teeth are through. There is published evidence on the value of fissure sealant as a preventive programme for those individual teeth. So, it is still continuing.

[135] **Lynne Neagle:** I have a question on special care dentistry. The national oral health plan raised some concerns about access to dentists with special interests. How confident are you that there is good access across Wales to these dentists with special interests for those people who need one?

[136] **Ms Howells:** Yes, I am just—

[137] **Mr Thomas:** I will start and you finish, as they say. We did raise those concerns and what I have done is create a strategic group of special care dentists from across Wales—in fact, there is a meeting of this group tomorrow. We have developed managed clinical networks on the same model that we use for orthodontics. I can report that we do have special care dental specialists available in every local health board bar, I am afraid, Powys, but we are working on that. Powys does have access to the specialists who work within other local health boards. These specialists are based both in the community dental service and in the hospital dental service. They obviously provide a wide range of services from, for example, bariatric care, right through to services for people with mental illness and children with a physical handicap, but also patients with other medical compromises. That may well include, as Mr Asghar said, people who have diabetes. So, I believe that we are addressing this now. There is more work to do. We now have two trainees in Wales, which is an advance on none. So, I think we are moving forwards on that.

[138] **Ms Howells:** What I wanted to pick up was the role not just of specialists who provide care for people with special needs, but of the wider community dental service. It is not only specialists who can care for people with special needs.

[139] **Lynne Neagle:** Is there training, then, for all dentists on the particular needs of people who, say, might have sensory impairments, or mental illness?

[140] **Ms Howells:** Yes, particularly in the community dental service, there is.

[141] **Leighton Andrews:** Going back to your point about fluoridisation based on your Birmingham experience, would you like to just set out your views on it?

[142] **Mr Thomas:** My personal views?

[143] **Leighton Andrews:** Yes.

[144] **Mr Thomas:** From a scientific point of view, fluoridation of the water supply certainly provides an improvement in oral health for all members of the population.

[145] **Leighton Andrews:** Does it have a particular impact in the earlier age range?

[146] **Mr Thomas:** One of the things that the research shows is that it affects not only those people who are the haves, but also the have-nots, so it has a fantastic effect in reducing inequality.

[147] **Leighton Andrews:** So it is a broad public health measure, in effect.

[148] **Mr Thomas:** Yes.

[149] **David Rees:** May I ask a question on the private sector, in one sense, and the

regulations relating to the private sector? The BDA seems to consider that there should be changes from a register of individual dentists to a register of practices. What is your view on that?

[150] **Mr Thomas:** We have set our policy out in the national oral health plan. We are aware that the private dentistry regulations do actually regulate individuals, and what we will be doing is consulting, after Christmas, on changing those regulations to a practice-based scheme, and also bringing in the regulation for dental care professionals, and—what was the other thing?

[151] **Ms Howells:** National minimum standards.

[152] **Mr Thomas:** Oh yes—developing and publishing some national minimum standards for private dentistry.

[153] **David Rees:** When do you expect to publish those national minimum standards?

[154] **Mr Thomas:** We will have to consult on them, so we will be consulting—I cannot remember—

[155] **Ms Howells:** It may well be towards the end of next year, the full consultation on both the new regulations and the national minimum standards, because there is obviously quite a lot of work to build up and consult informally on any standards such as that.

[156] **David Rees:** Are there any further questions from Members? Yes, Kirsty. We have got some time, do not worry.

[157] **Kirsty Williams:** Could I just ask about tooth whitening, and the availability of tooth whitening via the internet in a pretty unregulated environment? I know that some guidance has been issued recently about trying to encourage people, if they are to go down the tooth-whitening route, to see a dentist first. I am just wondering how problematic this is in Wales, and what we are trying to do to raise public awareness of the potential dangers of buying tooth whitening without professional oversight.

[158] **Ms Howells:** There are two particular risks, I think. First is people buying ‘do it yourself’ tooth-whitening kits over the internet, where there is the potential that either they will not work at all and be a waste of money, or will cause you harm. The other issue is people who are not registered with the General Dental Council doing tooth whitening—beauticians, for example. I am sure any of you who have walked through the shopping centre in Cardiff will have noticed, some years ago, a tooth-whitening area in the middle of the shopping centre. That is the illegal practice of dentistry, and it carries a lot of risks for patients, so our advice is: talk to your dentist, and possibly your hygienist, about it. The first step is to get advice on keeping your teeth properly clean, so that they are as white as they can be normally, and then, if tooth whitening is what you really want to do, you have it done safely through a professional route.

10:30

[159] **Mr Thomas:** I would just add that, as Lisa said, the GDC will prosecute people for practising dentistry illegally. We have identified people, and we are at the moment working with Cardiff trading standards department, which is liaising with all the other trading standards departments in Wales to identify people who may be providing illegal dentistry, and they are then going to liaise with the General Dental Council on this issue.

[160] **Kirsty Williams:** But there have not been any prosecutions to date in Wales.

[161] **Mr Thomas:** Not in Wales, but there have been in other parts of the UK. However, I am not sure that there are not some in train.

[162] **David Rees:** May I take up that point? I think that it is a crucial element that you have raised about the appropriate individuals, but the big question that young people face is the cost—it is the temptation of it at the lower cost. So, in a sense, when do you expect a response from Cardiff, which is now liaising with others, to actually get something done?

[163] **Mr Thomas:** I would have to check with Cardiff to see where we are with that, but I am happy, as a commitment, to inform the committee of what is happening.

[164] **David Rees:** That would be very helpful. Rebecca is next.

[165] **Rebecca Evans:** I have just two questions on practice visits. Could you give us an update on how practice visits have been co-ordinated since Public Health Wales dental practice advisers took over the job in April this year? Also, do you think that there will be a move in Wales to a more office-based, enhanced risk-monitoring system as is currently operating in England? Do you see any particular risks or challenges in the English approach?

[166] **Mr Thomas:** As you are aware, NHS dental services were providing services up until April 2012, and then they declined to carry on with that system. Public Health Wales, plus NHS dental services, are providing the service at the moment. We are in discussions with the Health Inspectorate Wales to take over the process to inspect NHS and private dental practices. We are planning to use the same system that we used before; we are not planning to use an office-based system. We believe that there is no substitute for going to visit the dentist in the dentist's practice and reviewing what is going on there. I cannot really comment on what happens in England, I am afraid.

[167] **Rebecca Evans:** Are there capacity issues in terms of being able to undertake that extra work? If so, do you expect to receive the resources that would be needed to do it?

[168] **Mr Thomas:** The Welsh Government has the resources to invest in the new inspection system. It will be the same resource that he had invested in the NHS DS system. So, it should be the same.

[169] **Rebecca Evans:** Lovely. Okay, thanks.

[170] **David Rees:** Are there any other questions?

[171] **Mohammad Asghar:** *[Inaudible.]*

[172] **David Rees:** Yes, you can.

[173] **Mohammad Asghar:** My question is this: doctors sometimes come to the home on a visit—doctor on call. Why can you not have some sort of dentist on call to give a real service to the public in Wales?

[174] **Elin Jones:** There is.

[175] **Mohammad Asghar:** I have yet to find anybody who has phoned and had a dentist come to their home.

[176] **Mr Thomas:** Information is available in the quarterly national statistics on the number of domiciliary visits carried out. Mainly, domiciliary visits are carried out for people

who are unable to leave their home. I have the data for the last community dental service here somewhere—roughly 2,000 visits were carried out last year. (1) That information is available on the internet.

[177] **Mohammad Asghar:** Between 800 dentists?

[178] **Mr Thomas:** To dentists, yes.

[179] **Mohammad Asghar:** There are 800 dentists around the country, and—

[180] **David Rees:** If you could provide that information to the committee, it would be very helpful.

[181] **Mr Thomas:** Yes, I can.

[182] **Mohammad Asghar:** Great.

[183] **Mr Thomas:** It is not every dentist that does it, because not every dentist is required to do it. It is for people who are absolutely unable to travel.

[184] **David Rees:** Seeing as there are no other questions from Members, I thank you. Perhaps you might wish to raise any issues that you think the committee may wish to take forward and consider in a future inquiry that we might want to think about. Are there any issues that you think are important to be addressed and looked at, particularly strategic policy directions?

[185] **Mr Thomas:** Not at this moment, I do not think, Chairman.

[186] **David Rees:** Okay. Thank you very much for attending. The responses that we have received have been very helpful. You will be given a copy of the transcript to check for accuracy and make factual corrections. Once again, thank you both for coming here this morning.

10:35

Papurau i'w Nodi Papers to Note

[187] **David Rees:** We have received additional information from the various organisations in the follow-up to the stroke-risk reduction session that we had, and we would like to note those. We have also received letters from the Minister for Health and Social Services on the measles single vaccine provider that we queried and the unscheduled care and formal winter plans and the timetable for publication of each of the boards' plans. Are we happy to note those? We are. Thank you.

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd ar gyfer Gweddill y Cyfarfod Hwn Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

[188] **David Rees:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

[189] I see that all Members are happy with that.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:36.

The public part of the meeting ended at 10:36.

(1) Note received from David Thomas: ‘The actual number of patients seen by community dental services on a domiciliary basis during 2012-13 was 10,977 and not roughly 2,000, which was quoted in error.’