

The Welsh Assembly's Health, Social Care and Sport Committee's Inquiry into Dentistry in Wales 2018

Response by the BDA Wales “More than Words”



The BDA

We are the voice of dentists and dental students in the UK. We bring dentists together, support our members through advice and education, and represent their interests. As the trade union and professional body, we represent all fields of dentistry including general practice, community dental services, the armed forces, hospitals, academia, public health and research.

Contents

Introduction	Page 1
Dental Contract Reform	Page 2
Clawback and Handback in General Dentistry	Page 2
Training, Recruitment and Retention	Page 3
Access to NHS general dentistry	Page 4
Orthodontic Services	Page 5
The effectiveness of oral health improvement programmes	Page 6
Recommendations	Page 6
Conclusion	Page 7
Appendix 1: Summary of results from BDA Wales membership survey	Page 8
Appendix 2: Regulations governing NHS and private dentistry in Wales	Page 10
Appendix 3: The 2006 NHS GDS contract, UDAs, clawback, contract reform and members' views	Page 11
Appendix 4: Data showing dental activity over the last six years	Page 17
Appendix 5: Recruitment and Retention of Dentists	Page 17
Appendix 6: Orthodontic services	Page 19
Appendix 7: Comparison of GDS, CDS and PDS budgets 2016-2017	Page 20
Appendix 8: Oral health programmes in Wales	Page 21
Appendix 9: Glossary of Terms	Page 22
References	Page 23

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- ✧ Mr Roger Pratley, Vice Chair Welsh Council
- ✧ Mr Tom Bysouth, Chair, Welsh General Dental Practitioners Committee
- ✧ Ms Lauren Harrhy, Vice Chair, Welsh General Dental Practitioners Committee
- ✧ Dr David Johnson, Chair, Welsh Committee for Community Dentists
- ✧ Dr Kenneth Hughes, Vice Chair, Welsh Committee for Community Dentists

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Introduction

- 1 The BDA Wales greatly welcomes this inquiry into dentistry and the opportunity to present our views, which have been carefully crafted by gathering and analyzing various data, many of which are not normally in the public domain, and by consulting widely with our craft committees and our membership who are daily facing the challenges of delivering dentistry in Wales. We undertook a survey of our members in Wales especially for this inquiry and the results are in *Appendix 1*. We have representatives from the Local Dental Committees (LDCs) on our committees and expect the LDCs to make their own submissions. We look forward to making our oral presentation to the committee on 27 September 2018. The focus of the inquiry, and therefore our response, is general dentistry, orthodontic dentistry and certain aspects of community dentistry. However, we acknowledge the important contributions to patient care by all the dental crafts.
- 2 The BDA Wales wishes to highlight the very important part that good oral health plays in the overall health of the person. When oral health suffers it can have detrimental effects on a person's mental health as well as physical health. We have long-held the view that "the mouth needs to be put back in the body". The Royal College of Paediatrics and Child Health's report, *State of Child Health 2017*¹ asserts that **good oral health is essential for children's overall health and well-being**. Furthermore, when considering services for health and social care there needs to be "proper joined-up thinking". This philosophy is captured in the tenets of *Healthier Wales 2018*², which is warmly welcomed. Such tenets, however, need to be translated into action and system change.
- 3 We also wish to emphasize that the various challenges surrounding general dental practice - including the 2006 General Dental Services (GDS) contract & Units of Dental Activity (UDAs), clawback, contract reduction, poor recruitment/retention and practice closures - are tightly inter-linked and that the combination is leading to a substantial problem with patient access to NHS dentistry. We trust this response helps to explain these complex inter-dependencies. In the current term of the Assembly, BDA Wales has strenuously engaged with stakeholders including Assembly Members to convey the evidence that NHS dentistry in Wales is at a tipping point.
- 4 A major challenge in presenting this report has been the difficulty in accessing relevant data - much of them were derived by Freedom of Information (FOI) requests. There are other data that are simply not available. Assembly members may think that all is well with dentistry in Wales. However, "*absence of evidence is not evidence of absence*". We believe the Government and Health Boards have a crucial role to play in ensuring this evidence is comprehensively gathered, fully analysed and made publically available.

Dentistry services - NHS and private - are highly regulated and quality assured, as are dental professionals. The Government website is out of date so a summary of these regulations from 2006 onwards (including those for patient charges) is given in *Appendix 2*.
A glossary is provided in *Appendix 9*.

Dental Contract Reform

- 5 The 2006 England and Wales General Dental Service Contract and Welsh pilots for contract reform are discussed in detail in *Appendix 3*.
- 6 The 2006 GDS contract was flawed from its inception and has caused untold havoc ever since. Many practice owners in the intervening decade have struggled to make it work and then given up, either by handing back their NHS contract and only practising privately, or by selling their practice - often to a corporate (see pg 18 and *Appendix 9*) - and then working (often reduced hours) as an associate in that practice. The other option favoured by increasing numbers of practice owners is to simply retire early, as the reduction in the lifetime pension allowance might tip the balance. (See the *training and recruitment* section.)
- 7 Because of the nature of the 2006 dental contract, dentists can be reluctant to take on patients with higher needs as they are effectively penalised for doing so. This is because the NHS funding system operates blind to the extra costs of these patients and furthermore dentists need to achieve 95% of their targeted units of dental activity (UDAs) to avoid clawback of funding from the local Health Board. As a result, there is a systemic disincentive for dentists to take on the patients who need their services the most. We refer to this as the *inverse care law*. (See *Appendix 3* for further explanation.)
- 8 To test alternative systems of payment to dentists and new approaches to the delivery of NHS dental services in Wales, The Welsh Dental Pilot programme³ was developed. It ran from 2011 to 2015 and focused on widening access; improving quality; and incentivising prevention. Two of the eight pilots moved on to a trial of a more advanced 'prototype' of the new contract in 2016 based on 85% capitation/15% quality. However, following the announced contract reform⁴ by the new CDO in 2017, the 'prototype' contract was not rolled out, with the two 'prototype practices' remaining as such and not returning to UDAs. Instead, in September 2017 a new pilot scheme began, now with 21 practices taking part. This pilot scheme works with a modest 10% of UDAs given over to oral health needs assessment data collection.
- 9 The BDA Wales supports any reform of the contract that allows for prevention and the oral health needs assessment element. We are pleased to be part of the contract reform project board and a source of expertise and guidance. However, we have yet to be convinced that, without root and branch reform of the GDS contract, these goals of prevention can be achieved. We support a direction of travel that results in UDAs and clawback eventually being outmoded.

Clawback and Handback in General Dentistry

- 10 The BDA Wales has conducted several FOI Requests looking into the amount of monies clawed or handed back by each of the Health Boards in Wales and also the contract reductions resulting from clawback. In May 2017 we published our findings in *BDJ in Practice*⁵ and have added to the data since then. We have submitted our findings to the *BDJ* (August 2018)⁶. Clawback is explained thoroughly in *Appendix 3*.
- 11 In three years, from 2014/15 to 2016/17, a total of £16,322,445 was clawed or handed back to the Health Boards in Wales. See table 3 in *Appendix 3* for a breakdown. Table 4 in *Appendix 3* shows the number of practices affected by clawback in the last three years. It is evident that many practices, (indeed in some health boards the majority of practices), have experienced clawback in this period. In Wales overall, 31% of practices experienced clawback in 2017 which compares with 41% in 2016. These findings chime with the sample of 20 practices in the BDA telephone survey in 2017 which

showed that 60% of practices experienced clawback. In those telephone conversations it was apparent that practice managers and practice owners felt a strong sense of failure, and were hesitant to discuss their own clawback circumstances until it was explained that clawback is actually wide-spread, affecting around one third of practices.

- 12 The fact that fewer practices had clawback in the last year but the total clawback remained the same means that those practices affected will have suffered higher rates of clawback. This is however, not the full picture.
- 13 After two years of clawback such practices are then at risk of permanent contract reductions.
- 14 The BDA discovered that all Health Boards were applying permanent contract reductions to a greater or lesser extent. Table 5 in *Appendix 3* shows contract reduction over the three-year period between 2014/2015 to 2016/2017. Our research shows that over a **quarter** (26.5%) of all NHS practices in Wales have experienced **contract reduction** in the last 3 years. This amounts to approximately **£4,323,078**. Hywel Dda Health Board alone effected more than half of this contract reduction.

The sums of clawback, handback and contract reductions combined add up to
£20,645,987
of the dental budget removed in just three years from general dentistry
away from direct patient care.

(The breakdown is shown in Appendix 3.)

- 15 Health Boards have not yet disclosed what happens to the monies clawed back, handed back or reduced from GDS contracts: Replies to our FOI requests are overdue from six Health Boards. We know unofficially that some use it to “balance the books” i.e. the money has been used for areas other than NHS dentistry. One Health Board is proactive in seeking to reinvest a portion of the clawback into practices’ infrastructure.
- 16 It is vital that Health Boards are transparent in their accounting practices, and that they are held accountable by the Welsh Government. Given the amounts of money clawed back every year, there are ample yet unrealised opportunities for greater investment in existing oral health programmes, including Designed to Smile. (*See section on oral health programmes.*)
- 17 It seems perverse that the Welsh Government has put up patient charges twice in the last two years, obtaining an estimated extra £2.6 million in the process, and yet in that **two-year period** alone there has been a total **clawback of circa £13 million**. It is well-understood that patient charges were originally introduced to cause rationing of dental care. Remarkably, there has been *a sharp increase in the proportion of patients paying charges relative to the increase in patient numbers in Wales in the last six years*, according to the Government’s own data, as shown in *Appendix 4*. This is inexplicable. Whilst we acknowledge that charges are lower than in England, we challenge this creeping escalation and the impact it will have on lower income families who are not exempt.

Training, Recruitment and Retention

- 18 Government data show that NHS general dentistry in Wales is at a time of significant change. The number of providers who are also NHS performers (providing-performers) across Wales has more than halved in the 6 years from 2010 to 2016, from 418 to 201. The fall in providing-performers is unexplained because no systematic Wales-wide survey has looked at this issue. However, if numbers

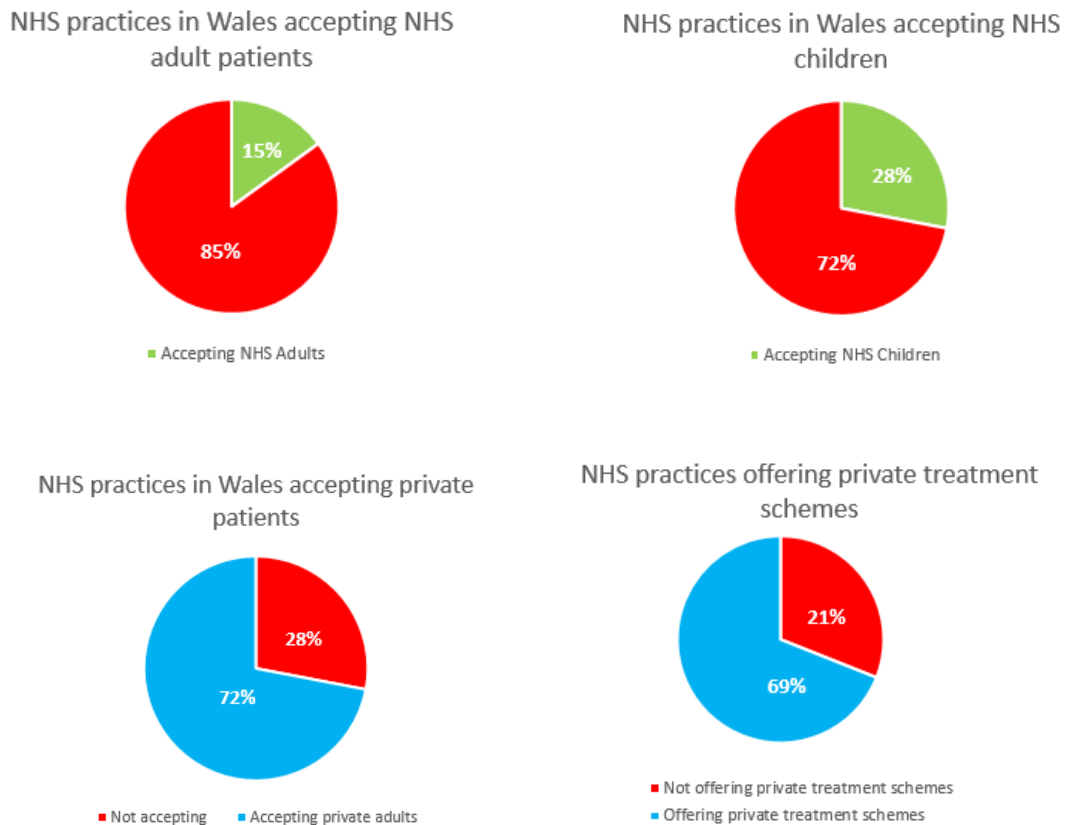
continue to decline at current rates, there will be near zero providing-performers left in NHS dentistry in five years' time. NHS Digital this month⁷ said: "*Nearly two-thirds of Principal dentists and over half of all Associate dentists across the UK often think of leaving dentistry.*"

- 19 Many practices in rural Wales are struggling to see all their patients, let alone new patients, as they are having trouble recruiting and retaining associates. The BDA Wales telephone survey in 2017 covered all the Health Boards and showed that of those 20 practices surveyed, 50% of them believed their problems with recruitment and retention had led to clawback, thus affecting patient access.
- 20 Problems with recruitment and retention of associates, together with a vast reduction in providing-performers, has inevitably resulted in NHS dental contracts being reduced or returned altogether and large numbers of patients being left without access to NHS dental care. Such matters have been made clear to Welsh Government including in the last DDRB evidence. Yet in last year's evidence the Government held down the number of training places for dentists, despite continuing and predicted population growth as shown by the public health observatory (2016)⁸. They instead proposed increased numbers of training places for Dental Care Professionals (DCPs). This however masks the fundamental issue that we need more 'home-grown' dentists in Wales. (Please refer to *Appendix 5* for a fuller picture.)
- 21 The depressed environment of NHS dental practice has contributed to some of the lowest scores for motivation and morale across dentists in Great Britain. This is discouraging young dentists from undertaking a career within NHS dentistry and compelling experienced dentists to leave the NHS or the entire profession. NHS Digital this month⁷ said: "*The more time dentists spend on NHS/Health Service work, the lower their levels of motivation.*" The recent announcement from the DDRB of a 2% pay uplift (yet to be confirmed in Wales - but in England will not be backdated so is in effect 1% for the 12-month period to March 2019) again represents another pay cut in real terms and will only exacerbate the present situation.

Access to NHS general dentistry

- 22 The BDA Wales wishes to draw particular attention to the impacts that the GDS contract, UDAs, clawback, under-recruitment of dentists, dental practice closures and under-spend of the GDS budget are having on access to dentistry in Wales. In 2017 BDA Wales undertook research into levels of patient access, and we submitted our findings in a paper to the British Dental Journal (BDJ) in August 2018⁶. This research shows that access for new NHS patients to primary care dentistry has plummeted in the last few years to an all-time low. Figure 1 below summarizes key findings.
- 23 In 2017 we found that only **15%** on average of all NHS practices were accepting **new adult NHS patients** and only **28%** of all practices were accepting **new child NHS patients**. In many cases this was with a waiting list. Therefore, based on current levels, nearly three quarters of children being born in Wales today will struggle to access an NHS dentist. This is down to the contract cap put on each dental practice by the Health Boards, which in turn are constrained by the Government's dental budget allocations. The Royal College of Paediatrics and Child Health's report *State of Child Health 2017*¹ lists **access to timely primary dental care** as a key health objective. The reality is that this objective is currently not possible. If children cannot easily access NHS dentistry, then good oral health cannot be achieved and maintained.
- 24 This problem of access is not peculiar to Wales. In January 2018, Healthwatch England, the patient watchdog, published six priorities for NHS England including *Tackling access issues in NHS dentistry*⁹. Healthwatch England and their 52 branches have published extensively about problems with access to dentistry in the last few years. Wales needs a strong voice for patients. The Community Health Councils are being wound down and in any case have lacked patient experience of dentistry data.

Figure 1 showing percentages of dental practices accepting new patients (including via waiting lists).



- 25 The newly reconfigured National Survey for Wales^{10,11} asks 11,000 people every year about their health and lifestyle and access to services. We are disappointed that the only question asked currently is how many natural teeth the person has. No questions are asked about access to dentistry.
- 26 The population of Wales is projected⁸ to increase by almost 9%, from around 3.1 million in 2011 to over 3.3 million in 2036. The 65-to-84 and 85+ age groups are projected to have the largest increase by 2036, when an estimated 1 in 4 people in Wales will be aged 65 and over. This changing demography will require additional resources to meet the increased need for restoration. Yet the latest Government figures¹² show an actual fall of 0.4% in courses of treatment in the last year 2016-2017.

Orthodontic Services

- 27 The number of orthodontic performers in Wales has reduced by 38% from 133 to 82 between 2008-09 and 2015-16. There is evidence of significant reductions in performers in Betsi Cadwaladr and Hywel Dda. The budget for Personal Dental Services (PDS) has reduced in the last three years. (See *Appendix 6*.) Not surprisingly this has had a severe effect on waiting times. Dentists working in various Health Boards in Wales have been known to refer patients more than 3 years in advance of their needing treatment as this is the only way for dentists to ensure that patients are treated at the time they would need orthodontic services. In 2014, an FOI request¹³ discovered that Cardiff and Vale had the second largest waiting list in Wales. (See *Appendix 6* for further information.)

- 28 In 2017, there was a target to reduce waiting times to 6 months for Hywel Dda Health Board. There was no plan included in this target. Now, Hywel Dda has a 5-year waiting list. This year, the commissioning of UOAs (Unit of Orthodontic Activity) has a reduced unit value.
- 29 We appreciate the work being done by the Welsh Government on the new electronic referrals system which should markedly improve data quality by ensuring robust systems for **data recording** and transparent reporting on all aspects of orthodontic provision in all provider settings.

The effectiveness of oral health improvement programmes

- 30 Tooth decay is an entirely preventable disease and using schemes to educate children on oral health can have a significant positive impact on oral health. Wales has had some success in recent years with Oral Health improvement programmes, but there is much more to be done.
- 31 The Well Being in Wales (2017)¹⁴ report claims that oral health in children is improving. However, this presents a partial picture and is based on comparisons with old data from 2007/8. We would suggest that the Well-being of Future Generations (Wales) Act 2015 is forward looking legislation and that a true picture of oral health improvement is more nuanced, including the adverse effects of deprivation. (See *Appendix 8* for further information)
- 32 Of those BDA members who took part in our survey, 90% would like to see new oral health programmes for older primary school children. There is plenty of evidence showing that many older children and young teenagers in Wales still have poor oral health. In 2016-2017 on average 29.6% (37.5% most deprived quartile) of 12-year old children had dental decay¹⁵. In 2013 66% of 15 year-old children had obvious dental decay experience¹⁶. NICE Guidance¹⁷ recommends raising awareness of the importance of oral health, as part of a 'whole-school' approach in all primary schools and secondary schools too. Considering only a quarter of GDS practices across Wales are accepting new child patients then the Government needs to substantially invest clawback money in preventative schemes aimed at all children and also their parents.

Recommendations

See *Appendix 1* for the full list of responses from BDA members

GDS Contract

- 1) The Welsh Government must make the pledge that everyone should be able to access good quality NHS dental services - and then provide the resources to fulfil it, including establishing minimum UDA values and an uplift of UDA values in areas of deprivation.
- 2) The contract must move away from UDAs and towards meaningful performance measures and capitation for effective preventative dentistry and the provision of care needed for patients with poor oral health.

Clawback

- 3) It is vital that Health Boards are transparent in their accounting practices, and that they are held accountable by the Welsh Government for any underspend of the GDS budget.
- 4) Welsh Government should enforce Health Board KPIs for delivery of the GDS contract. Health Boards should account for how the clawback will be fully reinvested, including in oral health programmes for children of all ages. No clawback money should be reabsorbed into the general budget.

Patient experience

- 5) Systematic research should be conducted showing the experience of patients and would-be patients, including access to dentistry and the impacts of this on the population as a whole.
- 6) The National Survey for Wales must include patient experience of dentistry and access to dental services. The latter could be addressed by a simple question – *When did you last visit a dentist?*

Workforce

- 7) The Government should take fully into account the changing demography of Wales and the future requirements of the population in planning the dental workforce of the future.
- 8) Welsh Government must conduct an evidence-based review of the dentist workforce ensuring the requirements for the future for all dentistry crafts, including community dentists, will be fully met. The Government must not rely on skills-mix as the alternative to training more dentists in Wales.
- 9) The Welsh Government must ensure dentists' pay does not continue to be eroded as it has been in the last decade, and from now on should ensure annual uplift keeps pace with real inflation.

Orthodontics

- 10) As advised in 2016, the Welsh Government and the Orthodontic Strategic Advisory Forum should lay out a clear **strategy** for orthodontics in Wales for the next 5 years.
- 11) Health Boards must produce clear plans on how they intend to reduce waiting lists for orthodontic services, as well as updates on the effectiveness by showing outcomes data.

Oral Health Programmes

- 12) The Government should fund the D2S programme sufficiently that the 5 and 6 year-old children can receive the same benefits of inclusion as they did previously, including fluoride varnish.
- 13) The Government should ensure that age-appropriate oral health programmes for up to 12 year olds are delivered through schools in all Health Boards in order to address high prevalence of decay in that age group. There are more than enough funds from clawback to provide this.
- 14) The Government should do much more in promoting oral health messages and restricting access to sugar and sugary drinks in schools, hospitals and other public-funded organisations.

Data Analysis and Reporting

- 15) Official data about dentistry and oral health need normalisation against population numbers to allow for proper intra- and inter-Health Board comparisons on performance.
- 16) Many elements of data collection and reporting across the Health Boards need a major overhaul. Comprehensive data on dentistry budgets need to be systematically collected and transparently and routinely reported by these procuring authorities for public access.

Conclusion

This inquiry must produce **more than words** to make a real difference to dentistry in Wales.

Appendix 1: Summary of results from BDA Wales membership survey

The BDA conducted a survey of its members in Wales in August 2018 to help inform our response to the inquiry. Those who responded were GPs (68%), community dentists (19%) and 12% working in hospital or other dentistry roles. We are very grateful to the 79 dentists who took part.

We received responses from across all the Health Boards. The largest response came from dentists in the Betsi Cadwaladr University Health Board (24.36% of respondents), closely followed by Cardiff & Vale University Health Board (20.51%).

Table 1. Recommendations from the BDA Wales membership to the Welsh Government:

Recommendation	Strongly Agree or Agree	Disagree or Strongly Disagree
Invest more in dentistry in Wales, to improve access and address oral health inequalities	96%	1%
Freeze patient charges, and provide additional investment from general taxation	38%	30%
Provide a prevention-based NHS dental contract that makes a decisive break from targets	87%	1%
Limit the marketing and promotion of sugary foods and drinks to young children	94%	1%
Ensure Clawback from NHS dental contracts should be reinvested back into NHS dentistry	97%	0%
Do more to encourage younger dentists to work in Wales	86%	0%
Raise awareness of the fact that NHS dentistry is free for under-18s, and exempted groups	78%	3%
Do more to inform parents of young children about the dangers of sugary food and drinks for good oral health	96%	0%
Extend the Designed to Smile programme to children aged 5-12, to address the concerning levels of tooth decay in these age groups	90%	5%

There were five response options:

strongly agree, agree, neither agree nor disagree, disagree, strongly disagree

Table 2. Members' reports on dental caries and oral health status of young children and oral health promotion activities

Question	Yes	No	?
Q3 Practices who saw more than 40% of younger child patients with visible signs of tooth decay?	36%	61%	3%
Q5 Do you do any unfunded oral health promotion from your practice or work place, e.g, putting up posters in your practice highlighting the dangers of sugar, or whilst carrying out school visits, etc.	86%	11%	3%
Q4: What other preventable oral health problems are you seeing in young child patients?	<i>Tooth loss, erosion (including acid erosion caused by fizzy drinks, or perceived 'healthy' fruit juice drinks), gingivitis and abscesses, poor oral hygiene and poor diets, dummy usage up to school age</i>		

Appendix 2: Regulations governing NHS and private dentistry in Wales

The government web page is out of date so the up-to-date list is provided here:

2018

The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2018

2017

- a) Private Dentistry (Wales) Regulations 2017
- b) The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2017

2015

The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2015

2014

The National Health Service (General Dental Services Contracts and Personal Dental Services Agreements) (Wales) (Amendment) Regulations 2014

2013

The National Health Service (Dental Charges) (Wales) (Amendment) Regulations 2013

2012

The National Health Service (Primary Dental Services) (Amendments related to Units of Dental Activity) (Wales) Regulations 2012

2010

The Local Health Boards (Consultation with Local Dental Committees) (Wales) Regulations 2010

2006

- a) The National Health Service (General Dental Services Contracts and Personal Dental Services Agreements) (Amendment) (Wales) Regulations 2006
- b) The National Health Service (Performers Lists) (Wales) (Amendment) Regulations 2006
- c) The Functions of Local Health Boards and the NHS Business Services Authority (Primary Dental Services) (Wales) Regulations 2006
- d) The National Health Service (Dental Charges) (Wales) Regulations 2006
- e) The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006
- f) The National Health Service (Personal Dental Services Agreements) (Wales) Regulations 2006
- g) The Functions of Local Health Boards (Dental Public Health) (Wales) Regulations 2006
- h) The Health and Social Care (Community Health and Standards) Act 2003 Commencement (Wales) (No. 4) Order 2006
- i) The General Dental Council (Professions Complementary to Dentistry) (Dental Hygienists and Dental Therapists) Regulations Order of Council 2006

Appendix 3: The 2006 NHS GDS contract, UDAs, clawback, contract reform and members' views

A) The NHS Dental Contract explained

1. The NHS General Dental Services Contract was developed by the Department of Health and came into force on the 1st April 2006 in England and Wales. (Scotland and Northern Ireland operate different types of GDS contracts.)
2. Dental practices are constructed to run as independent businesses; having to cover all running costs, capital expenditure and overheads as well as salaries. Practices contract with the commissioner, (in Wales this is the Health Board), for an NHS dental contract. The practice performance is scrutinised and closely managed against targets. (See section on clawback.)
3. The contract's system consists of three bands that determine how much the patient is charged for their treatment and how much the dental practice is remunerated by the Health Board.
 - i. Band 1 includes diagnosis, treatment planning and maintenance, for example a clinical examination, assessment and report and an x-ray.
 - ii. Band 2 includes all necessary treatment covered by band 1 plus additional treatment such as fillings, root canal therapy and extractions.
 - iii. Band 3 includes all necessary treatment covered by band 1 and band 2 plus more complex procedures and provision of appliances, for example, bridges, crown and dentures.
4. The patient charge costs in Wales have been increased by Welsh Government twice in the last two years: Band 1 costs £14; Band 2 costs £44; Band 3 costs £195. Patients on benefits are exempt from paying dental charges and all patients are exempt from paying drug prescriptions. <http://www.healthcosts.wales.nhs.uk/proof-of-entitlement>
5. The 2006 contract changed the way that dentists are contracted, through the introduction of UDAs (Unit of Dental Activity). Dental practices are evaluated on the UDAs they achieve against the contracted allowance of UDAs allocated by the health Boards. These UDAs are linked to the three-band system.
 - i. Band 1 is classed as 1 UDA, Band 2 is 3 UDAs and Band 3 is 12 UDAs.
 - ii. UDA values vary considerably between practices and between Health Boards. Average Health Board values vary between £23.38 and £29.96, but there is considerable variation and many UDA values are too low to be workable.
6. The contract does not take into account the extent of the work required within a band. For example, in Band 2 a dentist will receive 3 UDAs whether they perform one filling on a patient, or three fillings and an extraction on a patient. This is considered to be one single course of treatment – regardless of the dentist's time taken and the cost of materials required. (Dentists' activities are highly scrutinised by NHS Business Services and HIW and

outliers are individually inspected and fined for any separation of activities within a course of treatment.)

7. It is worth considering that the dental budget spent in the last three years (£133,005,780 per annum) equates to £42.72 per capita per annum. That compares with the whole Health budget of £2,300 per capita per annum, or 1.9%. Given that 54% of the population were treated in 2017 (1,710,254) that equates to approx £78 per patient, or roughly 3 UDAs.
8. The real costs of treating high needs patients are therefore not accounted for within the contract and can often represent a loss to the dental practice business. Where there may be high needs patients not currently registered with a practice their potential treatment costs would not be covered by the UDA value, so there is no incentive for practices to alter their patient lists to include them.
9. The contract therefore acts as a strong disincentive for dentists to treat high needs patients owing to the broken business model. It is a misnomer to talk about units of dental activity when they are clearly expected to be infinitely elastic and not a unit in any normal business sense. The UDAs do not work for high needs patients and are consequently not fit for purpose.
10. Not only do dentists not receive remuneration commensurate with the work done for high needs patients, but in areas where good oral health predominates dentists are not remunerated should they attempt to treat more patients than their contract allows because of the cap imposed by the contract. This creates a barrier to improving patient access generally.
11. Over 90% of dentists say the 2006 contract has limited their capacity to treat patients with high needs.

B) What is Clawback?

1. If a dental practice fails to achieve 95% of their UDA target they will face clawback.
2. These Health Boards have a variety of different ways of handling clawback. Some clawback everything owing, others allow the dentist to carry 5% over to next year and only claw back the excess, some deal with dentists on an individual basis.
3. Setting targets can be helpful to productivity in many circumstances, but it does not work with UDAs. A dentist facing clawback could have worked longer hours and helped more patients with more challenging ailments than a dentist who has completed their UDA targets. This is in part due to the banded systems relation to UDAs. (See previous section.)

C) What is Handback?

1. If a dentist is struggling to achieve their UDA target for that financial year they may choose to give back a percentage of their UDAs to the Health Board. Handback may also occur if a dentist chooses to close their practice or if they retire for example.
2. These UDAs can then be auctioned back to dental practices within the Health Board, although this reinvestment does not always occur. In Betsi Cadwaladr for example there has been a net closure of 8 practices in the last three years with a knock-on effect on patient access.

Table 3: Clawback handback and contract reductions in all Health Boards over three-year period and resulting underspend.

Health Board	GDS Budget from 2014/2015-2016/2017 TOTAL	Clawback and handback from 2014/2015-2016/2017 TOTAL	Contract reduction from 2014/2015-2016/2017 TOTAL	GDS Spent from 2014/2015-2016/2017 TOTAL	Percent of budget unspent	Percent of equivalent budget (with contract reductions included) unspent
Betsi Cadwaladr	£83,507,000	£3,937,222	£318,382	£79,251,396	5.1%	5.5%
Cwm Taf	£49,375,173	£1,402,929	£252,305	£47,719,939	2.8%	3.3%
Cardiff and Vale	£76,747,000	£1,520,000	£216,827	£75,010,173	2.3%	2.5%
Powys Teaching	£15,426,215	£1,818,656	£616,952 (approx.)	£12,990,606	15.8%	19.0%
ABMU	£88,712,738	£2,724,903	£488,537	£85,499,297	3.6%	4.2%
Aneurin Bevan	£68,902,203	£1,704,983	£196,672	£67,000,548	2.8%	3.0%
Hywel Dda	£36,993,000	£3,213,770	£2,233,391	£31,545,383	14.7%	19.6%
Wales Total	£419,663,329	£16,322,463	£4,323,066	£399,017,342	4.9%	5.9%

Table 4: Number of practices which experienced clawback over a three-year period

Health Board	Number of Practices facing Clawback 2014-2015	Number of Practices facing Clawback 2015-2016	Number of Practices facing Clawback 2016-2017
Betsi Cadwaladr	35 (50%)	36 (51%)	35 (50%)
Powys Teaching	11 (55%)	12 (60%)	11 (50%)
Hywel Dda	7 (16%)	10 (23%)	8 (19%)
ABMU	32 (50%)	31 (48%)	17 (27%)
Cwm Taf	8 (28%)	13 (45%)	6 (21%)
Aneurin Bevan	16 (26%)	16 (26%)	21 (34%)
Cardiff and Vale	17 (21%)	26 (39%)	12 (18%)
All Wales	126 (36%)	144 (41%)	110 (31%)

Table 5: GDS contract reductions in each Health Board

Health Board	Number of Practices	Total Amount
Betsi Cadwaladr	18	£318,382
Powys Teaching	11	22884 UDAs (approx. £616,952)
Hywel Dda	20 (11 temporary)	£2,233,391 (£1,336,214 temporary)
ABMU	11	£488,537
Cwm Taf	7	£252,305
Aneurin Bevan	15	£196,672
Cardiff and Vale	12	£216,837

D) How are Clawback and Handback affecting Dentistry?

1. Clawback and Handback mean that the patient access issues being faced in Wales will only worsen, especially when two years of clawback in a practice results in permanent contract reduction.
2. Clawback and handback have resulted in millions of pounds that should be used for dentistry not being reinvested. **In the last three years alone £20 million has been taken out of NHS general dentistry in Wales due to clawback and contracts reductions**, but only a small fraction of this has been reinvested into dental practice facilities by one or two Health Boards.
3. To illustrate the loss of patient treatment resulting from clawback in 2015-2016:
 - The money clawed and handed back in Hywel Dda was equal to 51,348 Band one treatments; that is 37% of the Band 1 work Hywel Dda did that year.
 - In Cwm Taf 9,752 more Band two treatments could have been performed with the funds they clawed back.
 - A shocking 50% more Band 3 treatments could have been performed with the clawback in Hywel Dda if the funds had been reinvested.
4. The current system of clawback and handback only exacerbates the growing patient access problem because taking on new patients is a risk to dentists trying to achieve such tightly managed targets. Dentists are disincentivised in the current contract to treat high needs patients because there would be a significant financial loss to the practice.
5. Scaled up, a large proportion of high needs patients can result in a practice failing to reach its targets and facing clawback, handback or contract reduction despite the increased expense to the practice. This is a double negative impact – the loss of revenue and the higher costs of treatment.
6. Clawback is prevalent in all Health Boards, meaning that patients with poor oral health are disproportionately affected. *Inverse care law* is felt acutely in general dentistry.
7. Many overheads such as running a chair and employing staff are fixed commitments. Therefore, clawback and contract reduction have a direct impact on staff employment, particularly ancillary staff. Such a model will always work against the interests of high needs patients. This requires to be fundamentally changed.

8. There needs to be new thinking 'outside the box'. Clawback is pernicious, counter-productive and operates with a bureaucratic machinery. We welcome any advances within contract reform that help to use this money directly for the benefit of patients and the support of practices.
9. The cost of materials has been rising above inflation for many years, and now with the new environmental regulations concerning the use of mercury, amalgam use is being sharply reduced and the more expensive restoration materials used in its place. This will further strain an already broken business model.
10. There is a growing trend for practices to be bought by corporates rather than early career dentists taking on their first practice ownership, because this is becoming prohibitively expensive for the majority. Yet corporate practices are finding that NHS contracts are unworkable and, after suffering clawback and contract reduction, are as a result closing in ever larger numbers. In one area alone there have been closures in Knighton, Machynlleth, Dolgellau and just recently Builth Wells. The latter is the corporate, 'MyDentist'. This matter of practice closures has been made clear to Welsh Government by dentists' representatives on several occasions, and yet in their most recent evidence to the DDRB the Welsh Government does not acknowledge there is a problem with provision of NHS dentistry services.
11. One dentist wrote to their AM and MP in 2017 to seek support for their practice situation as such pleas had fallen on deaf ears in the Health Board. This is a rural, single-handed dentist who could not recruit an associate in two years and had to give back their NHS contract in 2017. This extract sums up succinctly the very real problems that many dentists are facing throughout the country, and especially but not exclusively in the more rural areas.

"The NHS contract is a disgrace - it promises patients comprehensive care, but in reality, is so poorly resourced and constructed, that care takes place despite it. The current environment is simply not fit for purpose. On the ground, officials do care, and they do their best, but the system and available resources are grossly inadequate. Someone, somewhere, should be held accountable for the current situation. In the longer term, there has to be some integrity and honesty about what the state is prepared to provide through the NHS."

12. There are similar comments from members who took part in our August survey:

"Everybody seems to agree that we should focus on prevention yet prevention is simply not 'recognized' in the UDA system as an 'activity' and therefore it is not remunerated. We are expected to deliver prevention to each and every one of our patients for free while trying to meet UDA targets in order to keep our practices afloat, and indeed, most of us are doing it because we care about our jobs and our patients, and the Government is taking this for granted.

When are we going to look at the elephant in the room and see it for what it is: there hasn't been any new money going into NHS dentistry in the past 10 years, money is being taken away from us (through claw backs) and used to patch up holes in other NHS departments. NHS dental practices are struggling to survive, some are closing down and others are just about managing to break even, there is a huge recruitment crisis all over the country because the value of our work is not being recognized and the highly skilled work that we do is not fairly remunerated.

I am not a pessimistic person and I love my job, but after 11 years working under the current NHS contract I fear for the future and frankly I'm expecting the worst."

“The system needs to change. We are penalised when we see patients with high need. This is a disincentive to opening the books to new patients. It’s also a ticking time bomb for the older generation with heavily restored mouths. The system will not recompense sufficiently to treat this considerable group, many of whom had the original treatment at different practices (and countries) years ago. So despite what the CDO may say I think oral health and dental care for the majority is on the slide unless we move away from a targeted based system and concentrate on patients need; which will vary between areas.”

E) What is Contract Reform (and will it help)?

1. Contract reform has taken place in several different Government pilots in Wales since 2011 and the BDA Wales has endeavoured to be the Government’s critical friend and a support to practices undertaking such pilots. Eight practices took part in the original scheme. Those taking part in the pilots favoured this new way of working and argued that whilst the UDA system focused on numbers, the pilot focused on people (capitation). This ethos of prevention was strengthened in the 2016 prototype contract run in two practices in Swansea which had no UDAs. However, although those two practices remain on that contract until today, the new CDO introduced a different type of pilot in 2017⁴, based on the current contract of UDAs.
2. The new pilot in Wales has been running since September 2017 and operates based on 10% of UDAs used for data gathering of oral health needs assessments, which is the first small step to improving a patient’s oral health. However, the BDA would like to see a much greater percentage of UDAs (at least 30%) being used for prevention to make it a workable prospect.
3. In an ideal world the BDA Wales would prefer all practices to be given the type of contract that the two prototype practices in Swansea are operating, which is 85% capitation and 15% quality measures. With such a contract no clawback is imposed, and preventative dentistry is at the front and centre of its operations. The ‘prototype practices’ saw an initial reduction in patient numbers at the early stages because preventative treatment is more resource intensive initially until the high needs patients are stabilized, but two years on and the most recent data show that patient access has returned to the required levels.
4. One of the key aspects of contract reform propounded by the Welsh Government is the use of skills-mix^{18,19}, which essentially is employing dental hygienists and therapists to take on some of the work usually done by dentists. (These DCPs might also be upskilled to optimise this arrangement.) The proposed theory is that in turn dentists would be freed to upskill to more specialist dentistry, thereby maximizing the use of their expertise and skills outside of the practice on an intermittent basis, making room for the DCP to work in their stead. This arrangement, together with extended recall times for patients with good oral health, would in theory allow capacity for increased access of patients. Whilst this appears to be a rational approach, we wonder if it is practicable. The BDA has requested from Welsh Government the business model that demonstrates how this skills-mix would work, particularly for single-chair dental practices.
5. There are many fixed overheads in running a dental surgery chair and apart from the salary differential (which is not a great saving) there are no other obvious savings to the practice. DCPs have a limited repertoire, even with the upskilling, and tend to be slower. Should the model need an extra dental surgery chair for the DCPs it is unclear a) how this can be afforded by the

practice, b) how the return on investment (ROI) makes good business sense, and c) whether patients would be comfortable being seen by several different practitioners rather than just their dentist. In fact, the patient view is currently missing altogether from this model, although we trust the pilots will include this in the data collection. The BDA reports anecdotally that only a minority of dentists would be interested in upskilling and we would ask where the money for such training and the backfill would come from.

6. We were involved in the discussions that form the response²⁰ by the CDO to the Government's policy *A Healthier Wales*. However, we would like to see this fleshed out to include the critical financial, operational and cross-service reform considerations.

Appendix 4: Data showing dental activity over the last six years

Government data when computed as shown in table 6 demonstrate that the percentage of patients who are paying charges is rising much more steeply than the population increase.

Table 6: Comparison of courses of treatment, number of patients treated, patients charged and the total population between 2010-11 and 2016-17 (Data from Stats Wales)

Period	total courses of treatment	number of patients treated	Patients who paid charges	Population of Wales
2010-11	2,316,330	1,653,797	932,917	3, 050, 000
2016-17	2,383,391	1,710,254	1,071,298	3, 113, 000
Increase in six years (N)	67,000	56,457	138,381	63,000
Increase in six years (%)	2.9%	3.4%	14.8%	2.1%
Average yearly increase (%)	0.48%	0.57%	2.47%	0.35%

Appendix 5: Recruitment and Retention of Dentists

- 1 Substantial evidence of recruitment and retention problems was provided by the BDA to the last DDRB review, which included sections from Wales describing the knock-on effects of clawback on patient access - some of that clawback was a result of practices not being able to recruit associates. Nevertheless, the DDRB chose to ignore the collective UK BDA evidence describing it in July 2018 as anecdotal²¹, and instead favoured the Governments' figures¹⁹ that suggested that all was well with NHS dentistry. The official Welsh Government statistics, in their evidence to the DDRB, failed however to account for population growth which means that NHS dental activity as a percent of the Welsh population has remained stubbornly at 54% for the last 6 years. (*See Appendix 4.*)
- 2 The BDA Wales will be presenting new evidence to this year's DDRB suggesting that this percentage is likely to decrease in the near future with access now being very low for new patients, and with many practices now experiencing clawback and contract reductions, problems recruiting associates and more practices closing, including corporate practices such as MyDentist.

- 3 There have been several closures of MyDentist practices in England and Wales in the last few years, in many cases because of not being able to attract enough associates and because they operate a different business model to practitioner-owned practices and have not found dentistry profitable enough. Peter Ward, the CEO of the BDA, in 2017 pointed out, 'dentistry isn't the only area where the corporate "consolidators" have entered the fray.' This has happened in both pharmacy and optical services, but for them 'the clinical component of the income streams for both businesses is relatively small and the merchandising activity is vast.' Dentistry is different, in that 'the biggest part of what patients pay for is the dentistry itself – the actions of the clinically trained professionals.'
- 4 The BDA produced an extensive report on The State of General Dental Practice in 2013²². Section 16.2 states: *"Recruitment seems particularly difficult in Wales. Welsh associates have the highest pay of any region which probably reflects their difficulty in recruiting. Practice owner pay in Wales is much lower than that in the other countries. Welsh practice owners seem to be paying themselves less in order to engage associates to help meet their UDA targets."*
- 5 NHS Digital this month⁷ said: *"Whilst the results for Associate dentists are quite similar when comparing England & Wales to Wales only, there are larger differences for Providing-Performer dentists where dentists in Wales tend to work longer hours, take fewer weeks' annual leave and perform more NHS work."*
- 6 NHS Digital²³ also reported that in 2016/17 Providing-Performer dentists' average taxable income from NHS and private dentistry decreased by 7.3%. Associate dentists have also seen a decrease in taxable income by 2.1%
- 7 The BDA Practice Owners Survey 2016 has shown that morale is low for Welsh dentists who perform mostly NHS dentistry, only 26% of whom feel they are fairly remunerated. [NHS Digital this month⁷ said: *"The most common contributory factors to low morale are increasing expenses and/or declining income and the risk of litigation and the cost of indemnity fees. Regulations are also cited as a major cause of low morale amongst Principal dentists."*] Yet despite this long-running narrative from the BDA, the UK Governments appear impervious to these messages.
- 8 In the most recent statistics (August 2017) published by the Welsh Government it appears there has been little change in the number of dentists per 10,000 of the population. However, this figure does not consider the full-time equivalents (FTEs) providing NHS treatment and is merely a headcount. NHS Digital this month⁷ said: *"During the last decade there has been a notable drop in the amount of time dentists spend on clinical work across the UK."* The FTEs will be therefore lower. Also, the figure 1,475 includes Dental Foundation Year 1 posts. We therefore believe this latest report does not paint the whole picture.
- 9 The last time the Welsh Government systematically considered workforce issues was the survey²⁴ of 2012. The review states that 'On average during the period 2007-2010, 58% of Welsh-trained dental graduates entered the Welsh workforce after completing DF1. Undertaking DF1 training in Wales is a significant factor in the decision to continue working in Wales. Of these (58%), 90% undertook DF1 training in Wales and 10% undertook it elsewhere before returning to work in Wales'.
- 10 The Dental School in Cardiff was set up in the main to increase the Welsh dental workforce, which it appeared to have done successfully in the initial graduate years from 1967. The 2012 workforce survey says that 'Welsh trained dentists account for 41% of the dentists currently working in Wales'. However, since then the picture of Foundation Training has been changing with the recent introduction of the centralised Foundation Training Application Process²⁴ which is UK-wide, and which means that trainees cannot be guaranteed which country, let alone which county, they will be assigned to. This has a high risk of creating a highly volatile post-training workforce and with no guarantee that Welsh-born dentists will feel a strong imperative to return to Wales.

Appendix 6: Orthodontic services

Table 7 shows the most recent data available from FOIs¹³ in 2014 as well as a comparison to each Health Boards population. Cardiff and Vale, Betsi Cadwaladr and Powys were handling orthodontic waiting lists 3-5 times better than Hywel Dda. Moreover, ABMU and Aneurin Bevan were handling orthodontic waiting lists 20 to 40 times better. It should be noted that while this figure may show ABMU to be coping well, we are aware that there are difficulties within the orthodontic services in ABMU. The Review²⁶ of the orthodontic services in Wales 2008-09 to 2015-16 stated that a strategy needed to be developed for the future of Orthodontic services. The Strategic Advisory Forum on Orthodontics reports²⁷ periodically to the CDO on progress.

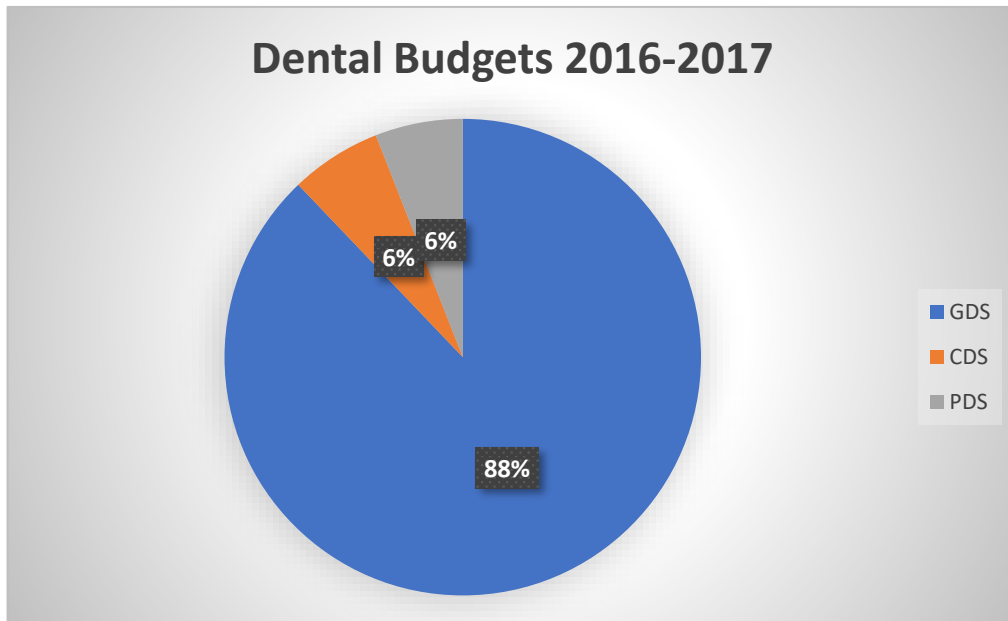
Table 7: Waiting list numbers for orthodontic services in 2014 for each Health Board

Health Board	Waiting list in 2014	Population aged 0-15 in 2014	Percentage of 0-15 Population
Hywel Dda	1584	65,236	2.40%
Cardiff and Vale & Cwm Taf	1019	144,193	0.70%
Betsi Cadwaladr	769	123,699	0.62%
Powys	100	21,919	0.45%
ABMU	83	91,439	0.09%
Aneurin Bevan	73	108,355	0.06%

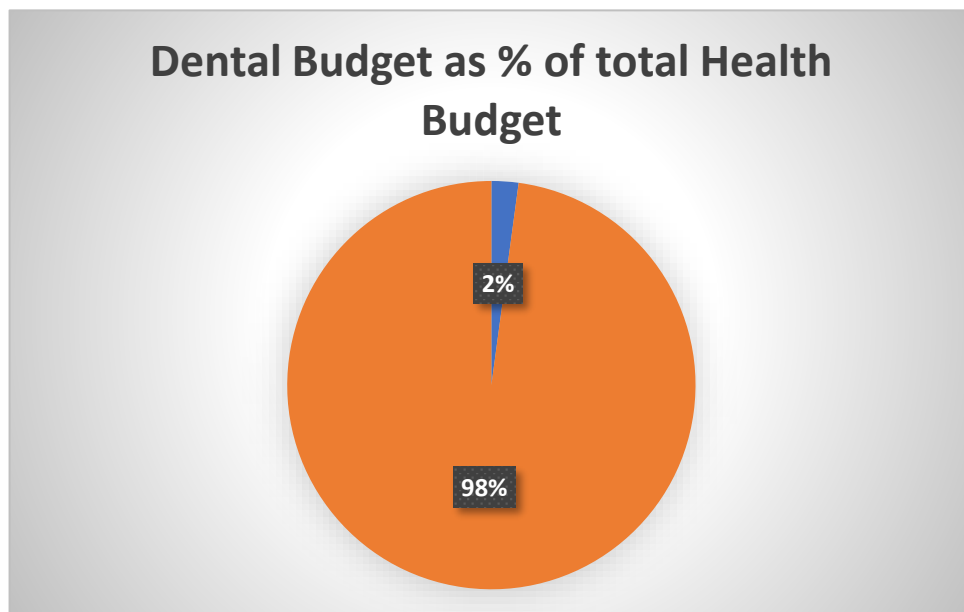
Table 8: PDS Budgets for 2014-15 to 2016-17

PDS Budgets	2014/2015	2015/2016	2016/2017
Betsi Cadwaladr	Not separate from GDS		
Powys Teaching	£521,611	£747,219	£966,115
Hywel Dda	£1,516,289	£1,550,786	£1,606,696
Cwm Taf	£168,804	£171,066	£172,948
Aneurin Bevan	£4,543,509	£2,484,571	£2,657,592
ABMU	Does not hold this information		
Cardiff and Vale	Have not responded		
4 HBs total	£6,750,213	£4,953,642	£5,403,351
Estimated Total	£11,812,872	£8,668,873	£9,455,864

Appendix 7: Comparison of GDS, CDS and PDS budgets 2016-2017



*The figure for PDS required estimation



Total Health, Well-being and Sport Budget £7,291,241,000 (2018-2019 figures)

Appendix 8: Oral health programmes in Wales

1. Cwm Taf Health Board²⁸ runs the scheme *Baby Teeth Do Matter* which works with GP practices and other health care professionals to promote the oral health of children, particularly those age 0-2 and 3-5. This scheme has seen an increase of 42% of children attending dental appointments in the Merthyr locality. There has also been a significant 70% increase of children aged 0-2 visiting the dentist. Cwm Taf also runs its own tooth brushing scheme. This scheme employs oral health educators to visit 38 schools in Cwm Taf. Now, only 15 schools in Cwm Taf don't participate in a tooth brushing scheme.
2. The CDS-run *Designed to Smile* (D2S) scheme has enjoyed some successes such as a tooth decay prevalence falling by 12% among five-year olds²⁹. The scheme costs approx £4m per annum to run³⁰. D2S has had a recent refocus³¹ to include children 0 to 3 yrs old, as it is extremely important to include this age group. However, this refocus of D2S now excludes children from fluoride varnish treatment just as their permanent teeth arrive and offers over 5's only tooth brushing. These children are expected to receive fluoride varnish in the GDS instead. Currently 66% of children visit a NHS dentist, leaving 34% who do not. Given the very low access for new children in many parts of Wales, the number of children treated in future is likely to go down not up. Therefore, this refocus is a gamble as it could greatly impact their future oral health. The BDA has previously called for additional funding of approximately £2m per annum to maintain their inclusion. One third of the GDS clawback would cover this.
3. Since the National Assembly for Wales Children and Young People Committee Inquiry³² into children's oral health in 2012 there has been some notable progress against the various recommendations put by the committee. However, without a modest increase in investment (from GDS clawback money) this programme will not reap all the rewards that are potentially there for children's oral health improvements.

Appendix 9: Glossary of Terms

Name/Acronym	Explanation
Amalgam	Dental amalgam is a liquid mercury and metal alloy mixture used in dentistry to fill cavities caused by tooth decay.
Associate	Dentists who contract with dental practices to provide general dentistry services
CDO	Chief Dental Officer
Clawback	Money deducted from the practice by the Health Board when fewer than 95% target UDAs are achieved
Corporate Dental Practice	<p>Corporate bodies are a relatively new phenomenon in dentistry; it is only 12 years since the GDC removed restrictions on the number of 'Bodies Corporate' who could operate.</p> <p>Cynically, there is an argument for the NHS to commission NHS dental contracts from a handful of large corporates rather than thousands of small independent practices.</p> <p>However, the impact of large dental corporates has not been a positive one. The largest group is currently "MyDentist", the second largest is BUPA/Oasis. Both of these large players have struggled to grow smoothly and profitably and have found it hard to recruit dentists to work for them, particularly in rural areas. This and other problems led to MyDentist bringing its acquisition campaign to a halt, and then to start selling off some practices.</p>
D2S	The CDS-run Designed to Smile Oral Health Programme in Wales
DCP	Dental Care Professional - includes dental therapists, hygienists, dental nurses, oral health educators
DDRB	Doctors and Dentists Pay Review Body
LDC	Local Dental Committees were set up in 1948, at the inception of the NHS. In England and Wales, provision in statute has been made for them to be recognised and consulted since the NHS Act 1977. Local NHS representatives may consult with LDCs on any matters of local dental interest.
National Survey for Wales	Each year the National Survey for Wales involves over 11,000 people across Wales. From 2016-17 the National Survey replaced the 2012-15 National Survey, the Welsh Health Survey, Active Adults Survey, Arts in Wales Survey, and Welsh Outdoor Recreation Survey, as agreed by Cabinet in 2014.
PCR	Patient charge revenue. Contrary to public perception the dental practice does not keep this money. It is returned to the Health Board. The BDA Wales would like to see patient charges frozen or restructured as they are a tax that involves a lot of bureaucracy and which acts as a deterrent to patients who are not eligible for benefits but are on lower incomes.
Pilot	A variant of the 2006 contract being trialed for a set period of time in selected dental practices. Different pilots have been running since 2011. Variation can be as little as 10% UDA for preventative work up to 85% of UDAs. The current Welsh pilot is 10% UDAs for oral health needs assessment data recording only.
Poor Oral Health Impact	The Global Burden of Disease study ³³ (2010) found that most disability amongst 5 to 9 year olds in the UK was caused by poor oral health. An average of 2.24 hours of children's healthy lives was lost for every child aged 5 to 9 years because of poor oral health. This exceeded the level of disability associated with vision loss (1.64 hours), hearing loss (1.77 hours) and type 2 diabetes (1.54 hours).
Providing-performers	NHS Contract holders who also perform NHS dentistry
UDA	Unit of Dental Activity
UOA	Unit of Orthodontic Activity

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Inquiry into Dentistry in Wales 2018**

**Response by the BDA Wales
"More than Words"**

Report submitted on 30 August 2018

Dr Caroline Seddon
National Director BDA Wales
Report Editor

BDA Wales has a policy of publishing key documents in Welsh and English (see our website)

<https://www.bda.org/bdawales>

Due to the time constraints of this consultation, it was not possible to translate this response into Welsh.