GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Inquiry into Dentistry in Wales

1.0 The Welsh Government's dental contract reform

1.1 Aneurin Bevan University Health Board (ABUHB) is fully engaged with the dental Contract Reform Programme (CRP) and selected three practices to take part in phase 1 of the programme, which commenced on 1st September 2017. A further five expressions of interest from practices have been received to take part in the programme from October 2018, resulting in 10% of the total General Dental Services (GDS) contract population taking part.

1.2 Practices participating in the programme have to undertake the Assessment of Clinical Oral Risks and Needs (ACORN) Toolkit for each patient over a 12 month cycle at their routine appointment. At this appointment the dental team uses the toolkit to lead patient discussion and provide oral health advice/education to the patient and explain any preventative treatment that they will benefit from. The dental team will continue to provide this information to patients but the programme is about raising awareness of oral health issues and how patients can help manage their own oral health needs in between their dental appointments to allow stabilisation of treatments.

1.3 The Health Board (HB) welcomes this approach, as it supports patient engagement and focuses on the education and prevention aspects to oral health as well as providing the necessary treatment.

1.4 There is some reluctance from practices to take part in the programme as they do not feel that 10% to undertake the ACORN Toolkit is a reasonable proportion for their contract to be adjusted. Whilst those participating in the programme have acknowledged the benefits of undertaking the toolkit and the positive approach to providing prevention and education, there is still uncertainty within the wider dental community. Further engagement and understanding of the programme is required. Consideration to a national public/patient awareness campaign of the contact reform programme is also required.

1.5 The HB is keen to expand the programme but needs to ensure that there is a transparent and consistent approach, which is agreed at an all Wales level, when developing the programme and how practices should be measured against key performance indicators.

1.6 Taking part in the programme will allow access rates to increase as over time, patient recall time intervals will extend allowing practices to accept new patients. It is anticipated that child access rates will improve. Between September 2017 – June 2018, there has been a 6% increase in access across the three practices taking part in the programme compared to the previous years activity rates.

1.7 At present there are no practices participating in the areas of most need, Caerphilly and Blaenau Gwent. ABUHB recognises that high incidences of poor oral health is linked to poor access to provision of dental services. Significant investment has been made in these two areas, as well as Torfaen and Newport over a number of years to improve access.

1.8 The programme aims to increase the total number of fluoride varnish applications in children, which will help reduce the number of children who have dental decay – therefore reducing the need for dental care, which in turn may reduce the need for general anaesthesia.

1.9 It is extremely beneficial that practices taking part in the programme can now submit their ACORN data using FP17w forms.

1.10 We are still in the initial stages of this programme however the first cut of data for each of the three practices is proven very useful and supports discussions with the dental teams. It provides a snapshot of the number of patients who have undertaken the ACORN Toolkit and provides a clear overview of the clinical needs of patients for each practice. The individual practice report highlights that there is scope to implement extended recall intervals. It is recognised however, that more data over a longer period of time is required.

1.11 The HB is keen to expand the programme and has established two task and finish groups to discuss and explore the opportunities that the programme can support in relation to increasing 'high street' access, prevention, child access and to explore the possibilities of working collaboratively with Neighbourhood Care Network (NCN) colleagues by developing integrated clinical pathways.

1.12 The HB is in the early stages of discussing the development and/or how the following clinical pathways can be implemented: Cardiac, Diabetes, Stroke, Oncology and Dementia. It is envisaged that a suite of service level agreements will be developed which dental practices can choose to participate in, in conjunction with the themes identified by the NCN.

1.13 It is recognised that practices participating in the programme need approximately six months to embed ACORN Toolkit and a further 12/18 months to capture the majority of patients. The next phase of the programme with these practices needs to be established to ensure that the momentum and engagement continues.

1.14 The programme highlights the importance of utilising a multi-disciplinary skill mix within practice to deliver the programme effectively. There are challenges in relation to delivering this which includes, training programmes, time, capacity, space, funds and regulations.

1.15 Many smaller practices have expressed concerns that the programme delivery is more achievable for larger practices, in terms of working from bigger premises which helps when adapting their working requirements and skill mix. Some practices operate from converted houses or have limited scope to expand and are therefore restricted when considering enhancing their skill mix/multi-disciplinary team. Consideration could be given to an Improvement Grant Scheme.

1.16 Introducing a new way of working has highlighted the disparity between dental practices with regard to their Units of Dental Activity (UDA) rate. Approximately 60% of contracts have a UDA rate which is less than the HB average of £26.00. The majority of these practices are situated in areas of highest patient need. The programme does not directly address this, however the HB is exploring ways how this can be addressed using contract reform as the vehicle.

1.17 There is potential that practices that underperform at year end may be more likely to take part in the programme as the percentage tolerance level is reduced. Whilst the HB works with practices to ensure contracted activity is achieved, where financial clawback is applied, the HB re-invests this within dental services.

2.0 How 'clawback money' from Health Boards is being used

2.1 In accordance with Paragraph 84 of the General/Personal Dental Services (G/PDS) Contract and guidance issued by the Welsh Government (WG) (NHS Dentistry *Revised guidance: primary care dental contracts - Advice on managing end of year issues*) the HB applies the agreed principles to all G/PDS contracts at year end.

2.1.1 Activity below 95% - there will be a financial claw back by the HB. Where a recurring underperformance has occurred below 95%, the HB will arrange to meet with Providers in order to negotiate a more manageable contract target. This may result in a contract reduction, which will be reinvested in areas of need.

2.1.2 Activity 95% to 100% - generally the HB will arrange to carry forward this under-performance against the following years contract ie the contracted UDA/Unit of Orthodontic Activity (UOA) level will increase with no corresponding increase to the financial value of the contract. However, where previous carry forward has been agreed and not met, the HB will arrange to meet with providers in order to make financial recovery or negotiate a manageable contract target.

2.1.3 Activity 100% to 105% - the HB will arrange to carry forward this over-performance to the following years contract ie the contracted activity will reduce with no corresponding decrease to the financial value of the contract.

2.1.4 Activity >105% - there will be no financial or UDA/UOA adjustment to the following years contract.

2.2 The HB monitors contracts and meets with providers regularly, especially where a potential underperformance is identified. The HB works with providers seeking a plan on how the activity can be achieved. The opportunity to

temporarily reduce the UDA target is offered and assurance provided that if the target can be met the contract will be fully reinstated.

2.3 In the event that the provider in unable to meet the UDA target a more manageable target is agreed.

2.4 Where a financial clawback is agreed, the provider is advised that a repayment plan can be agreed where monthly installments are made.

2.5 The HB is committed to improving dental services and aims to invest any clawback monies into primary care dentistry.

Since 2014, the HB has significantly invested in the following areas:

2.6.1 'High Street' Access
2.6.2 Primary Care Minor Oral Surgery
2.6.3 Primary Care Orthodontic Service
2.6.4 Prison Dental Services
2.6.5 Urgent Access
2.6.6 Dental Domiciliary Service.
2.6.7 Procured dental/medical equipment.

3.0 Issues with the training, recruitment and retention of dentists in Wales

3.1 Workforce data is currently collated as part of the annual contract review process. However a more robust process is required to inform succession planning, recruitment campaigns and to inform training needs/placements.

3.2 The Wales Deanery has shown that Welsh Domiciled Students, entering Cardiff Dental School, generally become dental foundation trainees in Wales and as a consequence usually remain in Wales as GDS performers. Further recruitment campaigns are required to help increase interest in dental students to remain Wales.

3.3 ABUHB has nine Dental Foundation Training practices. The HB is supportive of these practices and encourages other suitable practices to take part, not only to develop trainee dentists but to also help increase 'high street' access within the area. There has been a decrease in the number of Dental Foundation Training practices across the HB.

3.4 The Community Dental Service (CDS) experience difficulties in attracting suitable Specialists, particularly for Paediatric, Restorative and Special Care Dentistry. It is recognised that approximately 40% of the current CDS workforce will be retiring in the next 10 years. It has been highlighted that there is reluctance from dental trainees to work in CDS premises due to the restrictions that they impose. This issue has been acknowledged by the HB and will form part of the Estates Strategy.

3.5 The CDS is looking to recruit a Specialist in Paediatric Dentistry in CDS to support GDS and training. It is envisaged that training opportunities can be identified for dental providers and performers to enhance their skills to qualify as a Dentist with an Enhanced Skill (DES).

3.6 The HB will support training for GDS practice nurses on how to apply fluoride varnish. The HB will support the possibility of incentivising practices to undertake the necessary training in order for skills to be enhanced and more preventative treatment to be undertaken on the population.

3.7 There are plans to fully utilise the CDS Dental Therapists to provide Direct Access employed by the Health Board to work with Flying Start and Health Visiting teams to identify children 0-5 years old who are not accessing general dental services. The therapists can undertake dental check-ups, provide preventative treatment and dental care for children under 5 years at the Flying Start hubs utilising the Designed to Smile (D2S) Mobile Dental Unit. In addition, the CDS Dental Therapist will sign post patients to their nearest dental practice to receive ongoing dental care.

3.8 The HB employs an Oral Health Improvement Practitioner (OHIP) to:

3.8.1 Provide oral health training to Domiciliary Dental Service (DDS) users and their carers (in line with guidance issued by British Society for Disability and Oral Health as recommended

3.8.2 Deliver fluoride based prevention to DDS users following the Delivering Better Oral Health Toolkit (DBOH)

3.8.3 Work with DDS users, their carers and the DDS providers to ensure planned care does not turn into unscheduled/unplanned care

3.9 The DDS provider refers patients to the OHIP to continue preventative oral health advice/treatment.

3.10 The HB is exploring the possibility of employing an OHIP to work with vulnerable children and adults – linked with NCNs, Care Navigators, Flying Start Teams and School Nurses to support children gaining access to local dental services, identifying children absent from school with dental problems as a priority. It is hoped that this will increase preventative treatment for children under 5 years.

3.11 As part of the GDS Quality and Patient Safety (QPS) group, the HB facilitates an annual Continued Professional Development programme for dental teams. Topics discussed are collaboratively agreed with members of the GDS QPS and Gwent LDC.

3.12 The HB has established an Integrated Oral Health Group (IOHG) which is chaired by the Associate Director for Integration and Innovation, which consists of HB officials and representation from Public Health Wales, LDC, Community Health Council and Health Education and Improvement Wales (HEIW). The HB has developed a good working relationship with the HEIW.

3.13 The Health Inspectorate Wales (HIW) inspect all dental practices. It would be useful for the training courses relating to these areas be available for dental teams to attend to help support practices when undergoing a HIW inspection.

4.0 The provision of orthodontic services

4.1 The HB commissions nine PDS Primary Care Orthodontic contracts and provides Secondary Care Orthodontic services from two Hospital sites.

4.2 The Primary Care Team (PCT) collate waiting time lists from all orthodontic providers on a quarterly basis and issue this information to all dental practitioners. Access across the HB ranges between 3 to 25 months from referral to assessment and 6 weeks to 24 months from assessment to treatment.

4.3 The HB has non-recurrently invested in to Primary Care Orthodontic Services which has significantly reduced the waiting lists as an additional 200 patients were able to receive treatment over a two year period.

4.4 Secondary Care Orthodontic access across the HB ranges between 14 weeks from referral to assessment and 54 weeks from assessment to treatment.

4.5 Since 2015 the HB monitors the Primary Care Orthodontic contracts against the Key Performance Indicators which is reviewed by the HBs Independent Dental Advisors and ratified by the Orthodontic Managed Clinical Network. This information is shared with all orthodontic providers.The Orthodontic Managed Clinical Network (OMCN) developed a transfer and appeals policy which the HB has adopted.

4.6 Between 2008-16, a review of orthodontics was undertaken and recommendations highlighted for HBs to consider. The nine contracts are due to expire on 31st March 2019. The PCT has reflected on the recommendations made within the report, worked collaboratively with other HBs and the OMCN to develop a service specification. A formal tender process will commence.

4.7 The HBs average UOA is £67. The HB will commission orthodontic services based on £56, in line with Betsi Cadwaladr University Health Board. The full primary care orthodontic budget will be committed and will increase access immediately. It is recognised that increasing routine child access may impact on the referral rate to orthodontics.

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

5.1 It is positive to report that Designed to Smile has reduced decay in 5 year olds by 14% as at the last 5 year old survey. The recent 12 year old survey has shown a steady decrease in decay but the HB has the highest number of untreated decay in comparison to other HB areas; 24%. In addition, the highest number of people accessing urgent dental care is 16-45year olds.

5.2 There is still further work to do in relation to oral health improvement in children as identified in the recent publication of the Dental Epidemiological Survey of 12 Year Olds 2016/17. This will be discussed at the Oral Health Promotion Steering Group (OHPSG) and Integrated Oral Health Group

(IOHG). The CDS is undertaking the Dental Epidemiological Survey of 18-25 Year Olds.

5.3 The PCT and D2S Team have worked collaboratively to develop a ‘child referral pathway’ in order for more children to access dental services with local general dental practitioners. 7 practices within the HB area now receive direct referrals from the D2S Team which may be instigated by Health Visiting, Flying Start and/or D2S Teams. Children are given a unique patient code on referral in order to be tracked through the system in case they ‘did not attend’ appointments. The aim of this pathway is to allow as many children as possible to access mainstream dental services.

5.4 The HB purchased 80 Hall Crown Kits and will be providing training to all practices via the CDS Dental Therapists in 2018/19 where a kit will be provided to a practice.

5.5 The CDS Team is training in ‘Making Every Contact Count’ (MECC). This training needs to be tailored and rolled out to all GDS providers.

5.6 The HB is working collaboratively with the OHPSG and local authority colleagues to support the healthy schools campaign, in order to help raise awareness of oral health issues and prevention.

5.7 The HB continues to promote the DBOH toolkit, at every opportunity with GDPs. GDS practices looking to develop preventive models should be given evidence based Oral Health Improvement Programmes.

5.8 The HB has contributed to the 111 Dental Programme to agree principles for what is deemed an appropriate length of time for a child to access routine, urgent or emergency dental treatment.

5.9 The CDS has raised concerns in relation to the possible introduction of patient charges for CDS vulnerable adults and the negative affect this may have.