HEALTH, SOCIAL CARE AND SPORT COMMITTEE

INQUIRY INTO DENTISTRY IN WALES

- The Welsh Government's dental contract reform;
- How 'clawback money' from health boards is being used;
- Issues with training, recruitment and retention of dentists in Wales;
- The provision of orthodontic services;
- The effectiveness of local and national oral health improvement programmes for children and young people.

EVIDENCE FROM THE CABINET SECRETARY FOR HEALTH AND SOCIAL SERVICES

1. Purpose

1.1 This paper responds to the five points on which the Committee is seeking views.

2. Dental Contract Reform

2.1 Dental services need to be more responsive, equitable, effective and preventive. They need to be planned and performance managed, with a focus on population need not just on those who currently attend. Individual patient need and outcome can be measured and is being used in service and system redesign within the contract reform programme.

2.2 The principles of prudent healthcare mean supporting patients and the public to gain greater understanding of the dental disease process, and for them to have better self care skills and knowledge. Improving oral health for all and eradicating preventable decay in young children remain the overall goals. We recognise there is still a treatment burden, which impacts on patients and clinical teams that needs to be addressed. System change is necessary, to create the conditions, so that delivering quality, responsive dental care, to those who need it most, can happen, and the contribution of dental practices to 'well-being' and oral health improvement is valued. There is scope to make better use of the skills of the whole team in NHS dental care delivery to increase efficiency and prevention within existing resources

2.3 We have set out five key priorities for 2018-21 and beyond for transforming dentistry:

- timely access to prevention focussed NHS dental care;
- sustained and whole system change underpinned by contract reform;
- teams that are trained, supported and delivering value-based quality care;
- oral health intelligence and evidence driving improvement; and
- improved population health and wellbeing.

2.4 These reflect a shift in policy direction, supporting delivery and reform of the dental contract via whole system change focussed on health and well-being, with a preventive approach to care. At the heart of the change is the need for

new models of care to support a more patient focussed approach and a greater use of skill mix.

2.5 Learning is being used from previous dental pilot experience in Wales. The programme now involves key dental stakeholders in the development, collection and reporting of oral health risks, needs and outcomes of individual patients. Understanding individual and whole practice population need supports dental teams to effectively communicate and deliver personalised care to patients, and work with them to co-produce care plans and improved outcomes. It also supports improved delivery of evidenced-based prevention; implementation of needs-led dental recall intervals; and an increase in the use of skill mix.

2.6 Significant progress is being made to expand and develop the work, with clinicians adopting a risk and needs led preventive approach to care provision. Understanding patient need and risk, and using this information to plan care has been key to these improvements. 'Expectations' for the delivery of evidenced informed preventive interventions and advice have been shared with clinical teams. Communicating clinical findings and oral health risks to patients, and taking time to explain what actions they need to take to improve and maintain their oral health, is being used by dental teams to deliver preventive intervention 'expectations' and better communication with their patients.

2.7 All seven health boards are participating as part of the dental contract reform programme and 22 dental practices (some 5% of the all-Wales total) are collecting and using oral 'need and risk' assessment to plan care, give personalised preventive advice and agree appropriate recall intervals with patients. There is interest from more practices to take part in dental reform programme. It is intended that it will expand at pace and health boards expect to have a minimum of 10% of dental practices in their area taking part from October 2018.

2.8 A preliminary data analysis report for Quarter 4 of 2017-18 for the contract reform practices has provided some encouraging early findings on a number of indicators, particularly detailing the varying needs of practice populations and the proportion of patients with risks and needs. The findings also showed an unexpected increase in access and the application of fluoride varnish (in line with wider transformation), despite the practices only being asked to collect need and risk. While these early findings are positive they should be interpreted with caution as they represent the first returns following the introduction of the new oral health risk and need assessment tool.

3. Clawback money – recovery of funding due to contractual under performance

3.1 Contract payments are made to dental contractors monthly for completion of a required level of activity (measured as Units of Dental Activity "UDAs") assigned to the overall contract value. There can be variation in the value of a Unit of Dental Activity, which does not reflect numbers of patients attending a practice but broadly relates to courses of treatment. Where the contractor performs less than 95% of the activity required under the contract, the health

board is entitled to recover ('clawback'), the amount undelivered. Contractors can also hand back funding if, for example, they have performed within the 5% tolerance level but do not want, or are unable to, provide the level of activity in the following year.

3.2 In terms of the total primary care dental expenditure of £180m in 2017-18, the amount of clawback, at £6.5m, actioned by health boards is relatively small (3.6%). Health boards are contractually required to consider clawback where end of year delivery is below 95% of contacted Units of Dental Activity (UDAs).

3.3 However, while it is right health boards monitor contracts and take appropriate action where contracts are not delivering, we are concerned about overly rigid application and a focus only on % of UDA delivered in isolation to other measures of contract provision. In addition the 'value' of a UDA needs to be adequate to reflect cost of quality care delivery.

3.4 We want to see health boards providing greater year-round support to dental providers who are experiencing difficulty in meeting current activity targets, using contract reform principles, and not simply waiting to recover funding at year end. Particularly in cases where the unit price of the practice UDA is below regional averages, or when a practice has increasing access levels, and/or is delivering care to a high need population. When claw back is applied, without allowance of other factors, it is demoralising and can destabilise some practices. It disproportionally impacts on small practices as they tend to have less flexibility than larger corporate organisations and practices. All practices have fixed costs in the provision of a surgery and staff; claw back does not make allowance for.

3.5 Welsh Government continues to ring-fence the dental budget for those health boards without approved Integrated Medium Term Plans. We know a number of health boards reinvest some of the claw back resources into dental services, but this is not universal.

3.6 We want to see financially secure dental services that deliver greater value and which are supported and funded to deliver expectations safely. Welsh Government are holding health boards to account for the investment we make in dental services and have required improvement plans where we feel health boards need to make further and faster progress. This work is on-going.

3.7 We have set an objective to increase the proportion of contracts governed by measures other than Units of Dental Activity in performance monitoring, such as access, need, quality and outcome measures. We have also asked health boards to look at what more they can do to assist dental practices, established and new contract holders, who might be experiencing difficulty in delivering their contractual commitments.

4. Training, recruitment and retention of dentists

4.1 Despite there being a year-on-year increase in the number of dentists providing NHS care there are some recruitment and retention difficulties, particularly in the more rural areas of North, Mid and West Wales. This includes movement of staff within the larger body corporates from rural to urban areas.

4.2 This is causing difficulty in filling some vacancies and on occasion there are time-lags in commissioning and delivery of services due to recruitment and other issues, such as meeting planning and procurement requirements.

4.3 We are encouraging health boards to use the flexibility within the current contract to address local difficulties. This includes the contract value and associated activity measures, incentivising recruitment in areas where it's been difficult to attract dentists, and looking at making best use of the whole dental team through improved skill mix. They are being encouraged to create more favourable conditions to contract within and thereby attract workforce and stimulate the use of skill mix.

4.4 Health boards already have the ability to target and commission services where there is need. The current contract allows the flexibility to commission services at an appropriate value to reflect local circumstances, including the cost of service provision, potential service availability, level of need/demand etc. We are also starting to explore innovative models to provide care for small populations in rural and remote areas by working with existing practices and health boards to consider 'hub and spoke' arrangements. Some health boards have secured salaried general practice models managed through the community dental services using personal dental service contract models.

4.5 There is a need to ensure Cardiff University Dental School facilitate applications from North/West/Mid Wales as there is evidence that some students do return to their home region after qualification. In addition it needs to have a focus on fluent Welsh speakers and have been asked to consider promoting within the application process and/or expanding a pre-registration year.

5. Provision of orthodontics

5.1 An independent review of orthodontics, undertaken by Professor Richmond, Professor of Orthodontics at Cardiff University School of Dentistry, found the orthodontic resources currently available appear to be sufficient to provide provision to the current one-year cohort – there is broadly enough money in the system – perhaps not always where it is needed most. Past inefficiencies in referrals and contract delivery have led to delays in orthodontic provision.

5.2 NHS Wales spends some £13.4 million annually on orthodontic services. This represents almost 10% of the total primary care dental budget allocation and 40% of the total spend on children's dentistry in primary care dental services.

5.3 Whilst demand for orthodontic services has been rising for many years, we believe NHS orthodontics must be strictly provided in terms of need, and suitability for care, rather than demand. It is important health boards make provision for NHS orthodontics which is focused on health gain, and based on assessment of need, and not correcting the aesthetic cases that do not fall under the current NHS acceptance criteria.

5.4 There are regional variations in how long an individual may have to wait for both primary and secondary/hospital orthodontic treatment. Even within areas where there are practices and hospitals with good access some patients have to wait. There is evidence some are referred to multiple providers and/or too early due to the perceived 'wait'. A 'first come first served' approach is often taken in managing many orthodontic waiting lists and clinical priority is not sufficiently influencing waiting times. We expect action to be taken by health boards on these issues and to build on an improving position to ensure clinical priority and efficiency gains are realised.

5.5 We need to do more to ensure there is equitable access to orthodontic services across Wales, by driving through efficiencies. In some instances waiting list sizes are inflated through early referrals for treatment. For example, in 2015-16 compared with 2014-15, there was a 24.3% reduction in the number of "assess and review" appointments i.e. children not ready to receive treatment being held on a list and being reviewed annually until ready for treatment; thereby taking up specialist resource and adding to the perceived 'waiting time'.

5.6 Health boards are now using Managed Clinical Networks (MCNs) to develop processes to identify patients who have been referred to more than one orthodontist, or referred ahead of need, to free up capacity. Both of these practices have falsely increased the length of waiting lists in different areas of Wales.

5.7 The establishment of MCNs has created more efficient referral management process and driven forward improvements in quality and outcomes. Further efficiencies can and will be achieved, reducing early, multiple and inappropriate referrals. A planned electronic referral management service will support addressing these inefficiencies.

5.8 We are working with Public Health Wales, health boards and Chairs of the 3 MCNs to look at need, outcomes, benchmarking and the tender procedures for orthodontic services. This work includes expansion of Key Performance Indicators, particularly in relation to quality, outcomes and data collection.

5.9 One of our immediate priorities includes a continued focus on referral management and waiting lists, linked to the need for dental connectivity and e-referrals. In a direct response to this we have awarded a contract to establish a national Dental e-Referral Management System to FDS Consultants. The implementation is underway and it is expected that the system will be operational this year in the 2 vanguard health boards; with the rest to follow by March 2019.

5.10 The Dental e-Referral Management System will allow triage to influence the flow of *'timely'* referrals into specialist dental services. It will be used across NHS Wales, primary and secondary dental care. The system will improve the quality of referrals and reduce patient waiting times for treatment, including orthodontics. It is expected that between 45,000 and 50,000 referrals will go through the e-referral system each year. Once operational, Wales will be the first country in the UK to implement a fully electronic system for dental referrals in all dental specialties. Patients will be able to track and follow triage decisions and referral destination.

6. Local and national oral health improvement programmes

6.1 Good oral health is an important part of wellbeing. In children, it contributes to physical, educational and social development. Children have been the most significant beneficiaries of recent dental policies and due to the impact of the Designed to Smile (D2S) programme the oral health of young children in Wales is improving across all social groups. There is no evidence of widening inequalities. This is in contrast with previous positions when improved decay levels were normally associated with widening inequality. Improvement across all quintiles of deprivation is significant.

6.2 Trends from a series of surveys of oral health among 5 and 12 year olds conducted over the last two decades highlight a steady and improving reduction in both the occurrence of, and the average, dental decay experience among children in Wales. These survey results are pleasing evidence that prevention works and population health outcomes can be improved with sustained effort and investment in evidence informed practice in service delivery and community programmes.

6.4 The latest dental survey of 5 year old children in Wales (published July 2017) showed the continued steady progress in improving children's oral health, and the emerging impact on D2S. The results showed a 13.4% reduction in the proportion of 5 year old children with decay between 2007-08 (47.6%) and 2015-16 (34.2%). In absolute terms, the most deprived quintile has seen the largest reduction in decay prevalence (by 15%).

6.5 The latest dental survey of 12 year old children in Wales (published June 2018) showed there has been a 16% reduction in experience of decay in 12 year old children between 2004-05 (45.1%) and 2016-17 (29.6%).

6.6 Welsh Government launched the targeted D2S programme in 2008-09 to improve children's oral health in the most deprived communities and has also been piloting a preventive approach to care in dental practices across Wales. Welsh Government continues to invest in D2S and by the end of July 2017 there were 98,568 children in 1,537 schools and nurseries taking part. This represents 66% of all children aged from pre-school to Year 2. The programme also includes application of fluoride varnish by dental teams who visit the nursery or school.

6.7 The number of children undergoing General Anaesthesia for tooth extraction has also reduced from a figure of 9,036 in 2011 to 6,070 during 2017-18. This represents a significant reduction of 3,235 patients in 7 years - a 32.8% fall.

6.8 Whilst the reduction in dental disease in children is encouraging there is little room for complacency. We have recently refocused D2S to further align with the Welsh Government's national strategy, *Prosperity for All,* and to put an even greater emphasis on a child's first 1,000 days. Dental decay is unpleasant and can be painful to experience, is costly to treat and yet is largely preventable.

6.9 There is evidence that some young people (those in the 14 years old plus groups) who did not experience the benefits of D2S and who are from regions of material deprivation are experiencing impact of dental disease severely. Many are losing permanent teeth and some are even experiencing a clearance, of all their natural teeth which is not uncommon.

6.10 We have to date relied on Adult Dental Health Surveys to understand the impact of oral health in young adults. However it has been too small a sample size to make small area needs assessment possible. To that end we have commissioned an epidemiological survey of 18-25 year olds to understand the particular needs of young people and support any service redesign and population public health action as this is such an important group of the population to be oral health literate and economically active.