Welsh Liberal Democrats
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Filling the Gap - Fixing NHS dentistry in Wales

Filling the gap: Fixing NHS Dentistry in Wales

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Introduction by Jane Dodds AS/MS, leader, Welsh Liberal Democrats

Dentistry in Wales is in crisis. People who need NHS dental care find it almost impossible to get an appointment – and in many cases can only get one if they go private. Children in particular are missing out on the dental care and support that will set them up for a lifetime of good oral health.

We know that health services are facing huge pressures, and the Welsh Government is talking about the need for provision to match priorities. Sometimes dentistry isn't seen as a priority, when compared with cancer, or heart disease, or growing pressure on mental health services. But it's hugely important to people's quality of life that they should be able to live without pain or discomfort. And I know from my postbag, and from my day-to-day conversations with residents, that people really care about getting to see an NHS dentist.

We know that poor oral health is wholly preventable. We've seen huge improvements in dental health over the years, but we know that it remains a problem, and that there are massive inequalities. We know too that it is all too often linked to deprivation and social exclusion, with many of the same root causes.

I am particularly concerned about the impact of poor oral health on our children. Tooth decay remains the largest single reason for operations on children under general anaesthetic, and research shows that up to a third of children in some places already have tooth decay before they start school – setting them up for a lifetime of pain and discomfort.

This is a scandal and I want to see Government, Health Boards and communities working together to deal with this wholly preventable problem. We are a nation that is proud of its commitment to our future generations; we need to do everything we can to ensure that they enjoy good oral health.

Earlier this year, I chaired a roundtable meeting with dentists and other healthcare professionals, and heard their concerns at first hand.

In the short term, we must end the contractual disputes between the Welsh Government and dentists that are undermining mutual trust and turning dentists away from NHS work. In the longer term I want to see us make use of the skills of all the professionals working in dentistry; so that we have fair rewards across the board, so that dentists and all the other professionals working in the sector are incentivised to come to Wales, to stay here, and to undertake NHS work, while ensuring best value for the taxpayer. We need to do everything we can to encourage people to enter the profession, to attract practitioners to Wales, and give them every incentive to stay here.

Spending on dentistry is an investment. So, above all, spending decisions must not leave dentistry behind, and we need to bring spending in line with that in Scotland and Northern

Ireland. I know that the Government faces unprecedented funding pressures, but dental care must not be left behind.

My aspiration is that Wales should be a nation where we can be proud of our record on oral health, and where nobody is excluded from dental care. This report sets out our proposals for achieving that.

Executive Summary: A Liberal Democrat strategy for NHS dentistry

In too many communities, NHS dental services have become impossible to access. People are left waiting in pain for months or years, children are not being seen, and many more people are being pushed to pay for treatment. In rural communities, patients are travelling miles to access services. Some people have even turned to DIY dentistry. This simply isn't good enough.

Wales has a two-tier dentistry system, in which those who are able to pay for private care can get the care they need quickly while those who rely on NHS dentistry have to wait, or are unable to get routine non-emergency treatment. We believe that this is unacceptable.**]**

Dentistry was badly disrupted by the pandemic – during lockdown periods only emergency treatment was available and, inevitably, as we emerged from the tightest lockdowns, dental treatment was subject to serious restrictions. But the problems of NHS dentistry are endemic, going back long before the pandemic.

We need a strategy that deals with both the immediate problem of managing the aftermath of the pandemic, but also one that addresses those longer-term challenges.

Our priorities are to:

- Set clear, challenging and progressive targets for access to NHS dentistry, supported by adequate funding, to ensure that NHS dentistry is available to everyone who wants it;
- Take forward a renewed public health approach to oral care;
- Bring dentistry to the people;
- Make the best use of the professional skills in NHS dentistry, and ensuring those skills are properly rewarded;
- Prioritise oral care for children.

In preparing this report, we have spoken to dental professionals, health providers, but most of all to people who just want to see a dentist, and find they cannot. We have drawn on the evidence submitted to the Senedd Health and Social Care Committee report published in February, and on the first-hand accounts of the current state of NHS dentistry we heard from practitioners when Jane Dodds MS convened a roundtable at the Senedd in January. We have listened, and understood that the issues are structural and deep-seated; the way NHS dentistry is delivered has got to change.

That includes the way the Government and health boards fund dentistry, and the expectations that they have of dental practitioners, but it also involves changes to the way in which service-users access services, and changes to the ways in which treatment can be initiated.

NHS dentistry must:

- Promote dental care and oral health as a key priority;
- Ensure that NHS dental care is available for everyone who needs it;
- Recognise that dental decay is wholly avoidable, and deliver public health initiatives to prevent poor oral health, especially in children;
- Recognise that the causes of poor oral health are closely linked to the deprivation and inequality that lead to many other poor health outcomes;
- Making the best of the wide range of talents of the people working in dentistry, by ensuring that all professionals working within dentistry are properly recognised and rewarded, and with career structures and support that ensure that professionals want to come to, and stay in, Wales;
- Reflect the importance of ensuring that rural communities have the same rights of access to dental care as those living in our cities and towns.

These are the principles that inform the Welsh Liberal Democrats' strategy to ensure that everyone can access NHS dentistry.

We will:

- Increase expenditure on NHS dentistry to the per-capita levels in Scotland and Northern Ireland, while keeping charges at their present level;
- Set challenging targets for Government and Health Boards to manage and reduce waiting lists, especially for children;
- Ensure that we get the best from our dental workforce, by ensuring that those involved in dental care are fairly rewarded while providing best value for the taxpayer, and by removing the barriers which prevent dental therapists and nurses from initiating treatments;
- Integrating primary dental care more closely with other NHS primary care, especially to ensure that services are available in remote and rural areas.
- Ensuring that Welsh Government understands that good dental care is at the core of healthcare provision, not a secondary concern.

This report sets out our analysis of the state of dental care, and our five-point plan for achieving these aims.

We would like to acknowledge the many people who gave their time to talk to us, including dental professionals and others working in primary health care – and, most of all, the members of the public who shared their often traumatic stories with us.

Why dentistry?

When people think of priorities for health care, they often think in terms of waiting times in Accident and Emergency departments, or the importance of cancer treatment or dealing with heart disease. The NHS is – through no fault of the dedicated people who work in it – struggling to deliver the healthcare that we believe people have the right to expect. So why do we focus on dentistry?

Compared with cancer, or heart disease, or the growing incidence of dementia, for example, it rarely makes the news or features in politicians' speeches – it is the measure of the current crisis in dentistry that it has become newsworthy.

It is true that oral disease is rarely life-threatening. It is also true that many people are willing and able to go private.

But oral disease and tooth decay can have a profound effect on people's lives. Tooth decay causes pain, distress and loss of wellbeing, as well as having an economic impact through lost work days; and it disrupts children's education. And its incidence is closely linked to deprivation and the other illnesses associated with it; there is a correlation with poor diet, smoking and alcohol use.

And tooth decay is wholly preventable. But while all the evidence shows that oral health has improved in recent years, the inequalities have become wider. There is a particular issue in relation to children and young people. In 2015, survey evidence suggested that up to a third of five-year-olds were already suffering from tooth decay. Tooth extraction remains the biggest cause of surgery under general anaesthetic in children – more than 7000 operations in 2018.

And at the heart of dental care there is a paradox: that the people who are most likely to seek dental care are not those most likely to need it. Those who punctiliously visit their dentist for a regular check-up are those who are most likely already to be looking after their teeth; those who need dental care the most are least likely to be gaining access to dental care.

And we know that there are severe problems in the provision of dental services – and indeed across the rest of the UK.

In particular:

- **Workforce** – we need more dentists, and we need to ensure that the contracts between health boards, who commission NHS dental services, and dental practices provide decent rewards, appropriate incentives and value for money for the

taxpayer. In the long term we believe it is essential to ensure that full use is made of the skills of dental therapists and other professionals, while rewarding them and providing a fulfilling career structure.

- **Access/need** - ensuring that care is available to those who need it, without the need for undue travel or delay.
- **Public health** – while in general oral health, up to the time of the pandemic, was improving, we know there are serious inequalities and in particular that many children are facing a lifetime of discomfort because they have not developed good oral habits early in life.

We know that many people are unable to get access to NHS dental care at all, and are not able to pay for private care – or to travel large distances to get to see an NHS dentist. We also know that, in the grip of an unprecedented cost-of-living crisis, it is increasingly difficult for some of those who currently go private to continue to afford it. In a society where people face increasing challenges just to make ends meet, we believe that basic healthcare should not add to their worries.

Our starting point is that everyone who wants it should have access to NHS dentistry – which, means, in the first instance, that it should be possible to get an appointment with an NHS dentist within a reasonable timescale and reasonably close to home; and that once a course of treatment is started that it should be carried out in a timely fashion. To that end we set out below a number of proposals to ensure that this can happen.

But we also want to set out a longer-term vision for oral care. We want to consider what a renewed NHS dental service would look like; one that uses the full range of professional skills and talents available, and making the best use of the resources we already have as well as considering how dentistry can best be delivered alongside other primary health care. We need to ensure that the professional structure of NHS dentistry does not become two-tier.

Part of the challenge is to ensure that care is available on the basis of need. It is a key paradox of dental care that traditionally, those who are in most need of dental treatment are not those who regularly visit a dentist. Traditionally dental care has been based around the six-monthly visit to the dentist's surgery. But there is now clear evidence that it is no longer necessary for people with good oral health, who look after their teeth, to visit a dentist more than once a year.

The Government has been looking to encourage new patterns of oral care in the context of variations to the contract between health boards and dental practitioners, and use funding mechanisms to incentivise practitioners both to take on new patients and to move away from traditional patterns of care.

Against a decline in the number of dentists, we need consider not just how we retain current practitioners and ensure that they remain within the NHS, and are incentivised to do NHS work, but in the longer term to consider how better to integrate dentistry into existing primary care services, while empowering the many highly-skilled professionals, including dental therapists and nurses.

In other areas of primary care, we see the NHS working to persuade people that the GP is not necessarily their first port of call, and that primary health care can be delivered by a range of professionals, in different settings. We should also adopt that principle for dental care.

Background – NHS Dentistry

The Welsh Policy Background

The Welsh Government's core aspiration is to make NHS dental treatment available to everyone who wants it.

Its policy framework is set out in *The Oral Health and Dental Services Response to A Healthier Wales: Our Plan for Health and Social Care*, published in 2018[1]. That document sets out a number of policy objectives, as well as placing oral health in the wider context of improving health outcomes in a nation with well-documented endemic public health issues.

Its high-level objectives are to:

- Improve population health, oral health and well-being through a greater focus on prevention;
- Improve access, experience and quality of dental care for individuals and families;
- Enrich the well-being, capability and engagement of the dental workforce; and
- Increase the value achieved from funding of dental services and programmes through improvement, innovation, use of best practice, and eliminating waste.

In order to achieve those objectives it sets out a vision made up of three principles:

- Patients are empowered to protect and improve their oral health;
- Oral health and dental services place prevention at their core;
- Oral health is considered in all settings and in all relevant policies.

Welsh Liberal Democrats support those objectives, and the vision that underpins them. However, we argue that the provision of NHS dentistry currently falls short, and that innovative thinking and much work is needed to bring it up to an acceptable level.

Spending

In 2021-2 gross public expenditure in Wales on dental services was just over £195m, compared with just under £189m in 2019-20[2]. The income from dental charges in 2019-20 was £34.9 million.[3]

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[1] the-oral-health-and-dental-services-response.pdf (gov.wales)

[2] Source: Senedd Research. Figures for 2021 have not been quoted as the pandemic means that they are not comparable.

[3] NHS dental services: April 2020 to March 2021 | GOV.WALES

Pre-pandemic spending on NHS dentistry was £47 per head of population. This compares with spending of £55 per capita in Scotland, and £56 per head in Northern Ireland (and with £34 per head in England).

Funding for NHS dentistry has rested on the assumption that 50% of the population will need access to NHS services in any two-year period. Funding has in recent years largely increased in real terms, although following the Covid pandemic both an accelerating inflation rate, leading to increased costs for dental practitioners, and tight budget settlements applying across the budget mean maintaining current levels of funding will be challenging.

The Government's approach to funding and contracts recognises that many people choose private dental care as an option. It also reflects the fact that the clinical advice is moving away from traditional six-monthly check-ups that did not reflect the improvements in oral health in recent years, and that those attending a dentist regularly were typically not those in the greatest clinical need, while those most in need of dental care remained outside the system.

In the aftermath of the Covid pandemic, the Government announced a package of measures including £2m of additional funding for health boards and a contract variation for dentists to incentivise them to take on new patients, with a view to reducing the Covid backlog. Those changes have been controversial and are discussed in greater detail below.

<u>Structure</u>

Primary dental care is provided by the General Dental Service (GDS) and the Community Dental Service (CDS); and secondary care by orthodontists and dental services in hospitals.

<u>The General Dental Service</u>

Most NHS dental services are not provided directly by Health Boards, but by dental practices which are in essence businesses, paid by Health Boards for the work they do on their behalf, through a standard contract. Many of these practices undertake private work alongside the work they do for the NHS.

In 2020-1 there were 1389 dental practices that undertake NHS work. That represents a fall of 5.6% from 2019-20 (or 83 fewer dentists). Because individual dentists undertake both private and NHS work, it is difficult to estimate the full-time equivalent number of dentists doing NHS work.

Patients pay charges on a scale set by the Welsh Government, with three bands reflecting the nature of the work being undertaken – Welsh NHS dental charges are significantly lower than those obtaining in England (£14.70 for a basic examination, compared with £23.80 in England). Patients under the age of 25 or over 60 receive free examinations;

under-18's, pregnant women and those with children under one year old, some hospital in-patients and those in receipt of certain benefits or on defined low incomes receive free treatment[4].

In the years before the pandemic, around of 2.3 million courses of treatment were generally provided within the NHS – most of these falling within Band 1 (i.e. routine and minor treatments). The statistics showed a steady increase in treatments given to adults from 2009-10 to 2018-19, with a small fall in 2019-20. The number of courses for children was generally stable. Due to the pandemic, the number of paying adult patients fell in 2020-1 by more than 70 per cent, and of children by more than 80 per cent.[5]

These practices, as well as being owned by and in many cases employing dentists, also employ, often on a freelance basis, a range of dental professionals – dental therapists and nurses – who undertake a range of services.

The structure introduced in 2006 established three treatment "bands" against which dental practitioners could claim for Units of Dental Activity, depending on the nature of the treatment required. Those bands also provided the basis for charges paid by patients. However, concerns remained that a contractual structure based solely on UDAs, which while reflecting the treatment provided, did not adequately reflect needs, prevention, or indeed reflect the range of professional skills involved in dental care.

Since 2018, the Welsh Government has sought to move to a more holistic model of patient assessment – the so-called ACORN assessment - with patients being placed in red, amber or green categories, on whose basis the dentist can prioritise and agree a course of treatment with the patient.

Since the pandemic, when non-emergency dentistry largely stopped, the Government has provided additional funding to incentivise practitioners to take on NHS patients who have not received treatment in the preceding two years, in order to clear a backlog of people whose oral health may reasonably be expected to have deteriorated. While accepting the principle, dental practitioners and their representatives have been concerned that the contract does not adequately reflect the greater need that such patients require, or the additional work required to complete ACORN assessments.

In July 2022 Welsh Government announced[6] a variation to the contract which would mean moving from six-monthly to annual check-ups, while releasing more funding. The Government announced that 78% of practices had signed up to this variation and that appointments for 112,000 new patients would be created. However, dental practitioners

[4] NHS dental charges and exemptions | GOV.WALES
[5] NHS dental services: April 2020 to March 2021 | GOV.WALES
[6] Move to yearly dental check-ups to improve access to NHS dentistry in Wales | GOV.WALES

have argued that this figure does not reflect capacity constraints within practices, in particular as patients who have not had dental care in recent years are likely to require more expensive treatment with repeat appointments. The implications of those changes are discussed below.

These capacity constraints have led to some practitioners who are unable to meet these additional targets having to hand back funding in mid-year, causing further financial uncertainty at a time when practices are facing severe cost pressures. It has been reported that the implementation of the new contract has led to some dentists giving up NHS work altogether[7].

Community Dental Service

The CDS provides dentistry to those with particular needs – for example those with disabilities or learning difficulties. Its employees are salaried employees of health boards.

During the pandemic, it was deployed to provide emergency dental care within Urgent Dental Care Centres. In 2018-9, the CDS treated nearly 68,000 patients – with just over 160,000 patient contacts. While 10% of those were emergency cases, around 27% of those patients were unable to access the general dental service. The remainder were patients with particular needs, including mental or physical disabilities[8]. During the pandemic the CDS provided emergency care and, as a result of the pandemic, the CDS is now facing a substantial backlog, including many vulnerable patients.

Secondary dental care

The most common form of secondary care is provided by orthodontists - usually private practitioners to whom dentists refer typically young patients for specialist NHS. Emergency dentistry and other specialist services are provided in hospitals by health boards.

Again, there are significant waiting lists for secondary care. Statistics cited by the British Dental Association in their evidence to the Senedd Health and Social Care Committee[9] showed the number of patients waiting for oral surgery had increased from a little under 20,000 in January 2021 to more than 24,000 in June 2022 – having peaked in April 2022, when 50% of patients had been waiting 36 weeks for oral surgery. As conditions requiring surgery tend to involve further appointments at the referring surgery during the wait, this limits capacity in general dentistry further.

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[7] Why dentists are quitting the NHS leaving some people resorting to fixing their own teeth - Wales Online
[8] Community Dental Services in Wales, 2018-19 (gov.wales)
[9] D 20 - British Dental Association Cymru.pdf (senedd.wales)

Evidence[10] presented to the Committee suggests a particular problem for young people accessing orthodontic treatment, where waiting times can extend to four years or more – meaning that some patients are effectively spending their entire adolescence waiting for treatment.

Public health initiatives

Tooth decay and gum disease are largely preventable. That is borne out by the fact that dental health across all social groups has improved significantly in recent years – although that general improvement has not broken the link between deprivation and oral health. It implies that public health initiatives should be at the heart of oral care.

Public Health Wales points to three ways to prevent poor oral health:

- Leading a healthy lifestyle – in particular having a low-sugar diet, not smoking and consuming little or no alcohol;
- Good daily oral hygiene – brushing your teeth twice a day with fluoride toothpaste;
- Making best use of health services – having regular dental check-ups based on risks and need.

There is clear evidence that oral health is closely related to other public health issues – especially diet and smoking – and to deprivation. More than a third of children have tooth decay by the time they arrive at primary school, and Public Health Wales data indicates that children in the Cwm Taf Morgannwg University Health Board (UHB) are nearly three-and-a-half times more likely to undergo extraction of teeth under general anaesthetic than their peers in the more affluent Hywel Dda UHB.

The British Dental Association reports that before the pandemic, a third of children had not visited a dentist in the preceding two years; given the absence of general dental services during the pandemic, that number – and the deterioration in dental health associated with it – will inevitably have worsened.

Designed to Smile is the flagship public health programme. It is aimed at children up to the age of 7 and targeted at schools and nurseries in disadvantaged areas. Its aims are:

- Giving advice to families and providing toothbrushes and fluoride toothpaste;
- Encouraging a visit to the dentist before a child's first birthday;
- Providing a dental health programme for young children, including daily tooth-brushing and twice-yearly fluoride varnishing

[10] Health and Social Care Committee 13/10/2022 - Welsh Parliament (senedd.wales) – Paragraph 56

The initiative is widely perceived as successful, although it is widely argued that a similar scheme is needed for older children, and that it needs to be extended beyond the most disadvantaged areas. While there is a clear correlation between deprivation and poor dental health, that does not mean that a child growing up in a more affluent household will necessarily learn good dental habits.

In 2019-20, Designed to Smile gave more than half-a-million dental examinations, provided nearly 300,000 fluoride varnishes, as well as providing fissure sealants where necessary. During the pandemic the number of examinations fell by 99% and fluoride varnishes by 78%; the overall impact of this drastic fall will become clearer once PHW completes a survey of children's oral health in the academic year 2022/3, but the effect is likely to be necessary.

Gwen am byth is a programme delivered by the CDS that aims to improve oral health and hygiene for care home residents. It recognizes the fact that many older people are retaining their natural teeth for much longer, but often with complex needs. The aim of the scheme is to train and support care home staff to provide safe mouth care for residents – often helping them with simple tasks like brushing their teeth. The aim of the scheme is less about treatment of specific oral health problems but to support people at the end of their lives to live in comfort, without pain, and in dignity.

The Challenges

As noted that the start of this report, the basic problem facing NHS dentistry is that many people find it impossible to access it. Many more experience long waits for treatment. Why should that be the case?

The scale of the problem

While it is difficult to obtain information on the numbers of people on waiting lists – which until recently were not run by Health Boards – we know that waiting lists are at unacceptable levels, especially for children.

In Cardiff and the Vale of Glamorgan, around 15,500 people are on waiting lists, with an average waiting time of more than two years. More than 8000 of those are children. Nearly 800 children are on waiting lists in Powys.

The problem has been worsened by the pandemic, during which routine dental care was largely unavailable. But, equally, the structural problems existed before the pandemic. Covid greatly exacerbated the problems in NHS dentistry, but did not cause them.

These problems are by no means unique to Wales. Access to NHS dentistry for new patients remains difficult – and in many areas impossible - across the UK. But research by the BBC published in August 2022 indicated that access to dental appointments was worse, both for adults in children, in Wales than in the other nations of the UK, and substantially worse for children than in England or Scotland.

Table 1: Percentage of dental practices not accepting new patients across the nations of the UK, August 2022[11]

Nation	Proportion not accepting new adult patients	Proportion not accepting new child patients
England	91%	79%
Northern Ireland	90%	88%
Scotland	82%	79%
Wales	93%	88%

Addressing these problems involved facing two fundamental challenges. The first is recovering from the impact of the pandemic. The second is to deal with long-term challenges, relating to the recruitment and retention of which predate and have been exacerbated by the pandemic, and which together are the reasons why so many people

[11] Source: BBC, quoted by British Dental Association in their evidence to the Senedd Health and Social Care Committee, September 2022 D 20 - British Dental Association Cymru.pdf (senedd.wales)

find it impossible to access NHS dentistry, and even if they can get it are waiting many months for treatment.

Covid

General dentistry largely stopped during the pandemic. Emergency care was provided by the CDS. Public health initiatives like Design2Smile and Gwen am Byth also stopped.

The implications are, first, that there is now a massive backlog of people waiting for dental treatment, including routine appointments. The BDA estimates that nearly two million appointments were lost during the pandemic, and that the number of courses of treatment fell by 76.7%. Priority was inevitably given to urgent cases and routine check-ups were not available at all.

Second, the cessation of public health initiatives will mean that people – especially children - will have lost, or not had the opportunity to acquire, good habits and that two years without appointments will mean that minor problems have had time to get worse.

In July 2021 the Welsh Government set out a programme for recovery and further contract reform, which aimed to replace the UDA approach in dental contracts with four measures of activity against which dentists' remuneration could be determined, with a view to implementing the new contractual structure in April 2022.

Funding

Despite a generally increasing level of funding, per capita spending remains below that in Scotland and Northern Ireland – against the background of a generally low level of provision, measured against OECD averages.

Funding has to be considered against the background of extremely tight funding settlements as a whole. Recent cash settlements from the UK Treasury the remainder falls far short of the amount needed to sustain spending in real terms. While the Welsh Government can in theory allocate funding however it likes, the practical constraints mean that dentistry is fighting to maintain a share of a shrinking pot, at a time when areas of the NHS, including ambulance services, accident-and-emergency care and the social care sector are facing unprecedented pressures.

At a time when the Welsh Government is facing unprecedented financial pressures, and when there are urgent and pressing calls on resources from other high-profile parts of the NHS, it is essential that dentistry is not overlooked, and its funding base is protected.

Not enough dentists – recruitment and retention

According to the OECD, the UK has one of the lowest levels of dental provision in terms of practitioners per head of population in the developed world: and Wales, at 0.4 dentists per 1000 population, is at the lower end of the UK scale.

In 2020-1 there were 1389 dental practices that undertake NHS work. That represents a fall of 5.6% from 2019-20 (or 83 fewer dentists). More than 14 per cent of those dentists are approaching retirement age; that figure rises to 20 per cent in some rural areas. Other dentists may be considering reducing the amount of NHS care they provide.

Moreover, the incomes of practice-owning dentists have fallen substantially, and have fallen faster than elsewhere in the UK – between 2008-9 and 2019-20 the taxable income of dentists has fallen by an average of 12.6% in Scotland, 14.4% in England and 19.2% in Wales.[12] Like any other small businesses, dental practices have seen substantial increases in operating costs in recent years.

Organisations representing dentists believe that the current contractual situation is likely to drive practitioners away from NHS towards private care, reporting that increasingly practitioners are using their private practice to subsidise their NHS work.

Waiting lists

Dental practices do not have "lists" in the way that NHS General Practitioners do. Those seeking an NHS appointment have done so by contacting individual practices, who hold their own waiting lists. This information is not collated and it is usual for one individual to be recorded on the waiting lists of a number of different practices.

More recently, some Health Boards have sought to set up their own waiting lists, but the coverage and methodology varies between the different health boards and it is difficult to get any clear picture across Wales.

The NHS Business Services Authority recently reported[13] that 9.4% of all NHS dental appointments are missed – amounting to a total loss of appointments equivalent to 20 full-time dentists each year.

Efficient management of waiting lists brings real benefits to both patients and dental practices. While so far the work has been undertaken by the health boards, we believe it is important that there is a co-ordinating authority, to ensure that appointments can be offered across health authority boundaries where that is appropriate, and to ensure that there is a consistent approach across the country.

[12] Source: BDA evidence to Senedd Health and Social Care Committee, September 2022
[13] Over 100,000 extra dental appointments this year – but missed appointments continue to bite | GOV.WALES

Contract issues

NHS dentistry is provided largely in the private sector by dental practices commissioned by health boards, using a standard contract. Neither the Government nor health boards directly deliver dentistry; the service is delivered by practices who often undertake both NHS and private work, and have no obligation to work within the NHS. The terms and operation of that standard contract lie at the heart of delivering NHS dentistry. Contract revisions instituted in April 2022 were designed to incentivise practices to make appointments available for new patients, while moving away from the traditional model of recalling patients every six months, which NICE has now ruled is no longer clinically necessary. The Government argues that it has meant funding for 123,000 appointments for new patients, of which 76,000 have been delivered as at February 2023.

While the majority of practices has moved to the new contractual model, there is increasing concern among dentists about how the contract works in practice, with dentists' representatives argue that it has significantly damaged the traditionally good working relations between dentists and Government.

The British Dental Association, argues that the changes were introduced at short notice; and that capacity constraints mean that attempting to deliver those new appointments impacts on other work. It reports that local practices cannot deliver and in some cases are required to return funding to health boards ("clawback") – affecting their financial stability at a time of rising costs and falling incomes. Others are reported to be planning to walk away from NHS work altogether. Others are looking to return to the old contract. It argues that the changes have damaged the hitherto good working relationship between dentists' representatives and the Government.

The Government has argued that the revised contract is necessary to deliver value for money and appropriate incentives, and that in line with the NICE guidelines fewer appointments are necessary; that new appointments are being delivered, with 76,000 new patients seen in the first ten months of the changes; and that clawback is necessary to protect the taxpayer; and points to the fact that practices are, by and large, not returning to the old model.

Whatever the merits of the arguments, at a time when dental provision remains under intense pressure, it is essential that questions on the contract are resolved. A balance must be struck in which the need to achieve wider health objectives and the to obtain value for money. A situation in which the contract is constantly at issue is not sustainable either for practitioners or for the patients who use their services.

Making the best use of staff – empowering dental therapists and nurses

It is important to consider how the staff resources that already exist could be better deployed.

Dental therapists and nurses provide an essential part of the dental service, but it is clear that the current structures neither make the best use of their skills nor reward them adequately. Consequently, there is a shortage of these key staff members, alongside major issues of retention, even though – in contrast to dentists and dental technicians – their numbers have grown in recent years.
Dental therapists currently undertake three years of training and are qualified to undertake a large range of dental work – around eighty per cent of what registered dentists do.

However, they are not currently able to initiate courses of NHS treatment. Ironically, they have more control over clinical decisions when working in the private sector. Moreover, they often work effectively as freelancers, and often have no career structure, pension entitlement, or holiday pay or maternity/paternity provision. They do not have access to NHS resources or training. In their evidence to the Health and Social Care Committee inquiry[14], therapists' representatives expressed their concern at being a second-class part of the dental service, and feeling more empowered when they are working in a private sector environment.

As a matter of current practice, dental therapists are unable to initiate courses of treatment because they do not have access to NHS accreditation. The Senedd Committee revealed a state of confusion about the regulatory position, in which it is unclear whether it is legislation or bureaucratic practice that prevents dental therapists from gaining the NHS accreditation required to initiate treatments. This situation contrasts with the CDS, where therapists are fully integrated into NHS structures and are able to open courses of treatment.

Either way, it is essential that the Welsh government finds a way through the impasse. It is not acceptable that a muddle that inhibits the ability of practitioners to initiate and guide dental treatment when they clearly possess the necessary skills to do so. While Welsh Government action needs to be informed by the review currently under way in England, it is important that decisions are taken with reference to the needs of Wales.

Having said that, it is essential that extending the range of work done by therapists is not a rationale for saving money. The point of increasing the role of therapists is to ensure that dental care is more widely available, and one of the objectives of increasing their role must be to improve their own career structures and remuneration.

The provision of dental care in Wales, as elsewhere in the UK, is therefore a patchwork.

[14] Health and Social Care Committee 17/11/2022 - Welsh Parliament (senedd.wales) – Paragraph 24

The fact that the general service is provided largely by small private sector businesses means that it faces challenges that other healthcare sectors do not face – in particular the problem of designing contracts that meet the various demands of clinical need, value for money, and ensuring that practitioners are adequately rewarded and incentivised to remain within the service. But ultimately it is down to the individual practitioners how much NHS work they do, if any, and there is, for example, no obligation to continue NHS work when practices change hands.

Public health initiatives

Tooth decay and oral disease are largely preventable, and it is essential to build on the success of public health initiatives like Designed to Smile.

Designed to Smile has been targeted at younger children, often from deprived background, with the intention of addressing inequalities in oral health. There have been repeated calls for the scheme to be extended to older children, which we support. The approach behind Gwen am Byth – in which carers are empowered to support elderly care home residents in managing their oral hygiene – should also broadened to include other groups supported by carers.

Changing the landscape – a dental service for the future

Wales is a small, diverse and geographically-challenging country that faces unique demographic, economic and public health challenges. But it is also the country where the ideals behind the Tredegar model of public health care laid the foundations for the National Health Service. We need to shape a vision for dental care that both rises to the challenges but also matches the aspiration and vision that Wales once gave the world.

We will:

1. Reduce waiting times for treatment by allowing a wider range of professionals to treat patients.
2. Invest in NHS dentistry, so nobody is forced to travel for miles or pay for private care.
3. Ensure that every child can get treatment where and when they need it.

An oral health strategy

There is a clear need for an overarching strategy. Oral health depends both on ensuring that people develop the right habits in early life, and on the availability of treatment to anyone who needs it. Furthermore, the synergies between the drivers of poor oral health and those of other public health problems – including deprivation and inequality – imply a clear need for oral health, and dental health, to be integrated more closely into the wider provision of primary care.

The traditional dental practice, run in the private sector and providing special care, will remain at the heart of specialist oral health care. But the realities of providing health care in a nation that experiences poor public health outcomes and whose geography is challenging, with many areas of low population density, mean that we need to think about more effective ways of working.

We have developed five key aims for the future of dentistry:

- Ending two-tier dentistry with clear, challenging and progressive targets for access to NHS dentistry, supported by adequate funding;
- A renewed public health approach to oral care;
- Bringing dentistry to the people
- Making the best use of the professional skills in NHS dentistry, and ensuring those skills are properly rewarded;
- A focus on oral care for children.

Ending two-tier dentistry

Our first priority is to end two-tier dentistry. That means ensuring that anyone who wants dental care can get an appointment within a reasonable distance of home within a clearly-defined timescale, with any follow-up treatment also available within a reasonable timescale.

That means, first, adequate resourcing. Wales lags behind its neighbours with fewer dentists and lower per capita funding. As a priority, the level of spending must be brought up to per capita levels in Scotland and Northern Ireland, while ensuring that charges for NHS treatment are maintained at their current levels.

As part of that, Government and Health Boards must take a much greater role in the co-ordination of waiting lists.

Traditionally there have been no waiting lists as such – potential patients have registered an interest with a practice (or in some cases several practices) who have then contacted them when an appointment is available. But this system is inefficient, and it means that some offers of appointments remain unfulfilled.

Some Health Boards have set up waiting lists in recent years, but a much more systematic approach is needed, with resources made available so that waiting lists are properly managed. We believe that the right bodies to do this are Health Boards, as they are directly responsible for managing the contracts with dental practices, and it is essential that they are properly resourced to do so.

We believe that there need to be targets set for Health Boards to deliver dental appointments. Because dental practices are small independent businesses, without any obligation to provide NHS care, it is not feasible to set performance targets for them. How they achieve that is very much up to them; in addition to working through independent practices, they may choose to employ their own salaried dental staff, perhaps working alongside and in the same premises as other primary care providers.

We will:

- Increase per-capita spending from the current £47 to match the levels of Scotland (£55) and Northern Ireland (£57);
- Set targets for Health Boards in terms of numbers of, and waiting times for, appointments, empowering them to use salaried staff to achieve those targets as well as entering into agreements with private sector providers
- Resolve the outstanding contract issues, so that dental practices have a clear mandate and clear incentives to provide NHS care, providing the certainty that long-term dental planning requires, while ensuring best value for money for the taxpayers. We believe in principle that the contract process should have a clear

focus on outcomes, and that there should, as part of the targeting progress, be clear success criteria and metrics.
- We will set up a national waiting list system, properly resourced and working with health boards, to ensure that the process of getting an appointment is more efficient, and that fewer appointments are lost.

A renewed public health approach to oral care

Tooth decay is entirely avoidable and public health measures demonstrably make a difference. We believe that prevention of tooth decay must be at the heart of a dental health strategy, as we know that relatively simple actions and messages make an enormous difference.

We believe in particular that it is important to build on the success of existing schemes, like Designed to Smile, and want to increase the reach of such schemes to reach older children and to extend beyond the current focus on more deprived children.

We will:

- Extend Design to Smile to reach older children, and a wider range of socio-economic backgrounds
- Recognise the read-across between poor oral health and deprivation, and exploit synergies with other public health initiatives where possible
- Build on the success of Gwen am Byth, to ensure that support is available for those working with older people, and those working in other environments in which people are supported by carers

Bringing dentistry to people

Even where NHS dentistry is available, it often involves significant travel – especially in rural areas – which means that accessing can be incredibly challenging and disruptive. There is a need to ensure that people have easier access to dental services, especially for basic check-ups and preventative work.

Initiatives like Designed to Smile are already being delivered through local facilities like nursery and family centres, with the Designed to Smile bus having a key role in taking this public health message to children. Some health boards have in the past operated mobile dental services, which have been welcomed by communities.

We also believe that there is a strong case for integrating dental care with other aspects of primary healthcare, in particular by co-locating dental services, where possible, in GP surgeries and other community hubs. Initiatives like the Pathfinder project in Powys, in which public health initiatives are taken into communities and delivered in local schools

and village halls, and which offer the opportunity to deliver a range of public health messages, provide an important model.

We also understand the value of mobile schemes, and will look at ways in which Government and Health Boards can work together to make such services available.

We will:

- Explore ways of integrating dentistry more closely with other primary care services, possibly by making some primary dental care services, such as triaging and the opening of courses of dental treatment, available in GP surgeries
- Empower health boards to use initiatives like mobile dentistry to improve access to dental services in rural areas

Reforming the way dentistry is delivered

There is a clear case for changing the way in which dentistry is delivered. The traditional independent dental practice will always have a vitally important role in delivering dental care. But dental care needs to be delivered in a way that makes best use of the skills of dentists and others working within NHS dentistry.

We envisage a structure in which traditional dental practitioners continue to provide the advanced levels of treatment that they are trained and equipped to provide. But we see the structure around them changing, with greater use of other professionals – notably dental therapists - who we believe should be empowered to start courses of treatment, and undertake more treatment themselves, while referring patients who need more advanced dental care to dentists or specialists like orthodontists.

They may be working in traditional dental surgeries, or perhaps in communities, alongside other NHS primary care colleagues, or alongside their colleagues in the Community Dental Service. They may be salaried NHS staff, with the opportunities for career development, training, and access to benefits like pensions and parental leave.

The role of the CDS however must be protected. Their focus must be to work with the most vulnerable. During the pandemic, they inevitably found themselves filling the gaps in emergency care; it is essential that they return to their principal role of working with vulnerable patients.

We will:

- Ensure that dental therapists can play a greater role in primary care, in particular by empowering them to initiate courses of NHS treatment

- Protect and develop the Community Dental Services, and ensure that it can carry out its principal role in providing care for those with particular needs, without being seen as a stopgap for other services.

A focus on oral care for children

While children's oral health has improved, it remains unacceptable that a third of five-year-olds already have tooth decay and that operations to remove decayed teeth remain the biggest single cause of surgery under general anaesthetic for children.

We know that public health initiatives work but their reach is limited. We want to see a much greater focus on good oral health through adolescence; this can be achieved through much better integration of oral health into primary health care.

We will:

- Expand the availability of scope and availability of schemes like Designed to Smile, to reach older children, as well as a wider social base.
- Set targets for reducing the number of children undergoing tooth extractions under general anaesthetic