Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Deintyddiaeth

This response was submitted to the Health and Social Care Committee consultation on Dentistry

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Ymateb gan: | Response from: Cymdeithas Ddeintyddol Prydain yng Nghymru | British Dental Association Wales

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BDA Cymru Wales
Response to

Senedd Health and Social Care Committee

Consultation and Inquiry into Dentistry

23 September 2022

The BDA

The British Dental Association is the trade union and professional body
for dentists in the UK

BDA Cymru is the voice of dentists
and dental students in Wales

We campaign to promote the interests of our members
and to improve the nation's oral health

We bring dentists together, support our members through advice and education,
and represent their interests

We represent all fields of dentistry
including
general practice, community dental services, the armed forces, hospitals,
academia, public health and research

We are not a trade union or professional body for Dental Care Practitioners, however,
the BDA provides DCPs with considerable resources including CPD and examinations

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.

Acknowledgements

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❖ We thank all the BDA Wales committee members, particularly the Chairs and Vice Chairs, for their leadership and guidance. The BDA committees are:

Wales General Dental Practice Committee (WGDPC)
Wales Committee for Community Dentistry (WCCD)
Welsh Council

❖ We are grateful to BDA staff for their contributions to the document.

❖ We would like to kindly acknowledge the external sources of data - particularly **StatWales** and **NHS Digital** – and express our thanks to the individuals in those services who have been most helpful.

❖ We would like to kindly acknowledge **Senedd Research** which has provided helpful summaries of the issues surrounding patient access to different types of dental care and of the oral health gap. These articles both reference the work of the BDA:

Dentistry Part 1 – Can you access dental care when you need it?
Senedd Research July 2022

Dentistry Part 2 – Wales' oral health gap
Senedd Research July 2022

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Foreword

BDA Cymru welcomes this consultation and inquiry dentistry and the opportunity to present our recommendations, which are carefully crafted by gathering and analyzing various data and by consulting with our craft committees and our membership who are daily facing the challenges of delivering dentistry in Wales. We undertook surveys of General Dental Practitioners (GDPs) in Wales in March and again in August and the results are included.

We have representatives from the Local Dental Committees (LDCs) on our committees and work very collaboratively with the LDCs but expect the LDCs to also make their own submissions. We look forward to making our oral presentations to the committee in October.

The focus of our response is general dentistry, community dentistry, hospital dentistry and on the dentists who serve in them. However, we acknowledge the important contributions to patient care by all the dental crafts, including dental public health, and the wider dental team, including therapists, hygienists, dental technicians, dental nurses and educators.

BDA Cymru submitted extensive evidence to the Welsh Assembly's 2018 Inquiry into Dentistry, and we were heartened that the principles of many of our recommendations were carried through into the recommendations made by the Health Social Care and Sport Committee at the time. It was deeply disappointing that the Welsh Government's response to the committee's report was to say they accepted the recommendations but made it very clear there would be no new investment.

In the intervening period the BDA has undertaken numerous surveys about the sentiment and intentions of dentists as well gauging their levels of mental health. We have actively shared our findings with the government's advisory committee – The Welsh Dental Committee – and presume these have been escalated for the attention of the Health and Social Care Minister. We have also on occasion written to the Minister directly explaining our concerns.

At the same time, we have been active contributors to Welsh Government initiatives such as GDS (General Dental Services) contract reform but have been disappointed that our views were sought very late in the process of defining the new volumetrics. We have stated repeatedly that this is a pivotal year for general dentistry, to engender a sense of urgency into proceedings.

Dentists who have committed their careers to NHS dentistry are stalwarts and will work assiduously to make NHS systems work as well as possible for the benefit of their patients. Despite cheap quips and headlines, there are not many dentists who go into the profession for fame or fortune. The pandemic for some dentists was the proverbial straw, and their mental health was the personal price they paid to look after their patients. For many practice owners, the viability of their businesses has been a chronic concern, now turning acute in the current inflationary period.

High-street dentistry, which makes up the bulk of NHS provision, is provided by private business owners and corporate entities, who will look to saving their businesses first and saving NHS dentistry second. Sadly, we can see that the government is reaping what has been sown and high street NHS dentistry is slowly withering on the vine. It is likely with the cost-of-living crisis that demise will soon be accelerated unless some fundamental changes are made, with the support of the profession.

Our report covers other key areas of dentistry including community dentistry and hospital dentistry. The impact of the pandemic and the underfunding preceding it have had a similar negative impact on patient care and workforce resilience. It needs to be stressed that pressures in one dental service have direct impacts on the others. Moreover, GPs have reported a significant uptick in patients asking for help with dental pain and infections. This state of 'wack-a-mole' needs addressing as all services are under increasing strain from patient backlogs and staff shortages which look set to increase in the next six to twelve months. Meanwhile some patients in desperation are resorting to DIY dentistry, which should never happen.

Executive Summary

E.1 Access to Dental Services

The causes of reduced access to general dentistry, community dentistry and hospital dentistry are discussed. These can be summed up as chronic lack of investment in staff and infrastructure; difficulty in attracting and retaining dentists and dental care professionals (DCPs) within the NHS; patients with oral health problems exacerbated by the pandemic and poor diet; and wasted clinical time caused by missed appointments, excessive paperwork, and inefficient administrative systems.

The remedies are laid out in our recommendations. We call upon Welsh Government to make a firm pledge to invest the extra money needed to train and retain clinicians; invest in infrastructure; relieve practices from unnecessary bureaucracy, and bring about contract reform in general practice that fairly remunerates practices, dentists and DCPs for the treatments they provide patients.

Furthermore, the increasing pressures put on systems such as in the community dental services (CDSs) must be balanced with additional investment to offset the current loss of access for their core cohort of patients; including the most vulnerable patients in the case of the CDS.

E.2 Dental Workforce

The workplace environment and conditions of service that are imposed or brought about by neglect can undermine clinicians' mental health and resilience and so it behoves government to ensure these systems support the mental health of practitioners as a priority in future. Without dentists in the NHS there is no NHS dentistry.

More comparative analysis should be factored into workforce planning, which should be made a priority. According to the OECD, the UK has one of the lowest rates of 0.5 practicing dentists per 1,000 population. In the GDS in Wales the current figure is just 0.4. This is a head count not WTE. This should give pause for thought regarding the makeup of the dental teams and the capacity of the various NHS dental services in Wales.

E. 3 Oral Health Inequalities and Interventions

The many oral health surveys that are regularly undertaken in Wales together with intervention programmes *Designed to Smile* and *Gwên am Byth* have demonstrate how well these systems have been designed, executed, and monitored: Shining examples of government dental branch and Dental Public Health taking a long-term view to improve oral health in the most deprived or overlooked parts of the population. We urge Welsh Government to actively invest greater levels of funding and attract the workforce needed to ensure these programmes thrive and reach their full potential. There is still much to be done for these children and young adults in protecting their future oral health. The older members of our society deserve nothing less than to have access to a full range of dental services and to receive daily mouthcare provided by carers.

E.4 Public Accountability

To understand the scale of the service problems and to monitor the effectiveness of future remedies we call upon Welsh Government to improve the collection and reporting of all relevant data and make the processes and full analysis publicly accountable, rather than stakeholders relying so much on special requests or submission of FOI (freedom of information) requests.

Chapter 1: Access to Dental Services

The extent to which access to NHS dentistry continues to be limited and how best to catch up with the backlog in primary dental care, hospital, and orthodontic services.

1.1 Principles of Access

Simply put, balancing the two key drivers of demand and supply is needed for ensuring successful patient access. The other essential driver is finance – without sufficient funding the system cannot provide a comprehensive and timely service. Another important factor is rate of patient throughput – and the pandemic comprehensively flattened that for a considerable time.

Currently lacking in many cases is accurate data showing either the demand side (numbers of patients who seek ongoing NHS care), or the supply side (the whole-time equivalent number of dentists providing the service). StatsWales does an excellent job of presenting the data that they are supplied, to make our services publicly accountable. However, there are significant gaps in what data is supplied to them. We have tried assiduously over many months to get accurate data on growing patient backlog numbers in the CDS, but inertia in the system has been a barrier. It is subsequently a conveniently difficult premise to argue for more funding with partial data.

"Understanding the inequities in the provision and utilisation of NHS dental services by disadvantaged groups and across the life-course is needed if the Welsh Government's ambition to ensure NHS dentistry is available to everybody who wishes to take it up is achieved. Improvements to dental datasets are needed if we are to fully understand inequities in a more meaningful way." Senedd Research 2022

Nevertheless, the various NHS dental services are all straining with an enlarged backlog of patients (either documented or instinctively understood), thanks most recently to the pandemic, but also inherently due to a financially constrained system. At the same time the numbers of dentists in the GDS (General Dental Services) are shrinking and the numbers in the CDS (Community Dental Service) are beginning to decline. All the while the population of Wales continues to grow.

Inevitably, this pressure on the system has meant for some patients resorting to private dentistry, although affordability might severely curtail options for treatment. Saving a tooth can be an expensive undertaking privately, but when faced with dental pain an extraction without the long wait on the NHS can be an attractive proposition.

If there are inefficiencies in the services delivered, there is argument for these being adjusted. The current systems put no onus on patients to pay for missed appointments, for example. This seems to be the missing leg of the three-legged stool. If more patients were to take responsibility for their part, that might help patient throughput optimised.

1.2 Access to Primary Care General Dentistry

1.2.1 Complexity of Care – Impact on Access

The complexity of care and its impact on access is an issue not well understood. Patients' oral health status and treatment needs can vary hugely, and the current systems to reimburse dental practices are very blunt instruments.

The UDA system has at least some differential payment according to complexity but the capitation system on its own is completely insensitive. Moreover, neither system can differentiate between regular attenders who might become less stable if seen less regularly, and an unstable, high needs patient who might attend only when their needs become urgent but who nevertheless requires a large amount of chair time to stabilise them which then detracts from the time available for the regular attenders.

1.2.2 Reduction in Access

BDA Cymru previously published on the problems of access for new patients. In 2019 on average only a quarter of practices in Wales were able to offer new child patients an appointment and only 15% of practices could accommodate new adult patients. At the time we warned that the trend was worsening for adults accessing treatment.

During the pandemic nearly 2m appointments were lost. In 2020-21 the number of courses of treatment fell by 76.7% from the previous year, largely due to the suspension of dental activity caused by the COVID-19 pandemic. Activity decreased for all treatment bands except urgent cases which increased by 0.6%. This resulted in sharp falls for most common treatments, with 98.5% fewer examinations performed on adult patients and 99.4% fewer examinations on child patients than in 2019-20.

Since the pandemic, access for new patients has been even more difficult. Prioritising access to those in acute need was (rightly) the model during the pandemic. But that was short term. During the pandemic appointments were scarce and not available for check-ups so many regular patients haven't been seen in the last two or three years.

There has been a great deal of debate in the Senedd during 2022 regarding problems with access to NHS dentistry. Several MSs have asked why access is so poor; stating that there are many of their constituents who cannot get an appointment with an NHS high street dentist. But if they could afford to pay, they would probably get a private appointment.

Reports undertaken by Community Health Councils (CHCs) across Wales (e.g. Swansea Bay CHC and Hywel Dda CHC) say that finding an NHS dentist for many people is "impossible". They say this is having a significant impact on people's dental health, with many feeling the pressure to pay privately or have no treatment at all.

In the summer of 2022, the BBC reported that access for new patients to NHS general dentistry across the UK was very poor. Their interactive map, captured below, shows the figures by county, and most of Wales is shaded as 100% or 90% of NHS practices not taking on new adult patients who phoned for an appointment.

There is a serious backlog of patients in the GDS. Most if not all practices are working through extensive waiting lists, built up over years, many of which are so large practices are effectively closed to those that phone. New patient targets can be largely fulfilled by working through these waiting lists, which is why phoning a practice 'cold' is usually unsuccessful as the BBC demonstrated.

The table below shows the BBC's research results on access for new patients across the UK. Access for new patients in Wales is overall the worst in the UK:

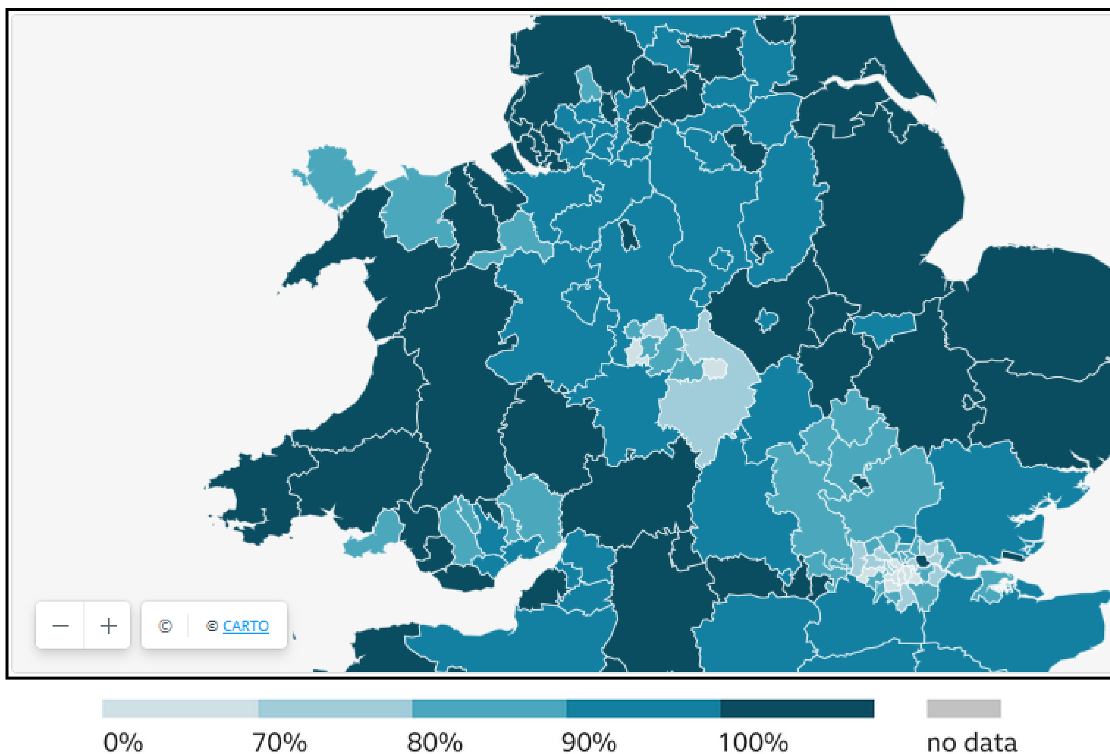
Table 1.1 Percentage of practices NOT accepting new patients in each UK country

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

Figure 1.1 Welsh counties showing majority have no practices taking new patients

Proportion of dental practices contacted by the BBC not taking new adult NHS patients

Percentage by upper tier local authority. Tap or click for more details



1.2.3 Patient Throughput

Infection control measures during the pandemic slowed down patient throughput to a fraction of pre-pandemic numbers. Dental practices were until recently operating under guidance (Dental Appendix) for enhanced infection control. This was withdrawn on 27 May 2022. The risk assessment had shifted from dental public health to individual practices. However, even now, risks must still be managed, as too staff absences and patient cancellations caused by ongoing covid infections; in the same way infection risks are expected to be managed in all workplace environments. It is unclear whether patient throughput rates are yet back to pre-pandemic levels.

1.3 Access to Community Dentistry

The access issues in the general dental service also have a negative effect on the CDS. In some Health Boards, CDS resources, staff and clinics are being used to relieve the GDS access issues, with CDS staff treating emergency patients. This is happening without additional funding, at the expense of CDS core patients – i.e. the most vulnerable and those without a voice.

1.3.1 Waiting lists

Waiting lists in the CDS have increased. The increased demands on the Service and the lack of access to CDS clinics during the pandemic are mainly responsible. Additional funding and staffing are essential to improve the current situation and provide prudent dental care to the most vulnerable group of patients, particularly adults with disabilities.

In a recent BDA Cymru survey, 85% of CDS dentists were very concerned about levels of patient backlog in the last six months. All CDS dentists had at least some concern. Investment in air handling installations had been very patchy and so fallow times had remained long in many surgeries, thus exacerbating the backlog.

BDA Cymru tried to ascertain accurate figures for CDS waiting lists in each Local Health Board but failed to obtain reliable data. This situation needs addressing as currently the system is largely unaccountable to the public.

1.4 Direct Access and Skills Mix

1.4.1 Skills-mix and the Changing Model of Dentistry

In May 2013, the General Dental Council (GDC) removed the necessity for patients to see a dentist before accessing certain treatments from dental care practitioners. Direct access arrangements mean that DCPs can carry out work within their scope of practice without a dentist's prescription.

This new way of working has been rolled out to all community dental services in Wales so they can use the full scope of DCPs skills. Designed to Smile uses a team approach to provide targeted prevention work to children in community dental practices.

HEIW espouses the value of skills mix and promotes its use using various tools including SOSET Skills Optimiser Self Evaluation Tool The SOSET dimensions also link to Wales Government's Prudent Healthcare objectives. Welsh General Dental Service Contract Reform emphasises team working to deliver preventive care.

Research indicates that as much as 73% of treatment in general dental practices could be carried out by DCPs. Adopting a teamwork approach to patient care can free up dentist time to concentrate on more complex and advanced care. Carrying out a variety of tasks and making the most of their scope of practice has also been found to increase job satisfaction.

Heathcare Education Improvement Wales HEIW

Research undertaken by colleagues at Cardiff University aims to understand the benefits of skills mix and a recent paper by Emma Barnes *et al* concluded that:

> Our case studies suggest that making a workable business case was a significant influencing factor in employment of DTs. We acknowledge that this is a major concern for practices that must operate both as businesses and healthcare providers. Policy change is vital; until funding and regulations ally with DTs scope of practice there will continue to be barriers to full use of their role within the NHS.
>
> Cardiff Unit for Research and Evaluation in Medical and Dental Education (CUREMeDE) Cardiff University

Skills mix undoubtedly has a place in NHS dentistry, especially in community dentistry settings where oral health services are needed to support those who are less able to look after their own oral health – particularly supporting the very young, the very old, and those with disabilities.

Skills mix can sometimes work well in general dental practice in larger practices that have multiple surgeries and dedicated rooms for consultation and education. However, many dental practices are smaller and don't fit this model. With smaller practices of one, two or three surgical chairs and no consultation rooms, skills mix doesn't easily work, and it is unclear how any policy change can alter the fundamental business modelling.

It is therefore disappointing that a recent announcement by the CDO proposing the increased use of skills mix to increase access to high street dentistry had disregarded this research evidence. Moreover, the announcement carried grossly inflated numbers of therapists and hygienists (**2,800**) which we corrected with ITVNews at the time to **500**.

1.5 Access to Hospital Dentistry

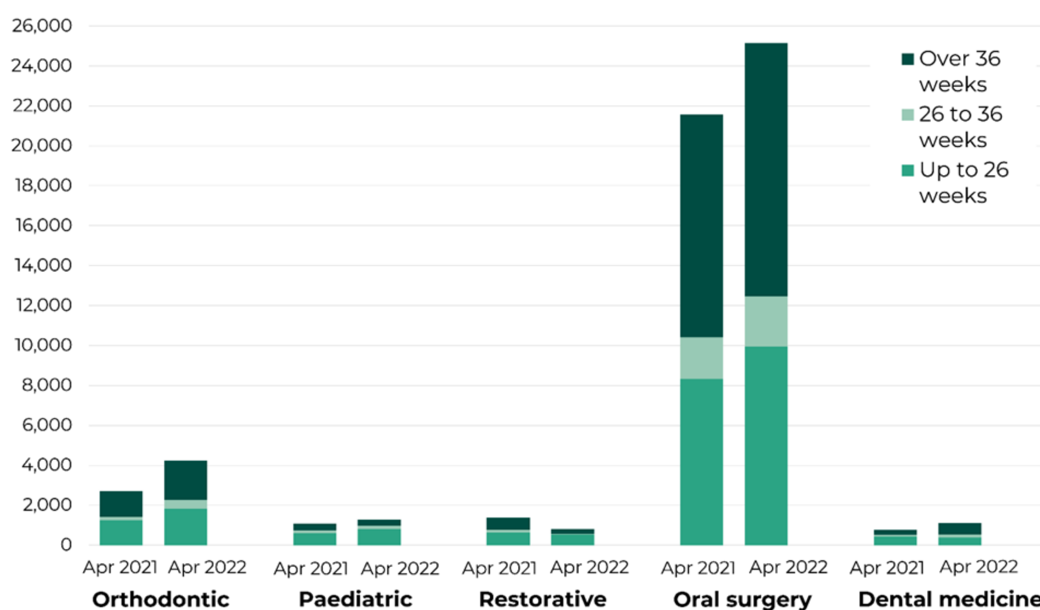
1.5.1 Waiting times

The impact of the pandemic has been acutely felt in secondary care, where there are a range of dental specialities including Oral surgery; Paediatric dentistry; Orthodontics; Restorative dentistry and Dental medicine. (See **Appendix A** for Glossary of Terms)

The latest data show the number of patient pathways waiting to start treatment increased for all specialities, except restorative surgery, between April 2021 and April 2022. While the percentage of patients waiting over 36 weeks for treatment decreased for most specialities over this period, these waiting times remain high for orthodontic treatment, dental medicine and oral surgery. In April 2022, 50% of patients had been waiting over 36 weeks for oral surgery.

Appendix B gives the breakdown of figures which show that total numbers of patients waiting for oral surgery went from 19,675 in January 2021 to 24,123 in June 2022 – an increase of 22%. Similarly, Dental Medicine went from 651 in January 2021 to 1,070 in June 2022 – an increase of 64% waiting. In both cases these June figures represent an actual improvement on the April 2022 figures which peaked with maximum numbers of patients waiting for treatment in both specialities. Thus, there is a glimmer that those services are just beginning to address the backlogs.

Fig 1.2 Patient pathways waiting to start treatment by month, grouped weeks and treatment function, January 2021 onwards



Source: StatsWales **(From Senedd Research)**

1.5.2 Knock on effects

Long waits for specialist care impact GDS dentists who often have multiple attendances during the long waits. This is a particular issue in the North where secondary care services are more stretched/limited than elsewhere. If patients are left to wait not just months but for years in need and possibly in pain or with difficulties in eating and talking then it stands to reason they will plead attention by their dentist – perhaps hoping such a visit might prompt a phone call to the hospital's admissions department, and in hope some relief might be found.

Chapter 2: Reform of Dental Services

This chapter focusses on the reform of GDS; the section on the CDS looks at the scope of service

2.1 GDS Contract Reform

2.1.1 The Need for Contract Reform

The quote below describes the state of dentistry in England. Given the legislation is virtually the same for Wales, as too the conditions affecting practices, this is a helpful summary:

"Stating the problem to be addressed in clear terms is a necessary prerequisite to then developing the policy solutions that can solve it. So, what is the problem? With regard to NHS dentistry, this is not exactly a difficult question to answer. Half the population does not have funded access to an NHS dentist. The UDA system is as perverse as it is difficult to explain. Despite patient need, thousands of practices face clawback each year because they can't jump through quite the right hoops to satisfy UDA targets. Practices are unable to recruit associates willing to do NHS work and dental nurses are looking at careers outside of dentistry which are more personally and financially rewarding. There are many, many more."

Contract reform - the BDA's view Tom King & Shawn Charlwood

Our report to the Inquiry into Dentistry 2018 provides a detailed explanation of the complexity and challenges that general dentistry operates within and would refer the committee to our 2018 report also for the technical details of the GDS contract, many of which still apply, given that the 2006 legislation is still in place.

2.1.2 Progress of Contract Reform

The new contract reform process began in 2017 and practices with an NHS contract could volunteer to take part. The contract offer initially involved a reduction of 10% of the discredited Units of Dental Activity (UDAs) in exchange for carrying out ACORNs - assessment of clinical risk and needs - once a year for each patient seen. Stage 2 involved 20% UDA exchange for additional targets of new patients. The minimum UDA value was lifted to £25 for those practices in contract reform. The percentage of children seen edged up a little from 2017 to 2019 but at the expense of the adult numbers which declined.

It should be stated that performing the ACORNs continues to take away patient contact time (5 to 10%) that could otherwise be used for clinical treatment. Furthermore, it has not escaped the profession that the practice's patient cohort RAG profiles were supposed to be built up over the last three years using the ACORN data to apply an appropriate weighting to volumetric targets. But this has not happened and the reasons for using the ACORNs need re-evaluating, possibly with an adjustment to frequency of use or some other modifications.

2.1.3 Units of Dental Activity (UDAs) – not yet in the bin

UDAs were suspended for two years during the pandemic but tracked in shadow statistics. With the pandemic conditions lifted, the current year contract volumetrics include an element of UDAs worth approximately a quarter of the contract value. This is because the 2006 legislation still governs the practice of NHS dentistry until such time any new legislation is passed.

2.1.4 Impact of the pandemic and the need to manage business risk

NHS dentistry in Wales benefited from timely support by the Welsh Government throughout the pandemic; and yet despite that, the profession had never experienced so much stress, and their businesses, NHS and private, never put at so much risk, as in the two years of the pandemic.

We demonstrated to Welsh Government how much pressure practices were under from all sides during this period; to keep their businesses viable and services compliant; to be able to serve their patient populations, while taking care of practice staff.

Dealing with constant change and challenging working conditions during the pandemic took its toll on the dental team and their resilience wore thin. Many dental nurses left their NHS roles and did not return, finding better working conditions either in private practice, agency nursing, or outside dentistry altogether. Numbers of dental nurses have recovered but they remain in short supply for NHS work. Numbers of dental technicians also declined but did not recover, **Appendix C**

Then in March the deputy CDO announced further changes to the contract conditions with just a few weeks' notice given for practice owners to consider their options and weigh up the risks of three options; the new volumetrics offer, the UDA-only default contract, or handing back of the NHS contract.

Our survey of dentists in March showed that many practice owners were very concerned about what the new volumetrics in FY 22-23 would mean for business sustainability. More than 80% were concerned about waiting times for existing patients. Over 90% thought the new patient target was too high. Moreover, over 90% were concerned about the likelihood of clawback against one or more of the metrics. Over half of the respondents were concerned about accurate data capture and data transfer and impacts on contract reconciliation.

Ultimately, for many practices (80%) the contract offer seemed the lesser risk, but this depended on each practice's business assessment. There were 20% of practices which stayed with the default UDA only and practice owners making this choice were likely to do so because they considered this might be the better business option and better for their cohort of patients.

2.1.5 Current Model of Service Reform

New volumetrics were announced in March 2022 for implementation from April 1st for one financial year. There was a follow up of facts and information by Welsh Government.

This lack of notice alone caused significant consternation to dentists who had little time to make an informed business decision to accept the contract offer. Many practices had bookings months ahead with their patient lists so couldn't start the new volumetrics from a standing start on the 1 April.

> "Our books were full with our own patients until July… we couldn't start the contract variation's new patient metrics until that back log was cleared."

2.1.6 Limitations of current Welsh GDS Reform Model

We support the principle of government contract reform, which is needs-led preventive care. However, there is no magic fix to a problem that lies fundamentally in underinvestment. There are some things that can have a positive effect such as using skills mix in the right setting and with the right training. But such tweaks can't put right a fundamentally underfunded system.

In the current year of contract reform, 25% of the value of the contract is given over to servicing new patients. Although laudable as a principle this only works with sufficient resources otherwise many regular patients who have already been waiting years to be seen will be displaced.

To maintain access for new patients, while operating within the budget restraints, the frequency of visits for regular patients can be reduced by extending the recall period, or so the theory goes. The CDO recently announced the extension of recall periods to 12 months would free up 112,000 extra appointments. We doubt the veracity of these figures which are totally unsubstantiated. Moreover, this announcement assumed that dentists have not already been applying the 2004 NICE guidelines that describe variable recall periods up to 24 months, depending on individual patient need. (The reality is a large majority of practices have either a lot of high needs patients or a mixed profile including high needs patients. Fewer than 10% of practices working the contract offer had mostly low needs patients. (See section 2.1.7)

We were not consulted on this move, which was promoted as part of contract reform. In fact, it came out of the blue, probably because of the Health Minister challenging the Chairs of the Local Health Boards to improve access. We drew attention to the fact it can take a dozen appointments of regular check-ups to provide sufficient "chair time" for a single new high-needs patient. A single high needs patient can take up many hours of surgery time for one course of treatment and the capped payment system simply can't cover the costs, leaving the dentist out of pocket.

New patients can be a business risk to practices in other ways, as they are more likely to fail to show up for appointments which means clinical time is then lost and this puts practices at greater risk of financial penalty. Service Reform needs to consider proper business modelling as practices must remain solvent or close their books to NHS patients.

Currently the reformed contract volumetrics make no proper provision for a casual patient i.e. they would only count as a new patient (NP) if they have an assessment of clinical needs and risk (ACORN) and a full course of treatment (COT), which can often require several visits and the practice doesn't get paid until the COT is closed. If treatment is given to a holiday maker, for instance a temporary filling; then the only claim that can be made is a 1.2 urgent. They pay the £14.70 but they don't show up on eDEN as a NP or historic patient (HP). The fact that urgent courses of treatment count for zero on NP/HP targets means there is a complete disincentive to manage "casual" patients, holidaymakers, walk in emergencies etc further reducing access.

BDA Wales has supported the principle that the prudent use of public money must be demonstrated. However, we have advised that any new target volumetric must be designed and applied carefully to avoid unintended consequences that disincentivise the treatment of urgent or high-needs patients, as was the case with UDAs. It is with that mindset that we have advised Welsh Government on developments of parameters within contract reform and will continue to do so.

2.1.7 BDA Wales Summer Survey - GDS Contract Reform

Over 150 dentists from all the LHBs responded to our survey in August about the GDS contract reform. Much of what was reported showed that the fears about the new volumetrics expressed in March are coming true.

Most respondents (80%) had chosen the reformed contract (volumetrics) offer and the remaining 20% chose to revert to UDA only. Of those practices on the new volumetrics contract half (51%) had a majority of high needs (red) patients and another 44% reported their patient profile as mixed high needs. Clearly those practices on the new volumetrics contract that saw mostly lower

needs patients were in a very small minority (<10%). For the UDA-only contract 35% of practices had a majority of high needs patients, and another 42% reported their patient profile as mixed high needs. This further lends weight to our arguments about the futility of the CDO's argument proposing that extending recall periods will create 120,000 extra appointments.

One practice owner who has provided NHS dentistry for 12 years without any clawback shared this:

"We currently have [hundreds of] open courses of treatment at the practice. The pandemic has had a massive impact on the regular patients we were seeing. Most have complex problems. Caries rates during lockdown have gone up! Treatment plans are on average 4 appointments for each patient.

Our dentists are staying behind each day to finish completing their notes. We have not got enough hours in the day to do our targets."

Dentist in contract reform (2022)

Many practices operating on the new volumetrics GDS contract are putting in additional resources to try to meet their new targets. Over half of respondents (59%) are working longer hours. And yet, despite these efforts, 89% of respondents were concerned about clawback. The majority (71%) had not received assurances for their Health Board that clawback would not be applied. Only 13% had received some reassurance but still had concerns, the rest were unsure.

The main barriers hindering their practice's ability to achieve targets included high needs patients, which is linked to new patients; unrealistic targets; issues with eDEN; too much administration and underfunding.

Respondents shared their concerns regarding new patients, which centred around many hours of clinical time and significant revenue lost due to appointments not attended since April. It is unclear whether these patients didn't attend because of issues with LHB's central waiting lists or some other reason.

"New patients do not turn up. They are historically poor attenders and waste clinical time with no consequence to their actions. The slots they leave empty are not accounted for in the metrics, yet we are expected to make up that time to see another patient."

Most respondents on the new volumetrics (71%) did not think they would achieve their targets. Only a small minority (9%) thought they were on course to meet their targets. Many respondents (53%) have found working the reform offer extremely stressful. Multiple dentists stated that they felt underfunded and undervalued. Almost all respondents (96%) were concerned for the future of NHS dentistry in Wales.

Most respondents working the reform offer (64%) plan to increase their private work, and 58% plan to decrease their NHS commitment. Multiple respondents shared they plan to hand back their contract or leave the NHS. Respondents were asked whether they plan to discuss contract reduction at their mid-year review; 28% said yes and a further 33% were unsure.

The responses from those dentists working the UDA only contract were surprisingly similar with regard to expectations to meet targets (28%), worries about clawback (61%), lack of assurances from LHBs (76%), and plans to increase private work in the future (69%). Many (87%) were worried about the future of NS dentistry.

Whichever contract type, many practice owners are expecting to be financially penalised at the end of the year for not meeting targets.

2.2 Community Dental Service

2.2.1 Role of the CDS

The Community Dental Service's core role is the provision of primary dental care to the most vulnerable groups of people in Wales, including adult and child patients with disabilities, mental health issues or severe anxiety. This includes dental treatment under Conscious Sedation and General Anesthesia where indicated and the clinical triaging of all the children. E-Referrals for treatment under General Anesthetic, in order to reduce the number of children GA admissions. The CDS also provides domiciliary care in care homes and residential settings.

The CDS also delivers prevention programmes in Wales, such as the children's programme, Designed 2 Smile, the national prevention programme for children, and Gwên am Byth which supports oral hygiene and mouth care for people living in care homes. The CDS also undertakes the yearly epidemiology survey, which will be restarting this year following the pandemic. The new Welsh Health Circular on the CDS and Services for Vulnerable People discusses the role of the CDS, including plans to expand its remit.

2.2.2 Pressures on the CDS

Dentists in the CDS are salaried, directly employed by the LHBs. The tasks undertaken by the CDS are ever growing, yet the service itself is stable at best, and in some cases shrinking. Currently, dentists' posts are being lost at retirement or advertised but remain unfilled. Recruitment and retention issues are felt particularly in more rural areas, which are notoriously difficult to staff. Retirement rates are likely to increase.

During the red-alert phase of the pandemic, CDS clinics across Wales became Urgent Dentalcare Centres, keeping dentistry going in Wales. Patients normally seen in the GDS were treated by the CDS to minimise the spread of COVID19. This meant that the vulnerable patients normally seen in the CDS were not seen, and waiting lists, which in some Health Boards were already long, began to grow.

The CDS is affected by chronic under-funding; in particular the estates (lack of equipment) and old IT infrastructure have been directly impeding the rate of patient throughput and adding to a growing backlog of patients. (Investment in air handling installations had been very patchy and so fallow times had remained long in many surgeries, thus exacerbating the backlog.) Despite this state of affairs, the number of tasks being performed by the CDS has been increasing.

"Each HB should be urged to support the CDS in IT infrastructure and operation as that always appears to be missed out in any major IT planning decisions. If we had robust IT and data support, then the CDS would be able to plan services better to address backlogs.

CDS Dentist

E-referrals were introduced in 2018 to streamline the referral process and reduce the number of General Anaesthetics (GAs) on children. This has led to a great deal of extra work in the CDS. The CDS has triaged a large number of uncooperative and high need children with no additional funding. While the number of child GAs in hospital has reduced, the CDS is treating double the number of children, and their inhalation sedation services have also increased. Because there has been no additional funding or resources, other CDS groups of patients have been disadvantaged as a result. The BDA supports the principle of reducing hospital GAs, but CDS resources, funding, and staffing must all increase to match the growing demands..

The access issues in the General Dental Service have a negative effect on the Community Dental Service as they are closely connected. In some Health Boards, CDS resources, staff and clinics are being used to relieve the GDS access issues, with CDS staff treating emergency patients. This is happening without additional funding, at the expense of CDS patients.

The BDA is concerned to learn that that plans are afoot to increasingly use the CDS as a backstop service for when a GDS contract is returned to the LHB. However, this is unlikely to work without 'spare' dentists available to step into salaried roles, as is being suggested, because most likely they will have moved into private practice. These new functions as described in the Welsh Health Circular would require significant investment by the Health Boards and there is nothing to suggest they have the extra funds to back up these well-intentioned but un-costed ideas.

2.2.3 Treatment of refugees

Only a few years after the wars in Syria and Afghanistan, a new war has started in Ukraine. As a result, millions of Ukrainian people, mostly women and children, have fled to find refuge in neighbouring countries. The UK has pledged to support and welcome refugees from the region and the CDS has always been the primary dental care provider for refugees in Wales. The Welsh CDS have provided essential and compassionate care to Syrian and Afghan refugees in recent years and continues to do so. There must be enough funding to treat all those who need it, including any group of displaced people.

2.2.4 Waiting lists

Many vulnerable patients, particularly adults with disabilities, are not able to receive the prudent healthcare they require, due to the pressure placed on the CDS. From the lack of access created for CDS patients when CDS clinics became Urgent Dental Centres during the pandemic, to the increased asks the CDS is facing, it is clear to see why waiting lists in the CDS have increased.

Without additional funding and staffing, it is difficult to imagine how the most vulnerable patients in Wales will get their treatment before their oral health deteriorates and pain and suffering ensues. These are the least well represented patients as they often have no voice and no advocate service, other than the CDS dentists and their BDA committee. In a recent BDA Cymru survey, 85% of CDS dentists were very concerned about level of patient backlog in the last six months. All CDS dentists had at least some concern.

2.2.5 The future of the CDS

The CDS needs to expand in order to meet its targets and continue to treat the most vulnerable children and adults in Wales. Increased funding is required for:

- Recruitment of Dentists, Therapists, Dental Nurses, and other members of the dental team.
- Utilisation of all the available clinics and infrastructure upgrade.
- Training and development of the dental teams to meet the increased complexity and variety of the CDS remit.

It is important that the Community Dental Service retains the treatment of the disabled and vulnerable groups as its core role. Any additional tasks and plans should not disadvantage them and lead to the reduction of the level of care these patients deserve to receive.

Chapter 3: Dental Workforce

Incentives to recruit and retain NHS dentists, particularly in rural areas and areas with high levels of need.

Workforce well-being and morale

3.1 Comparative workforce data

In 2018, there were between 0.4 and 1.2 practising dentists per 1,000 population across EU countries. According to the OECD, the UK has one of the lowest rates at 0.5 practicing dentists per 1,000. In the NHS in Wales the current figure is just 0.4. And that is a head count, not WTE. The average number of consultations per capita in Europe was 1.2 whereas in the UK it was 0.7. See **Appendix D** for OECD graphs.

This simple comparative analysis should give pause for thought regarding the makeup of the dental teams and the capacity of the various NHS dental services.

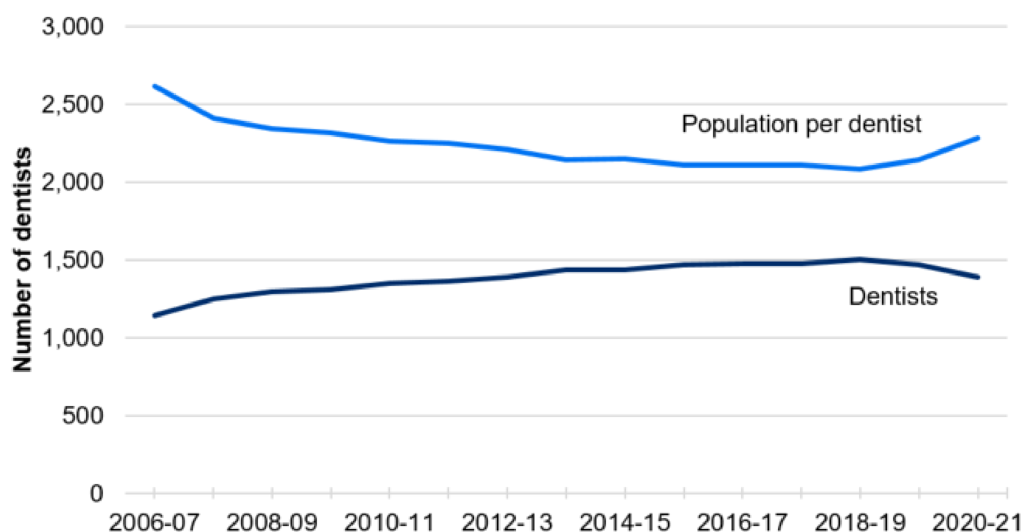
3.2 General Dental Service

3.2.1 Capacity

In recent years more dentists have left the NHS than are being replaced. There are no reliable figures of whole-time-equivalent (WTE) dentists in the GDS as they are nearly all independent contractors, so figures are a head count. These are unweighted numbers, so one dentist could work full time and another contract just half a day a week for NHS work and they would count the same.

In the last two reported years 117 fewer dentists were engaged in NHS work, (1,506 dropping to 1,389) which is a fall of nearly 8%. Also, many dentists have reduced their commitment to NHS work or are planning to do so.

Fig 3.1 - total numbers of dentists with NHS activity and population per dentist 2006-7 to 2020-21



Sources: NHS digital and ONS

3.2.2 The Dental Team

It can be seen from GDC registrant data that with the exceptions of dental technicians and clinical dental technicians over the last five years there has been an increase in each category of the dental team; ranging from 1% increase in dentists to 24% increase in orthodontic therapists, although the latter numbers are very small.

It can be seen in **Appendix C** that numbers of clinical dental technicians and dental technicians never recovered from the impact of the pandemic. The number of dental nurses went down by circa 100 at the height of the pandemic (not shown) but have since recovered and grown slightly.

What these data don't show is whether they are NHS workers or private contractors or provide services to both NHS and private practice.

Table 3.1 changes in total numbers of registrants in each category

Dental Worker	Change from 2018 to 2022	Increase or decrease
Orthodontic therapist	28 to 37	24%
Dentist	1669 to 1691	1%
Dental therapist	131 to 165	20%
Dental technician	259 to 232	-11%
Dental nurse	2882 to 3005	4%
Dental hygienist	283 to 341	17%
Clinical dental technician	14 to 11	-27%

There is an argument long-made by the office of the CDO and HEIW that skills mix can extend the finite resource of the GDS to provide more treatments. While the BDA recognises the value of the wider dental team and the skills that they can bring to effective dentistry, we are concerned that these putative efficiency savings are very optimistic and possibly simplistic.

Associates' average income is maybe 20% more than the average for therapists. Logic says you would need to replace 5 dentists with therapists in order gain one extra therapist. Thus, the cost saving argument wears thin very quickly. Therapists and hygienists can play an important role for maintaining good oral health and providing treatments within their scope of practice including fissure sealant and simple restorations, leaving the more complex restorations to dentists.

"Recruitment is worse than I can ever remember in the NHS. Therapists are becoming more difficult to recruit too. At £30-£35 an hour employed they are not far off the cost of an associate. Skill mix has a role to play I am sure. However, am I alone in finding it very difficult to justify putting a dental nurse, with a chaperone dental nurse, into a fully equipped surgery to apply their MPWIP knowledge and fluoride varnish to patients?"

Dentist in contract reform 2022

3.2.3 Provider Performers' income

Provider-performers (practice owners) in Wales have experienced substantial falls in taxable incomes in the last decade. They have seen their pay fall from a peak average of £131,287 in 2007-08 to an average of £98,900 in 2019-20. Compared to 2008-09 levels, their taxable income in 2019-20 had fallen by 19.2 per cent in Wales. This compares with 14.4 per cent in England and

12.6 per cent in Scotland, showing the adverse effect is much greater in Wales. These falls are in cash terms and take no account of inflation.

3.2.4 Associates' remuneration and contractual arrangements

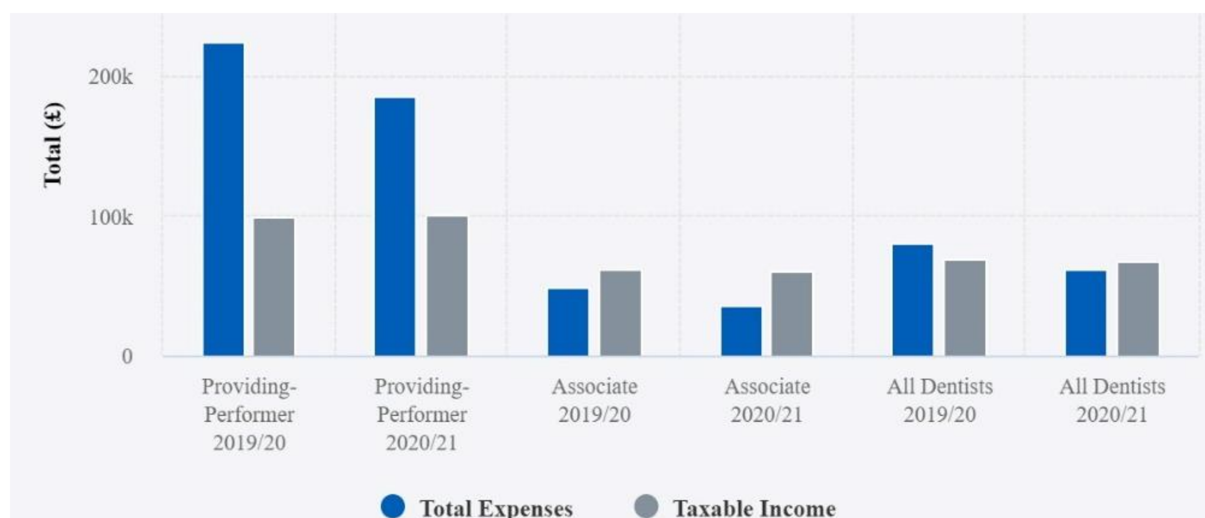
Associates are in almost all cases self-employed contractors. In England and Wales, where practice owners hold the NHS contract, associates have contractual rights to a limited set of NHS-funded parental leave and sickness payments, but there is no provision within the NHS contract that entitles associate to a particular level of pay or pay uplift. Associates agree with a practice owner to deliver a certain amount of NHS activity, the proportion of the UDA fee which they are paid, and the proportion that the practice retains in respect of the expenses incurred by the associate's work. Compared to 2008-09, associates' taxable incomes have fallen in cash terms by 6.9 per cent in Wales. These falls take no account of inflation. See **Appendix E** for more details.

When the DDRB recommends a pay increase for dentists and the Welsh Government lifts the value of the GDS contract there is no guarantee that associates will see a pay increase. This is largely because of dental inflation which isn't properly captured in the uplift and the fact that the value of the GDS contract doesn't cover infrastructure spending (capex) – often cross-subsidised by private income in a mixed practice.

It is our view that these factors have led to associates not seeing their incomes rise by the DDRB recommendation and that associate pay has instead fallen over the last decade. This downward trajectory in take-home pay has persisted despite the countervailing labour market pressures caused by the difficulty recruiting associates to NHS roles that would be expected to lead to higher pay, and points to the fundamental lack of NHS resources made available to provide dentistry on a sustainable basis.

The figures for FY 2020-21 from NHS Digital show in Wales those associates with any NHS activity in the GDS took a real pay cut of almost £2,000 (nearly -3%) and practice owners saw a very small pay increase of 1.5%. (See fig 3.2.) These average figures included private income. However, associates do the bulk of NHS work, and the majority of their work is NHS.

Fig 3.2 Expenses and Earnings of Dentists in Wales in 2019-20 and 2020-21 – includes NHS and private



Ref: NHS Digital

3.3 Community Dental Service

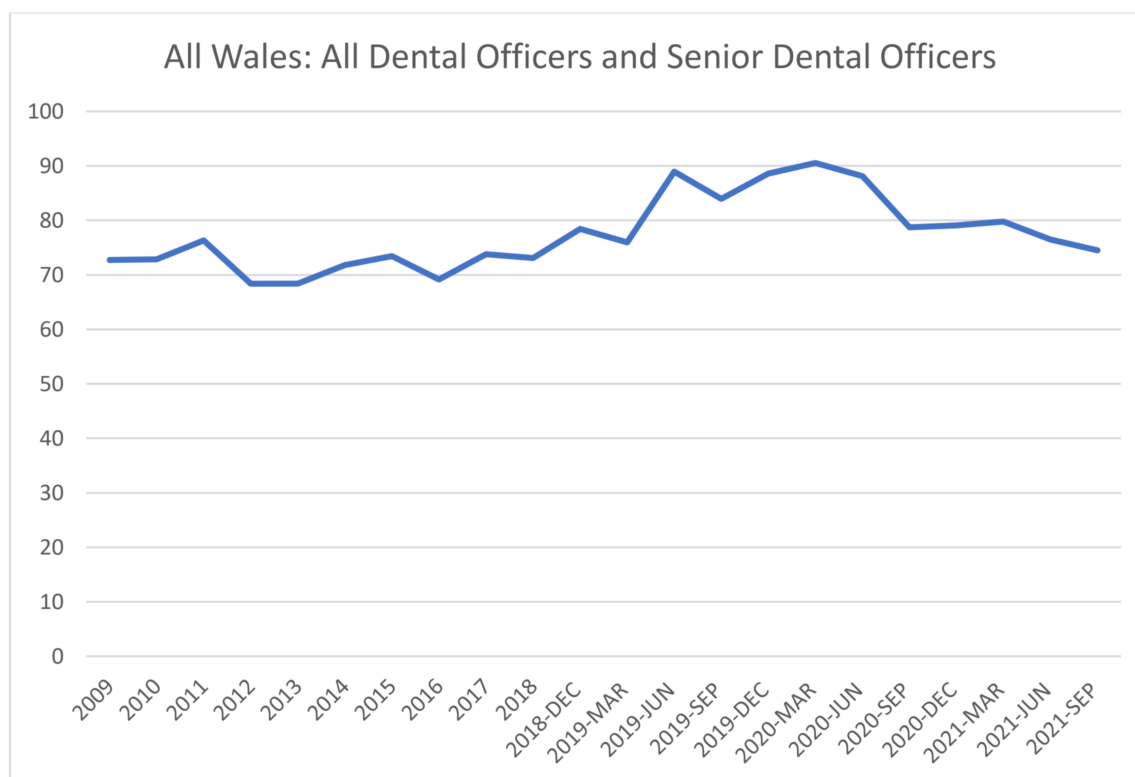
Overall, the WTE of Senior Dental Officers in Wales has increased since 2009, from 17.5 to 24.1. However, the WTE of Dental Officers has decreased, from 55.2 to 47.6 since 2009. This has led to an overall increase in all Dental Officers and Senior Dental Officers of just 1.7.

From 2011 to 2020 there has been an increase in the population of Wales of 3.45%, meaning there are 105,828 more residents in Wales. The overall increase of dental officers in that period is 2.2%, which means that WTE in the CDS has not kept pace with the population increase.

It is also vital to remember the context that CDS staff are working in. Throughout the pandemic, CDS clinics became Urgent Dentalcare Centres, meaning they were unable to treat their vulnerable patients (unless they counted as Urgent). Even when most of the UDCs closed CDS staff have been tasked in treating urgent GDS patients, with some Health Boards still carrying out this work in 2022. This has resulted in a large backlog of CDS patients, without an increase in staff to treat them.

The work of the CDS in Wales has changed dramatically from 2009, and this has not been reflected in WTE. (See fig 3.3)

Fig 3.3 Total dental officers in the CDS from 2009 to 2021



Data source: StatsWales

3.4 NHS Pension scheme – impact on workforce

Changes to the NHS Pension scheme and tax arrangements mean that many dentists who have worked predominantly in the NHS for many years may be faced with a cliff edge of a large tax bill in 2023 if they continue to undertake NHS work. Typical responses are to reduce NHS work or opt out of the pension scheme.

We have long advocated allowing members the flexibility to build up a lower NHS Pension by paying a lower contribution. This is a hugely complex area, and our dedicated Pensions committee has been collaborating with NHS partners to engender a change of policy by the Treasury.

The BDA is seeking a flexible arrangement that will give members a fair option to remain working for the NHS and in the pension scheme with an ability to control their exposure to tax charges. Without such a resolution it will inevitably result in many dentists withdrawing from the NHS over the next six months.

3.5 Mental Health of Dentists

The mental health of dentists was already problematic before the pandemic which then made the issues more acute. Previous surveys by the BDA and by NHS Digital show that those dentists with the highest proportion of NHS work suffer from the lowest morale and motivation and poorer mental health.

BDA Wales undertook two surveys of dentists in 2021 to understand the impact of the pandemic on their mental health and to flag up different mental health support services for them in the process. The results show that the pandemic conditions had a significantly negative impact on dentists' mental health.

From our survey in early 2021, when the effects of the pandemic were still acute, patient care was a large source of stress for GDPs. Limited time slots and fallow times caused much stress. Multiple GDP respondents stated that patients had been rude to them. Almost two thirds of GDPs rated their sleep quality as bad or very bad. Multiple respondents stated they woke in the night or struggled to sleep due to worrying about work. A third of GDPs had gone to work for more than 10 days during the pandemic when they did not feel mentally well enough. Finances and the future of dentistry were large sources of stress for GDPs. Added to that was uncertainty over contract reform which also was a source of stress for some respondents. Finances were a large source of stress for practice owners with over half reporting they were extremely stressed. Increasingly, dentists have been turning to private practice for their mental health and to practise dentistry in the way they believe is better for patients.

In the same survey over 60% of CDS dentists rated their sleep as very bad or bad. Over half of CDS dentists were having to do admin at their desks during their lunch break. All CDS dentists stated they found the rise in administrative tasks stressful. Worryingly, over 90% of CDS dentists had noticed a rise in the stress levels of the dental team in the last 6 months. Nearly 50% CDS dentists went to work while not mentally well enough for more than 10 days in a six-month period.

3.6 Recruitment and Retention of Dentists within the NHS

3.6.1 Workforce Planning

No amount of extra funding will be able to tackle patient backlog if you cannot find the workforce. This is true in the short term, the medium term, and the long term. But equally without appropriate funding tied to workforce planning there will be an attrition of the workforce.

Given the obvious importance of workforce planning, the government should make reviewing the situation in all the dental services a priority. The last comprehensive dental workforce review was a decade ago in 2012 and a great deal has changed since then. The review should include private practice.

HEIW have developed a workforce planning tool which is based on Cluster working. It is designed for various primary care services. However, dentistry has hitherto not had much involvement in cluster working, for various reasons. Of concern, there is no obvious component within the suite of tools that relates to the budget and financing the workforce that the tool designs. Workforce planning - and the education and training required - takes significant investment and commitment. However, to retain the workforce, the working conditions must be comparable with competing dental services.

The situation with planning for retirement for some dentists will be a factor in deciding whether to continue working in the NHS for the reasons previously outlined. Reasons to retire could include not just the pension position but also work-life balance and mental health protection. Any likely changes in retirement patterns and numbers also need to be factored in.

3.6.2 General Dental Services

Practices offering GDS services must compete increasingly with practices that focus on private dental provision. Generally, the working conditions in private practice are less stressful with less bureaucracy and with more opportunity to practice dentistry with patients who are committed to their oral health.

Several practice owners in Wales have handed back their contracts or reduced their contract value in recent months because they can't find associate dentists who want to work for the NHS. Indeed, Local Health Boards have been reporting more contracts recently handed back and the difficulties in reallocation to other practices. The difficulty in finding dental trainees to fill placements in some parts of Wales, particularly more rural areas, indicates this trend will worsen.

3.6.3 Community Dental Service

The terms of service can be helpful for retaining and supporting salaried dentists and the BDA works with government through the national joint forum to ensure these are kept current.

Currently, every LHB has a CDS with vacancies for Special Care Dentistry Specialists as well as dentist and senior community dentist vacancies. This is the same for dental therapists. The reasons for this are complex and the working conditions are an important factor.

"It is difficult to attract CDS staff to posts if the estates have not been maintained and the equipment is out of date when prospective staff can take their pick of posts. This leaves some CDS surgeries very understaffed and undervalued which ultimately impacts on the timeliness and quality of care for vulnerable patients."

CDS Dentist

3.6.4 Hospital and Academic Staff

A large proportion of dental academic staff are essentially part time practitioners. Salaries have been driven down in the same way as other groups of dentists.

Consultants pay scales for Wales do not mirror England or Scotland. The University pays lecturers on the pre-2009 contract, but Senior Lecturers and above post-2009. This doesn't help to attract individuals into academia early in their careers.

If more specialty doctors are trained, they could move around the community to different practices, giving direct opinions/consultations/limited delivery of treatment(s) reducing waiting times and reducing travel for patients, and also increasing the tacit learning of the practitioner base.

Chapter 4: Dental Budgets, Inflation and Practice Viability

Welsh Government spend on NHS dentistry in Wales, including investment in ventilation and future-proofing practices.

The impact of the cost-of-living crisis on the provision of and access to dentistry services

4.1 Welsh Government Health Budget

To put the dental budget in perspective; the budget for Delivery of Core NHS services in 2022-23 is £9,218m and over three years Welsh Government will provide £1.3bn in extra direct funding to the Welsh NHS. Most of that - £893m, is in this financial year. That is a **10.7% increase** on the current budget, with smaller increases in later years, reported by the BBC. Budget documents say the government's "highest priority is to address the backlog of treatments that have been delayed by the pandemic".

It is therefore disappointing that such an increase, which is nearer the current inflation rate, does not translate into the dental budgets or the uplift to salaries and contract values, which are left far behind at less than half that percentage. There seems little acknowledgement of the backlogs accrued in the dental services.

4.2 Dental Budget

4.2.1 Erosion of the dental budget

Speaking to the dental profession, no one is saying the system is sufficiently funded to meet demands. Funding has lagged for over a decade and been chewed up by inflation along the way. The BDA has warned for some time that this funding situation will lead to NHS dentistry withering on the vine.

Now, with a cost-of-living crisis already causing significant dental inflation, and the DDRB this year recommending awards at less than half the current inflation rate, there is no realistic prospect of continuing to do essentially the same thing in the GDS (with tinkering around the edges) and expecting a different result. Furthermore, robbing Peter to pay Paul, which seems the only strategy being actively pursued, is not fooling the profession.

The budget provided for NHS general dental services covers approximately half the population - that's for adults and children - and this is true in England and Wales. Investment in NHS dentistry has declined over the last decade. It has been shrinking as a percentage of the health budget and has seen erosion due to inflation. This means that there has been a cap on NHS dentistry which has become worse over time.

The *percentage* of the primary care budget spent on dentistry has declined each year from 2016-17 to 2019-20. It is therefore not surprising that the figure of expenditure per head remained almost unchanged and thus devalued by inflation year on year.

If the percent of primary care budget expenditure on dentistry had remained at 10.8% of total primary care budget in 2019-20 (£1,542,925,000) expenditure on primary care dentistry would be at £166,635,900, thus representing *a real terms loss of £6.771million* from the primary dental care budget in 2019-20.

The latest figures for 2020-21 did show a slight increase in *per capita* spend for primary care dentistry as this was in response to the loss of patient charge revenue during the pandemic. However, the percent figure is still less than in 2017-18 or 2016-17. Furthermore, the increase in primary care is offset by a sharp decrease in secondary care expenditure from 0.92% secondary care budget in 2020 to a tiny 0.7% in 2021.

Table 4.1: Expenditure on dental primary care in Wales (this is all primary care GDS + CDS + PDS)

Year	Percent of primary care budget spent on dentistry (%)	Expenditure on primary care dentistry (£000)	Per head (£) Primary LHB
2016-17	10.8	152,005	48.83
2017-18	10.6	153,960	49.26
2018-19	10.4	153,085	48.77
2019-20	10.36	159,865	50.70
2020-21	10.43	172,489	54.42

Source: StatsWales

Before last Christmas the Health Minister Baroness Morgan pledged additional funding of £3m in the last financial year and recurrent funding of £2m in this year and future years. While this news was welcomed in principle it cannot make up all the losses described. We don't know whether much or all the £3m was allocated for extra patient care after Christmas, as most practices were barely coping with their existing targets.

4.2.2 Abatements during the pandemic

Although clawback was suspended for the two financial years 2020-21 and 2021-22 due to covid support measures, there was nevertheless significant abatement of individual contract values (to 80% in the red alert phase and 90% in the amber phase) due to loss of patient charge revenue. Practice owners were expected to pay their staff at the same rates as pre-covid. Many did so but were left significantly out of pocket as a result.

Different LHBs stipulated different criteria for practices to redress this 10% shortfall in low amber phase. Unfortunately, there were many practices which remained on 90% of their contract values as they found the criteria too challenging for various reasons. This inevitably had a negative impact on the income of dentists – both provider-performers and associates.

4.3 Dental Practice Viability

This year the BDA wrote to the Health and Social Care Minister making the case that dental inflation was running at some 11% and that this needed to be factored into the uplift of the GDS contract value. Regrettably this request was not considered. (It should be noted that similar uplifts to GMP contracts have caused serious disquiet within the BMA.) The BDA is still considering the situation across the four nations of the UK.

Practice owners are increasingly not able to fill vacancies for associates to undertake NHS work, as the rates offered cannot compete against wholly private practices which can offer better incomes and better working conditions (less stress, less bureaucracy). In fact, for years, associates were paid better in Wales than in England in order to attract them to Welsh practices. However, it is now the case that dental graduates are going straight into private practice in bigger numbers, which, broadly speaking, reflects changing market forces.

Chapter 5: Oral Health Inequalities

Restarting the Designed to Smile programme and scope for expanding it to 6–10-year-olds

Improved understanding of the oral health needs of people aged 12-21

Capacity of dental domiciliary services for older people and those living in care homes and the 'Gwên am Byth' programme

5.1 Context of Oral Health

Oral health is an important, although often neglected public health issue. The economic burden of oral diseases is substantial. Oral diseases account for more than 5% of total health spending on average across EU countries, and productivity losses due to oral diseases have been estimated at around EUR 57 billion a year (Platform for Better Oral Health in Europe, 2019). Dentists play a key role in both preventing and treating oral health problems.

5.1.1 Disability caused by poor oral health

The Global Burden of Disease study (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).

5.1.2 The Role of Dental Public Health

The role of Dental Public Health includes undertaking regular dental epidemiological programmes to determine the current oral health and well-being status of Wales and describe existent inequalities across the life-course. It is also responsible for determining inequities present in the provision and utilisation of NHS dental service (e.g. oral health needs assessments). DPH should advise on evidence base, monitoring and evaluation of key oral health programmes and any innovative local/ regional/ national dental services transformation programmes.

5.1.3 Inverse Care Law

The Kings Fund has reviewed the concept of the inverse care law thirty years on from its original espousal to describe a perverse relationship between the need for health care and its actual utilization. In other words, those who most need medical care are least likely to receive it. Conversely, those with least need of health care tend to use health services more (and more effectively). We see evidence that this applies to dental care and oral health in much the same way.

"The availability of good medical care tends to vary inversely with the need for the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced."

Julian Tudor Hart The Lancet: Saturday 27 February 1971

The outcome is that poor oral health will disproportionately adversely affect the wellbeing of the least affluent quintile of the population. For adult patients, BDA Wales would like to see patient charges frozen or restructured as they are a tax that involves a lot of bureaucracy for dental practices, and which acts as a deterrent to patients who are not eligible for benefits but are on lower incomes.

5.2 Impact of the Designed to Smile (D2S) Program

5.2.1 Reach of D2S

The latest D2S report looked at the reach of the scheme in 2018-19:

> Across Wales, 1,396 primary/infant schools and nurseries participated in D2S daily toothbrushing schemes… … moving closer to our target of 100% of eligible nurseries and schools participating in the programme, up from 77% in 2017/18 to 82% in 2018/19.
>
> In total, 90,977 children were signed up to brush their teeth with fluoride toothpaste at school or nursery. This is so important because 1 in 3 five-year-old children in Wales has dental decay and unless we keep up efforts every day, the next group of youngsters could have worse decay.
>
> A new dental survey of five-year olds in Wales … will help to further evaluate the programme. 44,217 children also had fluoride varnish applied at nursery or school, to give their teeth extra protection from decay. 188,709 toothbrushing home packs were distributed across Wales, to encourage brushing twice a day at home as well.
>
> Monitoring Report **For the School Year 2018- 2019 Maria Morgan & Mary Wilson**

5.2.2 Impact of D2S on DMFT scores

The Designed to Smile Program has managed to help dispel the inverse care law effect in young child cohorts. In other words, the data now show no disproportionate effect of the lowest quintile on rates of decayed missing or filled teeth (DMFT).

The most recent oral survey of five-year olds in Wales reported a reduction in the proportion of children with decay between 2007/08 (47.6%) and 2015/16 (34.2%). Although not possible to determine causality, this reduction in disease level coincided with the inception of the D2S programme in 2009 and was noted as constituting the *'first significant and sustained improvement in the levels of dental caries experienced by children in Wales since records began'*.

In 2007/08, 14 out of a class of 30 children would have decay experience, and these 14 children would have an average of 4.2 teeth affected. By 2015/16 this had fallen to ten children out of a class of 30, and these 10 would have an average of 3.6 decayed teeth.

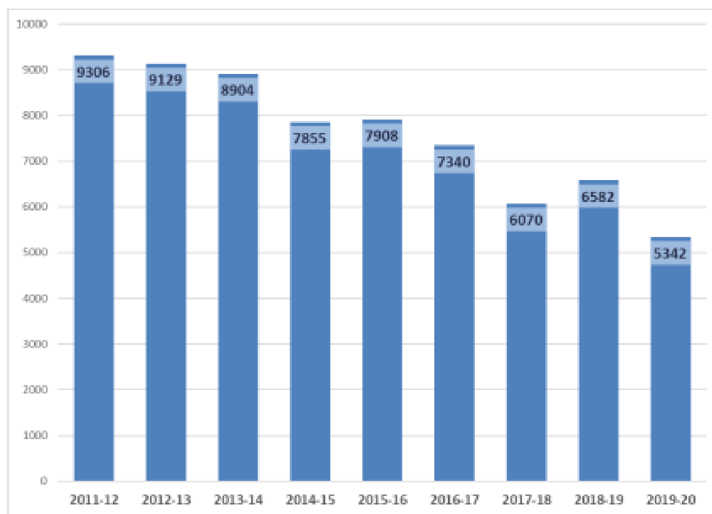
The oral health of children in Wales improved across all social groups, with the most deprived WIMD quintile seeing the largest reduction in decay prevalence (by 15%) and mean dmft score (by 0.6).

The most recent survey of 12-year-olds in Wales reported a 15% reduction in prevalence of dental decay from 45% in 2005/06 to 30% in 2016/17.

5.2.3 Impact of D2S on rates of extractions under general anaesthetic

The impact of the community dental service and D2S can also be seen on the year-by-year reduction of extractions under general anaesthetic. Changes in care pathways and local referral processes in some Health Boards have contributed to a reduction in GA Rates over the past 10 years. The latest report shows that:

Fig 5.1 Total numbers of extractions under GA from 2011/12 to 2019/20



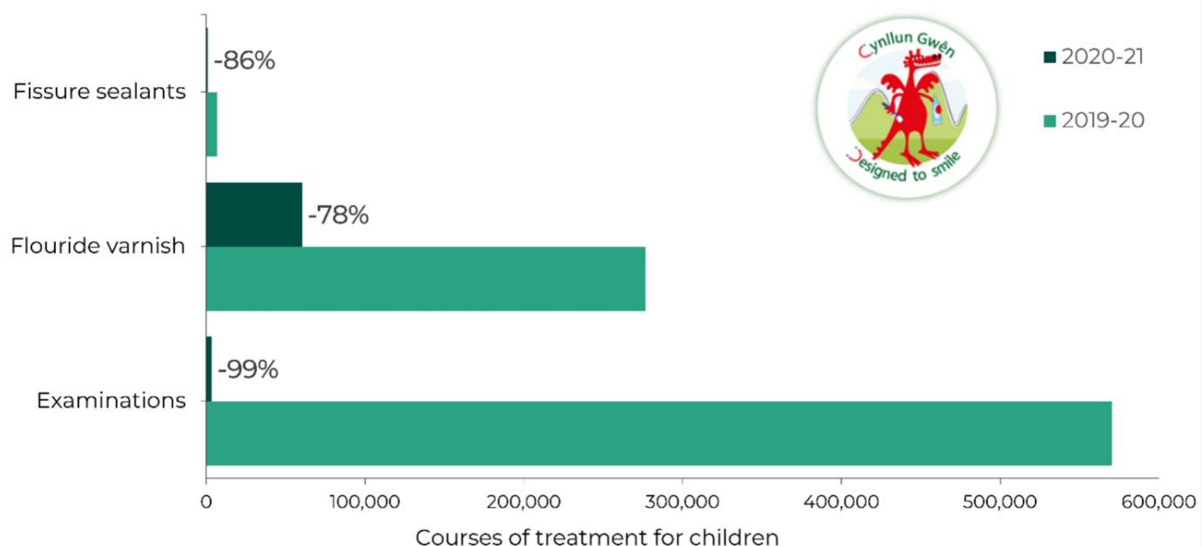
A total of 5,342 dental GAs were performed in Wales during 2019-20… This equates to 0.85% of the under 18 population receiving a dental GA in Wales during 2019-20. Or one in every 117 children across Wales receives a GA for dental treatment… The number of GAs for dental treatment in 2019-20 was 1,240 fewer patients when compared with 2018-19. There has been a 42% (3,874) reduction in GAs in children since 2011-12, allowing for some baseline adjustments. See fig 5.1 Child Dental General Anaesthetics in Wales (2021) Author: Maria Morgan

Source: Child Dental General Anaesthetics in Wales (2021)

5.2.4 Impact of the Pandemic on D2S

Fissure sealant, fluoride varnish and examinations are preventative treatments targeted by the Designed to Smile Programme aimed at improving children's oral health. The scheme had to be suspended during the pandemic for reasons of infection control and because D2S staff were redeployed in other duties to support the NHS dealing with Covid-19. The scheme has been restarted but is not up to full strength. Fig 5.2 shows all child preventative treatments in 2019-20 and 2020-21.

Fig 5.2 Change in the number of courses of preventative treatments[1] given to all children in Wales between 2019-20 and 2020-21



Graphic: Senedd Research

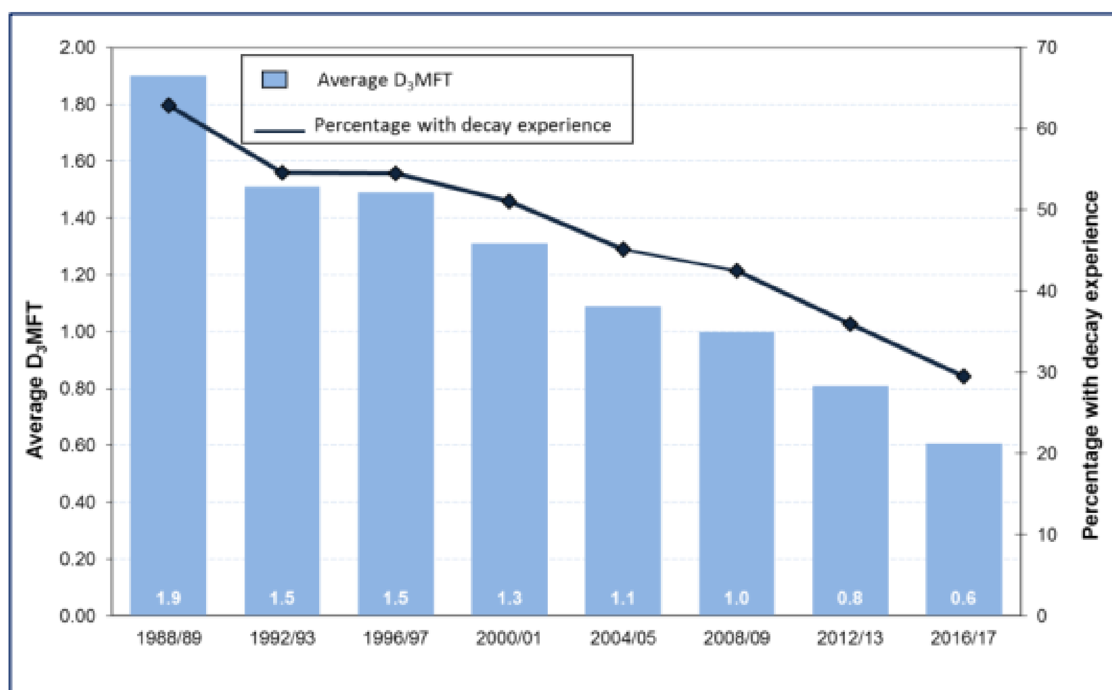
5.3 Understanding the oral health needs of people aged 12-21

Surveys of oral health status are carried out periodically for different age groups and reports are archived on the Welsh Oral Health Information Unit website.

5.3.1 Dental Epidemiological Survey of 12-Year-Olds 2016-17

This is the latest survey of this age group which continues to show a trend of improving oral health. Thus in 2017 in a class of 30 children about 9 will have some decay experience in their permanent dentition compared with 14 in 2004. This represents the average position; some will be better and some worse. See fig 5.3.

Fig 5.3 Trend in mean D3MFT and %D3MFT>0 for Wales between 1988-2017



Graphic: Survey report (2018)

5.3.2 Welsh Dental Survey of 18–25-Year-Olds

This latest survey of the dental health of 18-25-year-olds living in Wales was conducted during 2017-2019. Two thirds (62.4%) (799/1280) of participants reported that they brushed their teeth both morning and evening, every day. Less frequent brushing was associated with poor oral hygiene.

Just under a quarter (23.1%) showed moderate to severe gum inflammation. Poorer gingival health status was experienced by expectant and new parents, those attending emergency dental services and vulnerable groups.

Just under a quarter (23.9%) of all participants were free of visually obvious decay.

When asked to give a self-report of their oral health status just under half (43%) indicated that it was "fair" or worse. Emergency dental service users and expectant and new parents were more likely to report "bad" or "very bad" oral health.
Years 1 & 2 Main Report August 2020

5.4 Dental domiciliary services for older people and those living in care homes and the ‘Gwên am Byth’ programme

5.4.1 Oral Health Needs of Care Home Residents

Many care home residents require simple dental treatment, complicated by the need for extra time to deliver dental care. Although there is a large volume of need for improved oral hygiene, scaling of teeth, application of fluoride, and restorations among residents of care homes, relatively little of this need requires a specialist in special care dentistry. Much of the care only requires a professional with either some special care experience or generalist level experience. In addition, a considerable proportion of the disease present does not require aggressive interventional treatment.

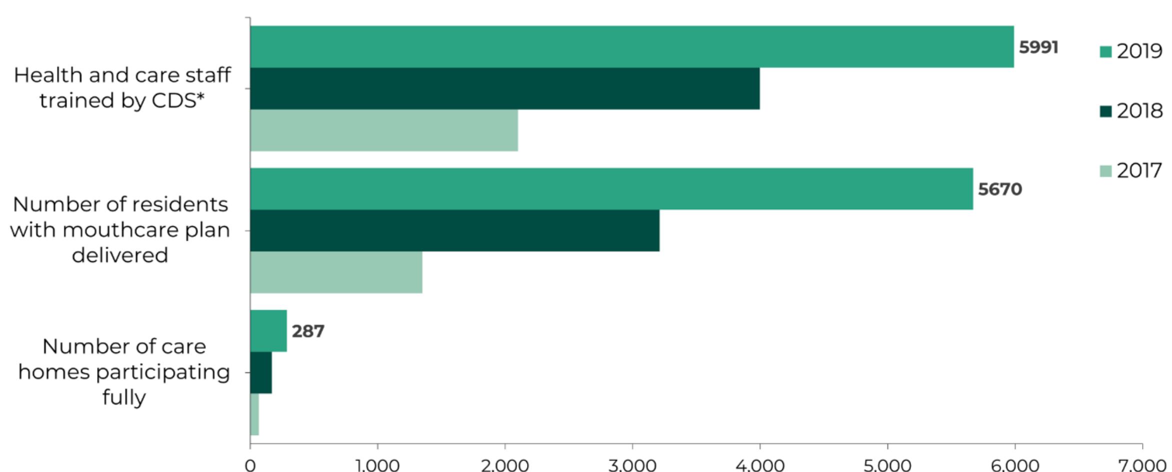
The last Welsh Health Circular about oral care of older people was published in 2015. The aim of the programme was to improve oral hygiene and mouth care for older people living in care homes through the development of a consistent all-Wales approach. There is no recent data on the oral health of care home residents or status of the Gwên am byth post-pandemic.

5.4.2 Gwên am byth

Gwên am byth is a national oral health improvement programme delivered by the Community Dental Services (CDS) to improve oral health and hygiene for older people living in care homes. Many older people are now retaining natural teeth, but often with complex needs that can make even basic care such as brushing teeth a challenge. Delivering improved oral health to the care home population requires investment with training and evaluation. The CDS provide training for care home staff and allows them to assess and provide safe mouth care for residents.

Over half of care homes are now participating in Gwên am Byth, and 5,670 residents have a mouth care plan being delivered. An increase in funding in 2019 was pledged to include all care homes 340 out of 650 care homes in Wales were targeted for this programme, and 278 were fully participating in 2019. See fig 5.4. Where capacity allows the principles of the programme would be developed to include the pre-care home cohort of older people.

Fig 5.4 Level of participation in the Gwên am byth programme pre-pandemic



Graphic: Senedd Research

Chapter 6: Recommendations

6.1 Pledge to invest

1) The Welsh Government must make the pledge that everyone should be able to access good quality NHS dental services who need them – primary and secondary care - and then provide the resources to fulfil that pledge. If the government wants to provide comprehensive care for the whole population, it needs to recognise that the current funding is wholly inadequate.

2) This pledge should include greater investment in dental services long term. The uplift to dental budgets should be evidence-based and predicated on accurate data showing patient demand and need, with prospective modelling and effective financial forecasting.

6.2 GDS Contract (some recommendations might come under new legislation)

3) GDS contracts must be uplifted in a way that accounts for dental inflation as well as wage inflation, and government must ensure annual GDS uplifts keep pace with real inflation.

4) The GDS contract must move away completely from UDAs and towards meaningful performance measures both for effective preventative dentistry and for the provision of care needed for patients with poor oral health.

5) An additional component of a general contract is required – so that urgent patients are properly counted.

6) There needs to be a separate weighting for new patients as these are often high needs and often within the urgent category. These patients cannot be lumped in with regular patients.

7) Any volumetrics must be properly weighted to allow for the time needed to conduct ACORNs - establishing an uplift to volumetric contract values in areas of deprivation and high needs, thus allowing weighting for high needs patients.

8) There must be a finer measure than a course of treatment to avoid the open-ended nature of treatment for higher needs patients. Phased treatment plans must be agreed to ensure fair remuneration for the work done.

9) Patients who do not attend their appointment should retain a nominal financial value within the practice contract reconciliation process so that practices are not penalised for taking on the business risk.

10) PCR should be collected centrally by the LHBs and restructured and simplified into a fee for a basic capitation charge that can be topped up. Currently PCR is a complicated tax charged at the point of treatment delivery that involves a lot of bureaucracy for dental practices, and which acts as a deterrent to patients on lower incomes but not eligible for benefits.

11) Ultimately, whatever the units of measurement of performance are agreed in the new GDS legislation, dentists must be fairly remunerated for the work they do. We cannot emphasise this enough – as it should be the starting point of negotiations not a bolted-on afterthought.

6.3 GDS Clawback

12) 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.

13) 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.

6.4 Community Dental Service Expansion

14) An increase in funding must be made available for the CDS to undertake the increased range of services asked of it while also ensuring all their patients receive the care they need. This includes new investment in estates.

15) Increases in numbers of CDS dentists, dental nurses and specialists' posts are required to ensure that the community service can continue to grow, as its patient base grows.

6.5 Workforce

16) The Government must take fully into account the changing demography of Wales and the future requirements of the population in planning the dental workforce of the future.

17) 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.

18) The Welsh Government must ensure dentists' pay is not eroded as it has been in the last decade, and from now on must ensure annual uplift keeps pace with real inflation.

6.6 Data Analysis and Reporting

19) Official data about dentistry and oral health must be normalisation against population numbers to allow for proper intra- and inter-Health Board comparisons on performance.

20) Improvements to dental datasets must be made to fully understand inequities in the provision and utilisation of NHS dental services in a more meaningful way

21) Many elements of data collection and reporting across the Health Boards need a major overhaul. Comprehensive data on dentistry budgets must be systematically collected and transparently and routinely reported by these procuring authorities for public accountability.

6.7 Patient Experience

22) Systematic research must be conducted showing the experience of patients and would-be patients, including access to dentistry and the impacts of this on the population. This should be done for the CDS as well as the GDS.

23) There must be a way to assess demand and the numbers of patients needing treatment; for example, by establishing central waiting lists in each Local Health Board. This must be done for the CDS as well as the GDS.

24) 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 – W*hen did you last visit a dentist?*

6.8 Oral Health Programmes

25) The Welsh Government must fund the D2S programme sufficiently that the 5- to 7-year-old children can receive the same benefits of inclusion as they did previously, including fluoride varnish.

26) The Welsh Government must 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 the prevalence of decay in that age group.

27) The Welsh Government must do much more in promoting oral health messages and restricting access to sugar and sugary drinks in schools, hospitals and other public-funded organisations, and consider a ban on sales of energy drinks to under 16-year-olds.

28) The Welsh Government must enhance the budgets for oral health support of older people including continuing to invest in Gwên am byth and increasing investment in domiciliary services.

Chapter 7: Conclusion

Many of the observations included in this report and many of the recommendations we have made are very similar to those in our 2018 report. If not déjà vu exactly, the echoes are loud and resonating. We asked for "More Than Words" as a response when we presented our evidence in 2018, but Welsh Government offered nothing more.

We recognise the efforts made by the Welsh Government to assist NHS dentistry through the worst of the pandemic. However, private practice and dental laboratories was not similarly supported, and our strenuous arguments disregarded. Despite that welcome NHS support, dentists and dental practices have been challenged in their recovery and are emerging from the pandemic and looking to the future with varying degrees of trepidation.

In the community dental service, dentists are concerned. They shouldered a heavy burden during the pandemic in providing urgent dental care centres, and with mounting concerns that their most vulnerable patients were not being seen in any reasonable time frame. These dentists are under new pressures to make up shortfalls in providing urgent day dental services and even plug the gaps for whole general dentistry provision. Somehow, they are meant to do this on existing budgets and not let down their vulnerable patients.

For dentists in the GDS, running a business is about balancing risks and for a growing number of practice owners that risk is being seen to lie within a service that is severely capped by budgetary restrictions and punitive targets during a highly inflationary period. Increasingly NHS dentists are being expected to deliver certain treatments to certain patients that result in financial deficit. Not only is this not sustainable, it also counter normal contractual conditions and potentially open to legal challenge should it become the norm. But by then the tipping point that we have been warning about will already have been reached. Our surveys this year make plain that unless contractual prospects in the GDS improve in the next sixth months there will inevitably be further movement away from it.

Whatever the financial constraints on the health budget, dentistry has not been receiving its fair share; including in the current financial year when the health budget has increased by 10.5% but the uplift to dentists' salaries, and to the GDS contract value is less than half, at 4.5%. This below inflation uplift is bound to influence the amount of service that can be delivered by those stalwarts who continue to try to make the system work – but for how much longer?

Perhaps the alternative option of private dentistry is seen by government as a cushion or buffer for the NHS, but there are limits around affordability – both for patients and for the practice owners faced with rapidly mounting costs of operation. Certainly, it would be constructive for government officials to work in partnership with the private sector and understand how it has helped in the past to sustain NHS dentistry in terms of capex expenditure for example, rather than the more usual arms-length approach. Talking about a two-tiered service is not fair inasmuch the quality of service in both sectors is comparable; and indeed, the private sector has been helping to alleviate the pressures on the NHS service. Many patients have recently turned to private dentistry who would not have imagined doing so three years ago.

The unspoken question is – "Is this the new normal?"

Appendix A: Glossary of Terms

Name/Acronym	Explanation
ACORN	Assessment of Clinical Oral Risks and Needs – ACORN is a toolkit that supports dental teams to carry out a comprehensive 'risks and needs assessment' in a systematic manner. It summarises findings from the patient history and clinical examination. It supports practices to give personalised advice and agree a preventive annual dental care plan. See also RAG*
Amalgam	Dental amalgam is a liquid mercury and metal alloy mixture used in dentistry to fill cavities caused by tooth decay.
Associates	Dentists who contract with dental practices to provide general dentistry services
CDO	Chief Dental Officer
Claw-back	Money deducted from the dental practice by the Health Board when GDS targets are not achieved. There is usually, but not always, an element of tolerance (5%) allowed which means the underachievement is carried forward to the next financial year with the aim to make up for the lost performance as well as meet the next year's targets.
Corporate Dental Practice	Corporate bodies are a relatively new phenomenon in dentistry; it is 16 years since the GDC removed restrictions on the number of 'Bodies Corporate' who could operate. Often referred to as a corporate entity. My Dentist and BUPA are two of the largest.
CPD	Continuing professional development
D2S	The 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 – produces annual report
Dental medicine	a branch of oral health
DMFT	Decayed missing or filled permanent teeth (rates of in population cohorts) standardised methodology means rates can be compared between countries.
eDen	Dashboard of performance of dental services provided by NHS Business Services Authority for use by contract holders – LHBs and practice owners.
EDS	Emergency dental service – a contract held by general dental practices to see an agreed number of urgent patients.
FOI	Freedom of information (request)
GDS	General Dental Services – often loosely referred to as high street dentistry – GDS makes up the bulk of primary care dental services. GDS, EDS and PDS contracts issued by the commissioning Health Board can be held by the same practice owner.
Gwên am Byth	The oral health programme for people living in care homes. The key aim is to improve oral hygiene and mouth care for older people living in care homes and is delivered by care staff.
HEIW	Heathcare Education Improvement Wales

HIW	Heathcare Inspectorate Wales
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.
MPWiP	Making prevention work in practice – application of fluoride varnish by DCPs as part of the prevention agenda and making skills mix work to increase access
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.
Oral surgery	Concerned with surgery to the teeth, jaws and gums
Orthodontics	Provides braces to straighten teeth and mainly provide services for children on the NHS
PCR	Patient charge revenue. Money collected from patients deemed liable to pay a contribution to their treatment. Contrary to public perception the dental practice does not keep this money. It is returned to the Health Board.
Patient Registration	With the inception of the 2006 contract, patient registration at a particular practice was no longer required. However, the term has persisted in common parlance - that patients register with a dentist as they do with a GP. In fact, each practice will keep their own list of regular patients who they will recall periodically. But patients are at liberty to ask to be seen by any practice, (whether successfully is another matter).
Paediatric dentistry	looks after children's complex dental needs
PDS	Personal dental services – usually for orthodontic contracts - which can be held by general dental practices.
Provider-performers	NHS Contract holders (usually practice owners) who also perform NHS dentistry
RAG profile	*RAG patient profiles (red, amber, green) can be built up from the ACORN data with the intention to weight practice targets to account for the % of high needs patients. This has not yet come to fulfilment.
Restorative dentistry	focused on the management of diseases of the oral cavity, teeth and supporting structures
Skillsmix	Usually taken to mean the use of DCPs as part of the dental team in providing treatments
SOSET	Skills Optimiser Self Evaluation Tool
UDA	Unit of Dental Activity
UOA	Unit of Orthodontic Activity

Appendix B: Hospital Dental Services

Table B.1 showing patients waiting to start hospital oral surgery by month, grouped weeks and treatment function, January 2021 onwards

LHB Provider (All Wales LHB (Provider)) | LHB Residence (Wales) | Treatment Function (Oral Surgery)

LHB Provider | Provider area code | LHB Residence | Residence area code | Treatment Function

Weeks waiting

Date	All			All
	Up to 26 weeks	26 to 36 weeks	Over 36 weeks	
Jan-2021	7,070	977	11,628	19,675
Feb-2021	7,403	1,428	11,159	19,990
Mar-2021	7,925	1,784	11,050	20,759
Apr-2021	8,335	2,069	11,156	21,560
May-2021	8,480	2,239	11,182	21,901
Jun-2021	8,943	2,023	11,398	22,364
Jul-2021	9,425	1,825	11,888	23,138
Aug-2021	9,464	2,062	12,168	23,694
Sep-2021	9,339	2,631	11,925	23,895
Oct-2021	9,285	2,765	11,736	23,786
Nov-2021	9,644	2,665	11,812	24,121
Dec-2021	9,540	2,787	12,190	24,517
Jan-2022	9,481	2,710	12,484	24,675
Feb-2022	9,808	2,589	12,471	24,868
Mar-2022	9,960	2,492	12,516	24,968
Apr-2022	9,947	2,517	12,689	25,153
May-2022	10,043	2,722	12,555	25,320
June-2022	9,908	2,454	11,761	24,123

Ref: SatsWales

Table B.2 showing patients waiting to start hospital dental medicine by month, grouped weeks and treatment function, January 2021 onwards

LHB Provider (All Wales LHB (Provider)) | LHB Residence (Wales) | Treatment Function (Dental Medicine)

LHB Provider | Provider area code | LHB Residence | Residence area code | Treatment Function

Date	Weeks waiting: All			All
	Up to 26 weeks	26 to 36 weeks	Over 36 weeks	
Jan-2021	316	25	310	651
Feb-2021	348	45	273	666
Mar-2021	382	73	243	698
Apr-2021	421	93	246	760
May-2021	412	110	262	784
Jun-2021	498	117	266	881
Jul-2021	457	107	313	877
Aug-2021	507	105	363	975
Sep-2021	458	131	398	987
Oct-2021	441	154	434	1,029
Nov-2021	432	148	496	1,076
Dec-2021	426	156	542	1,124
Jan-2022	396	158	540	1,094
Feb-2022	477	148	545	1,170
Mar-2022	433	138	574	1,145
Apr-2022	385	146	567	1,098
May-2022	381	123	584	1,088
June-2022	368	110	592	1,070

Ref: StatsWales

Appendix C: Wales: Annual View Dental Registrants

Table C.1 GDC registrants in Wales for the last five years

July 2022

		Total	male	female	
Wales	Orthodontic Therapist	37	0	37	0
	Dentist	1691	826	865	0
	Dental Therapist	165	4	161	0
	Dental Technician	232	161	71	0
	Dental Nurse	3005	27	2978	0
	Dental Hygienist	341	12	329	0
	Clinical Dental Technician	11	10	1	0

July 2021

		Total	male	female	
Wales	Orthodontic Therapist	34	0	34	0
	Dentist	1698	841	857	0
	Dental Therapist	160	4	156	0
	Dental Technician	241	168	73	0
	Dental Nurse	2997	21	2976	0
	Dental Hygienist	334	10	324	0
	Clinical Dental Technician	11	10	1	0

July 2020

		Total	male	female	
Wales	Orthodontic Therapist	31	0	31	0
	Dentist	1701	851	850	0
	Dental Therapist	151	4	147	0
	Dental Technician	247	174	73	0
	Dental Nurse	2951	24	2927	0
	Dental Hygienist	308	7	301	0
	Clinical Dental Technician	12	11	1	0

July 2019

		Total	male	female	
Wales	Orthodontic Therapist	30	0	30	0
	Dentist	1693	863	830	0
	Dental Therapist	147	5	142	0
	Dental Technician	260	188	72	0
	Dental Nurse	3051	28	3023	0
	Dental Hygienist	311	8	303	0
	Clinical Dental Technician	12	11	1	0

July 2018

		Total	male	female	
Wales	Orthodontic Therapist	28	0	28	0
	Dentist	1669	883	786	0
	Dental Therapist	131	6	125	0
	Dental Technician	259	191	68	0
	Dental Nurse	2882	24	2858	0
	Dental Hygienist	283	7	276	0
	Clinical Dental Technician	14	13	1	0

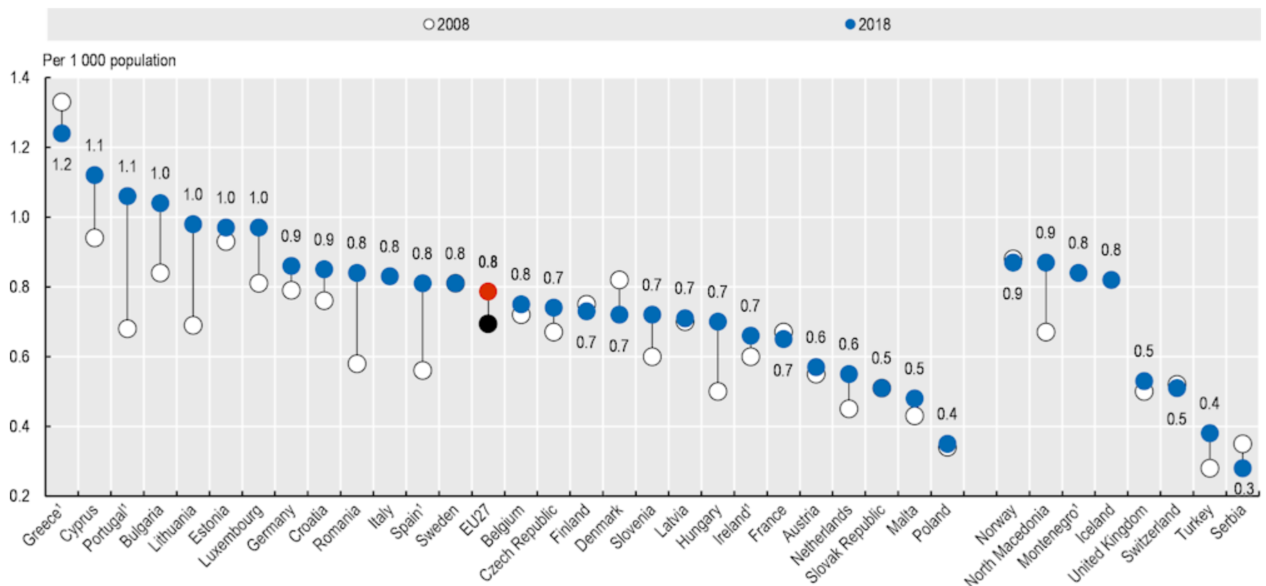
Total of each category of registrants shown – no distinction between NHS or private worker

Appendix D: Availability of Dentists and Consultations

Between 2008 and 2018, the number of dentists per capita increased or remained stable in most EU countries, except in Greece and Denmark where it decreased. The number of dentists per capita rose particularly strongly in Portugal, Spain, Romania, Lithuania and Hungary, with an increase of 40% or more since 2008. In most of these countries, this rise in the number of dentists was driven by a large increase in the number of students admitted and graduating from dentistry programmes.

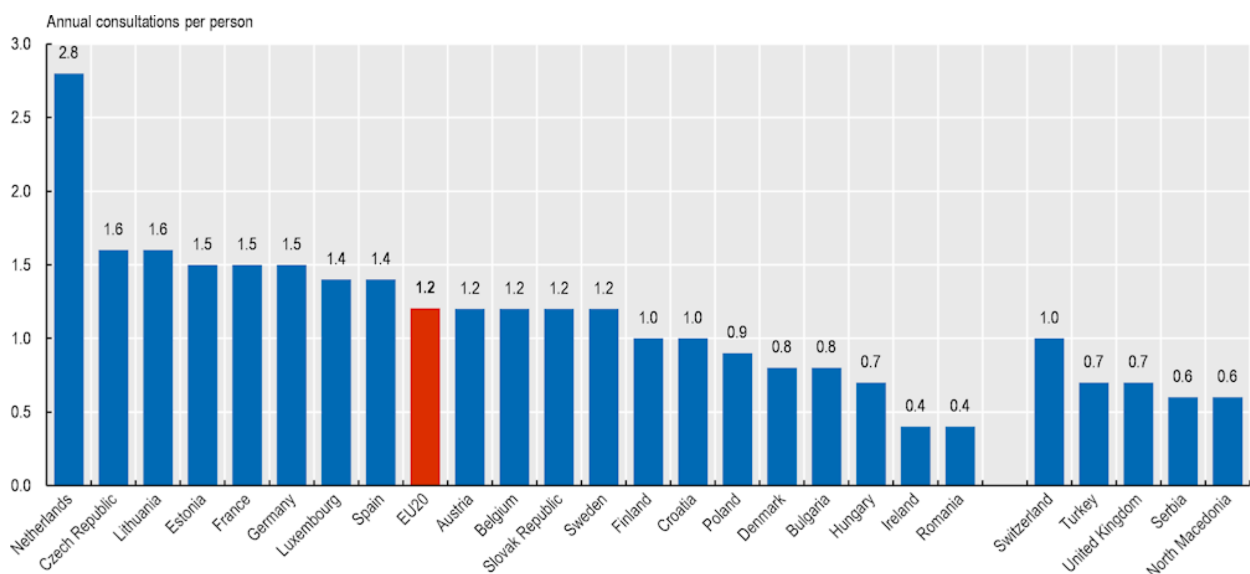
OECD: Health at a Glance: Europe 2020: State of Health in the EU Cycle [Data from OECD iLibrary]

Fig D.1 Practising dentists per 1 000 population, 2008 and 2018 (or nearest year)



Note: The EU average is unweighted. 1. Data refer to all dentists licensed to practice, resulting in an over-estimation of practising dentists. Source: OECD Health Statistics 2020; Eurostat Database.

Fig D.2 Number of dentist consultations per person, 2018 (or nearest year)



Note: The EU average is unweighted Source: OECD Health Statistics 2020; Eurostat Database

Appendix E: Dental Earnings

Table E.1 Expenses and Earnings of Dentists in Wales in 2019-20 and 2020-21 – includes NHS and private

Dental Type and Year	Total Expenses	Change	Taxable Income	Change
Providing-Performer 2019/20	223,600	-	98,900	-
Providing-Performer 2020/21	185,700	-17%	100,200	+1.3%
Associate 2019/20	48,100	-	61,900	-
Associate 2020/21	35,500	-26.1%	60,100	-2.9%
All Dentists 2019/20	80,400	-	68,700	-
All Dentists 2020/21	62,400	-22.3%	67,300	-2.1%

Wales - NHS Digital

NB: These data refer only to those primary care dentists in Wales who are self-employed and who have completed some NHS work in the financial year.

Arrangements in place April to June 2020
On 26 March 2020 the Chief Dental Officer for Wales wrote out to all practices detailing plans for business continuity and financial support for dental practices providing NHS services. Dental practices were funded at a level of 80% of their current NHS annual contract value.
https://www.badn.org.uk/common/Uploaded%20files/COVID-19%20Wales-2020-03-26%20-%20CDO%20Letter%20Covid-19%20Business%20Continuity%20and%20Financial%20Support.pdf.

Arrangements in place from July 2020
On 22 May 2020 the Chief Dental Officer for Wales wrote out to all practices describing expectations and financial support for dental practices providing NHS services. Dental practices were funded at a level of 90% of their current NHS annual contract value. *(https://www.bda.org/advice/Coronavirus/Documents/Wales%20CDO%20Letter%20Restoration%20of%20dental%20services%20220520.pdf)*.
These arrangements were in place for the remainder of 2020/21.
https://bda.org/advice/Coronavirus/Documents/wales-letter-cdo-updated-sops-171220.pdf

Sources of income

When considering the results, it is important to keep in mind some of the key differences between sources of income in the NHS and private dental systems. These include that:

NHS earnings in 2020/21 originated from a contract between the dental provider and the Local Health Board. Private earnings are determined by the amount of demand from individual patients who chose to receive private dental care, which may be in addition to the receipt of NHS care.

1/12th of the NHS contract value is paid to the Provider each month to deliver the contracted/pre-agreed NHS dental services. Private patients will either pay per visit or contribute to an insurance/capitation scheme which will pay/contribute on their behalf, which means that the level of private income may not be consistent from one month to another.

At the end of the financial year the amount of activity performed by an NHS provider is compared to their contract. If the contractor did not deliver the agreed number of units of activity some earnings can be clawed back by the Local Health Board from the Provider, who may then claw back from their dental performers.

Ref: NHS Digital

References

Listed here are the main references used – there are other materials referred to in this document and links are embedded in the text, but the full reference information not reproduced here.

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