PC 13
Ymchwiliad i ofal sylfaenol
Inquiry into primary care
Ymateb gan: Cymdeithas Ddeintyddol Cymru
Response from: British Dental Association

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Consultation on Primary Care

1. BDA Cymru Wales is pleased to provide a response to the National Assembly consultation on Primary Care by the Health, Social Care and Sport Committee running until Friday the third of February 2017. The British Dental Association (BDA) is the voice of dentists and dental students in the UK. We bring dentists together, support our members through advice, support and education, and represent their interests. As the trade union and professional body, we represent all fields of dentistry including general practice, community dental services, the armed forces, hospitals, academia, public health and research.

2. *How GP cluster networks in Wales can assist in reducing demand on GPs and the extent to which clusters can provide a more accessible route to care (including mental health support in primary care).* While we acknowledge that there is a demand on GPs and a demand to reduce the burden placed upon GPs, it is important to note that population increases in areas of Wales have negatively affected the primary care of said population, namely in dentistry. These population expansions are planned and accommodated within the funding arrangements for primary medical care, but not for dental, optometric and pharmacy services.
   This results in higher demand on dental, optometric and pharmacy services, making them less able to reduce the burdens on GPs. Clusters need to acknowledge that they also the key to maintaining access to dental, optometric and pharmacy services in these challenging times. So far there has been little to no dental engagement in Clusters. There are currently zero official health documents on dental health produced by Clusters. Dentistry, optometry and pharmacy services could help reduce the demand on GPs, but they are not being supported by Clusters, they are largely being ignored.

3. *The emerging multi-disciplinary team (how health and care professionals fit into the new cluster model and how their contribution can be measured).* Reducing ineffective elements of care, and engaging a multi-disciplinary team through delegating appropriate work may help free up some of the capacity to maintain access while reducing overall demand on primary health care workers. While real health and well-being outcomes may be difficult to measure short term, as the outcomes are likely to be long-term, measuring contributions is not impossible. Maintaining a focus on access to care and satisfaction with the care provided could aid in measuring contribution. Monitoring changes to the care itself (i.e. what care is increasing, what care is decreasing and what care is being administered differently) is a further way contributions to care could be measured.

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4. *The current and future workforce challenges.* Recruitment of dentists is an issue in Wales, and certain areas feel it more acutely. There are currently only 4.7 NHS contracted dentists per 10,000 population[1], which means access to an NHS dentist can be very difficult. Only a proportion of these 4.7 NHS contracted dentists are full time, so this figure is realistically lower. Low morale could also prove a problem in the future, with 32% of associates stating they had low or very low morale[2]. This low morale could make recruitment more difficult. Furthermore, only 7% of Welsh associates were completely satisfied in their job[2]. This could be worsened by Brexit. While the impact of Brexit is uncertain at this stage, 75.5 EU dentists currently work for the Welsh NHS. That is 5% of the NHS dentists working in wales. A further 9% are non-EU dentists[3]. As there are currently so few NHS dentists working in Wales, Brexit could place significantly further strain on an already pressured NHS dentistry in Wales.

5. *The funding allocated directly to clusters to enable GP practices to try out new ways of working; how monies are being used to reduce the pressure on GP practices, improve services and access available to patients.* The funding that is allocated by Clusters to GPs may not necessarily be being spent to reduce the pressure of GPs. The experience conveyed to us of our members is that GPs are keen to allocate the funding within GP practices. While this may be helpful to improving the work currently done by GPs, it does little to reduce the pressure that GPs are under. Access to dentistry is an issue for many Welsh people as there are not enough dentists to cover the population[1]. This may mean that GPs are having to deal with patients entering GP facilities with issues that should be handled by a dentist. About 600,000 people a year in the UK who develop dental problems now visit a GP rather than going to a dentist[4], creating further pressure on GPs. Optometry, pharmacy and dental services have been widely ignored by Clusters, meaning that Clusters and GPs miss out on an opportunity to reduce GP pressure by improving the access to other services. More funding should be placed in other aspects of primary care as well primary medical care. Furthermore, it takes time to create a project and to develop new ways of working. Unlike GPs, dentists are not funded the time to create projects. There are, as previously discussed, already limited opportunities for input, and dentists are not afforded the time to dedicate to new ways of working. Currently, dentists that have some involvement in clusters feel that the projects that clusters undertake reflect what GPs want to do rather than what is needed in that area.

6. *Workload challenges and the shift to primary prevention in general practice to improve population health outcomes and target health inequalities.* At the BDA we believe that prevention first is the

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key to good oral health. Population health can be vastly improved by focusing on prevention, as we have seen with the 6% reduction in tooth decay among five year olds due to the preventative focused Designed to Smile[5]. More work needs to be done in terms of targeting health inequalities in dentistry as inverse care law seems to be particularly true when it comes to oral health. The Adult Dental Health Survey 2009 estimated 388,000 people in Wales have delayed or avoided dental treatment because of cost[6]. Studies have also found children who are eligible for free school meals are more than twice as likely to have tooth ache than those without eligibility[7]. Dental care is being seen as a luxury that people cannot afford rather than a key aspect to overall health.

7. *The maturity of clusters and the progress of cluster working in different Local Health Boards, identifying examples of best practice.* Currently, Clusters are solely focused on primary medical care, rather than primary care. This results in Clusters being primarily concerned with GPs. Clusters should be the place where problems across primary care can be addressed – not just primary medical care. Clusters have a chance of working well if they stay connected to the primary care workforce. Clusters are not new yet there is no maturity in dentistry. We suggest that a pilot be set up of non-medical primary care clusters, as current clusters are too GP-centric. These clusters could allow non-medical primary care to develop new ways of working, which would ultimately reduce GP stress. A pilot cluster could demonstrate how non-medical primary care can be used to proactively 600,000 people a year in the UK who develop dental problems now visit a GP rather than going to a dentist[4], and the people who visit a GP when they should really visit a pharmacy. The development of non-medical primary care clusters will help address the pressure GPs are facing, and improve the health of the Welsh population.

8. *Local and national leadership supporting the development of the cluster infrastructure; how the actions being taken complement those in the Welsh Government's primary care plan and 2010 vision, Setting the Direction.* Clusters are an experiment, one that deserves the opportunity to succeed and one that we do not wish to see fail. That being said, failure is more likely if they are seen to be failing in some areas, be those professional or geographical areas. If they are seen to be failing, Wales needs to allow alternatives to emerge, or indeed put alternatives in place. Access to dentistry is an issue that Clusters have thus far failed to address. If this continues to be the case, alternative planning arrangements for such access will need to be maintained either until Clusters reach a higher level of maturity, or indefinitely.

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9. *Greater detail on the aspects being evaluated, the support being supplied centrally and the criteria in place to determine the success or otherwise of clusters, including how input from local communities is being incorporated into the development and testing being undertaken.* In terms of support, it is difficult for those who do not have much engagement with Clusters (namely primary nonmedical care) to comment. Dentistry, optometry and by and large pharmacy services have been neglected by Clusters. This begs the question of Clusters intention moving forward. Are they intended to focus solely on primary medical care, and if so, what could be put in place for primary nonmedical care. The criteria of the success or otherwise of Clusters depends on their standpoint of nonmedical services; currently, clusters are failing them. They offer no engagement, put out little to no official documents on them and seem to be disinterested in supporting them. With the focus being so heavily on GPs, Clusters need to decide whether it will be there official sole focus so that another initiative could be created to support primary nonmedical care or whether they will expand their scope to all aspects of primary care.

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