Agenda - Health and Social Care Committee

Meeting Venue:	For further information contact:
Hybrid - Committee room 5 Tŷ Hywel and video conference via Zoom	**Helen Finlayson**
Meeting date: 13 October 2022	Committee Clerk
Meeting time: 09.00	0300 200 6565
	SeneddHealth@senedd.wales

Private pre-meeting (09.00-09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Dentistry - evidence session with British Dental Association Wales and British Orthodontic Society

(09.30-10.30) (Pages 1 - 103)

Russell Gidney, Chair, Welsh General Dental Practice Committee, British Dental Association Wales

Dan Cook, Vice Chair, Welsh General Dental Practice Committee, British Dental Association Wales

Dr Ben Lewis, British Orthodontic Society

Dr Yvonne Jones, British Orthodontic Society

Research brief

Engagement Summary: Case Study Report

Paper 1 - British Dental Association Wales

Paper 2 - British Orthodontic Society

Break (10.30-10.45)

Senedd Cymru
Welsh Parliament

3 Dentistry – evidence session with Royal College of Paediatrics and Child Health, Age Cymru and Older People's Commissioner for Wales

(10.45-11.45) (Pages 104 - 128)

Dr David Tuthill, Officer for Wales, Royal College of Paediatrics and Child Health

Helen Twidle, Health and Social Care Policy and Campaigns Officer, Age Cymru

Heléna Herklots, Older People's Commissioner for Wales

Paper 3 – Royal College of Paediatrics and Child Health

Paper 4 – Age Cymru

Paper 5 – Older People's Commissioner for Wales

4 Paper(s) to note

(11.45)

4.1 Letter to the Deputy Minister for Mental Health and Wellbeing regarding Fifth Senedd Committee recommendations relating to mental health and wellbeing

(Pages 129 - 132)

4.2 Letter from the Deputy Minister for Mental Health and Wellbeing regarding perinatal mental health

(Pages 133 - 141)

5 Motion under Standing Order 17.42(ix) to resolve to exclude the public for the remainder of the meeting

(11.45)

6 Dentistry: Consideration of evidence

(11.45-12.00)

Agenda Item 2

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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

❖ We are especially grateful to all the dentists and staff for taking part in the March 2022 survey and the August 2022 survey - thank you.

❖ 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.

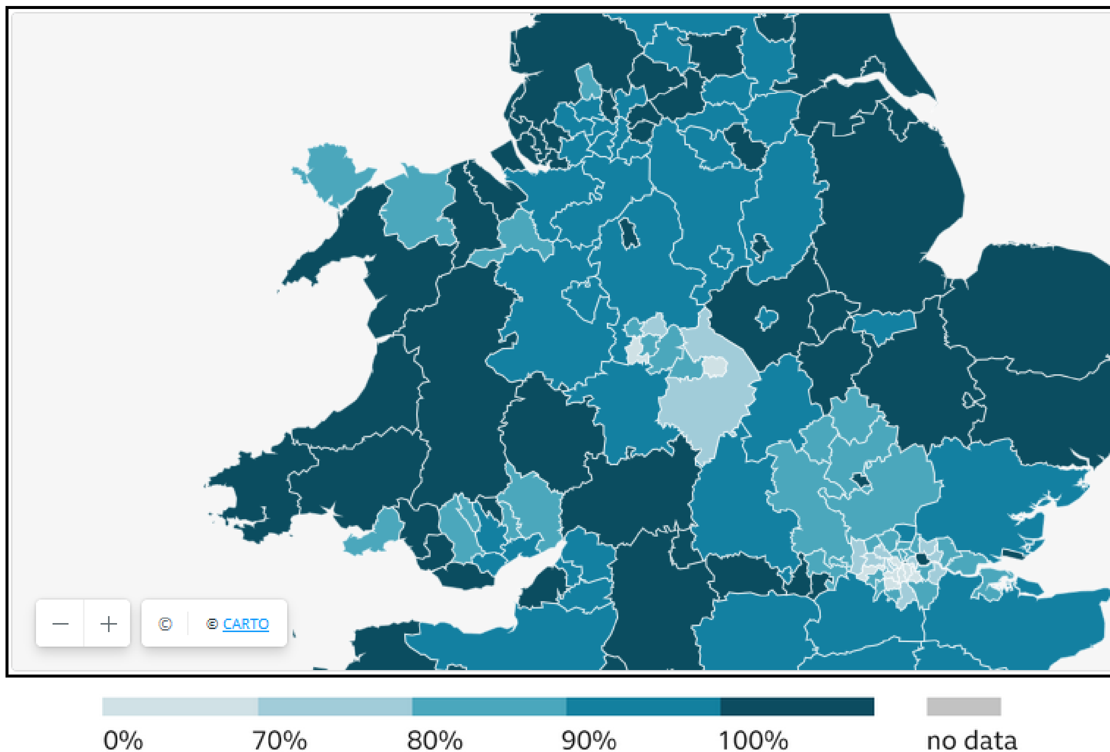
The table below shows the BBC's research results on access for new patients across the UK. Access for new patients in Wales is overall the worst in the UK:

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

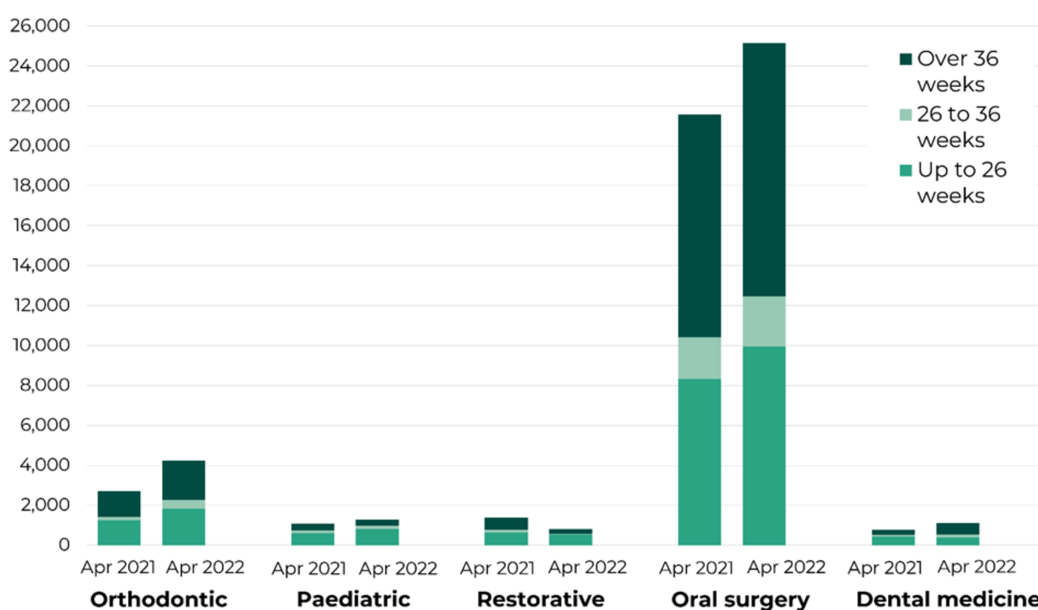
1.5.1 Waiting times

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.

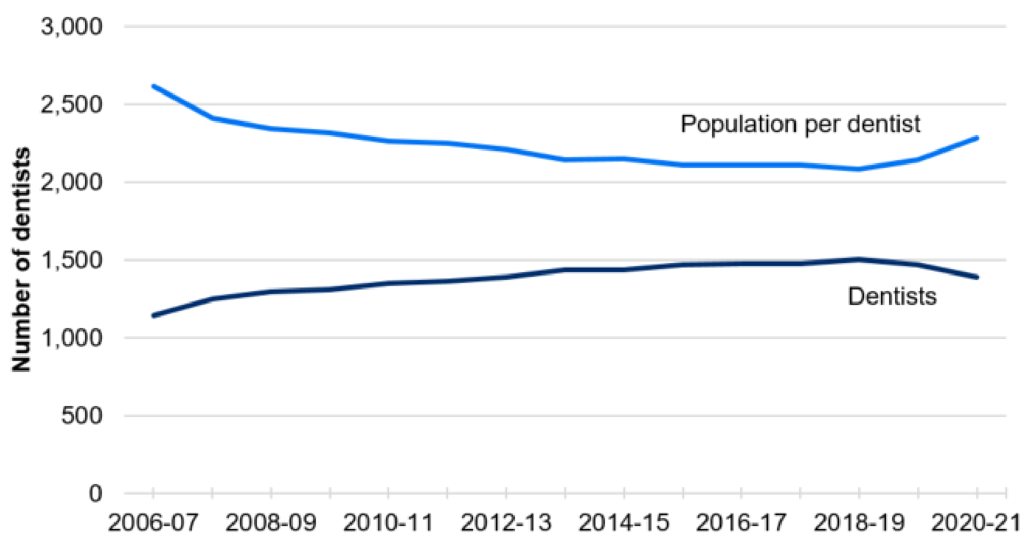
3.2 General Dental Service

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

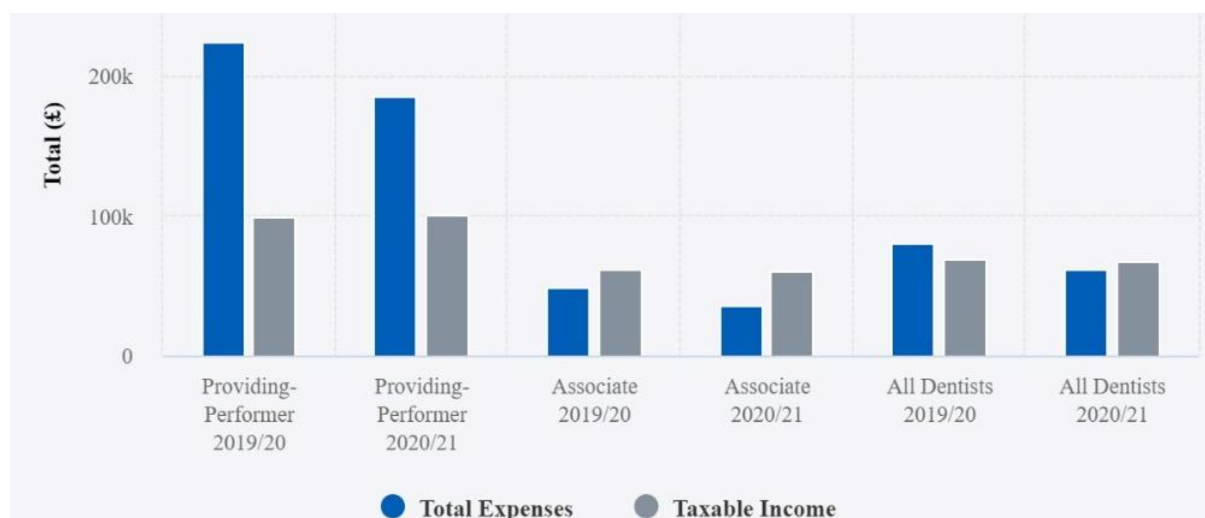
Associates are in almost all cases self-employed contractors. In England and Wales, where practice owners hold the NHS contract, associates have contractual rights to a limited set of NHS-funded parental leave and sickness payments, but there is no provision within the NHS contract that entitles associate 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

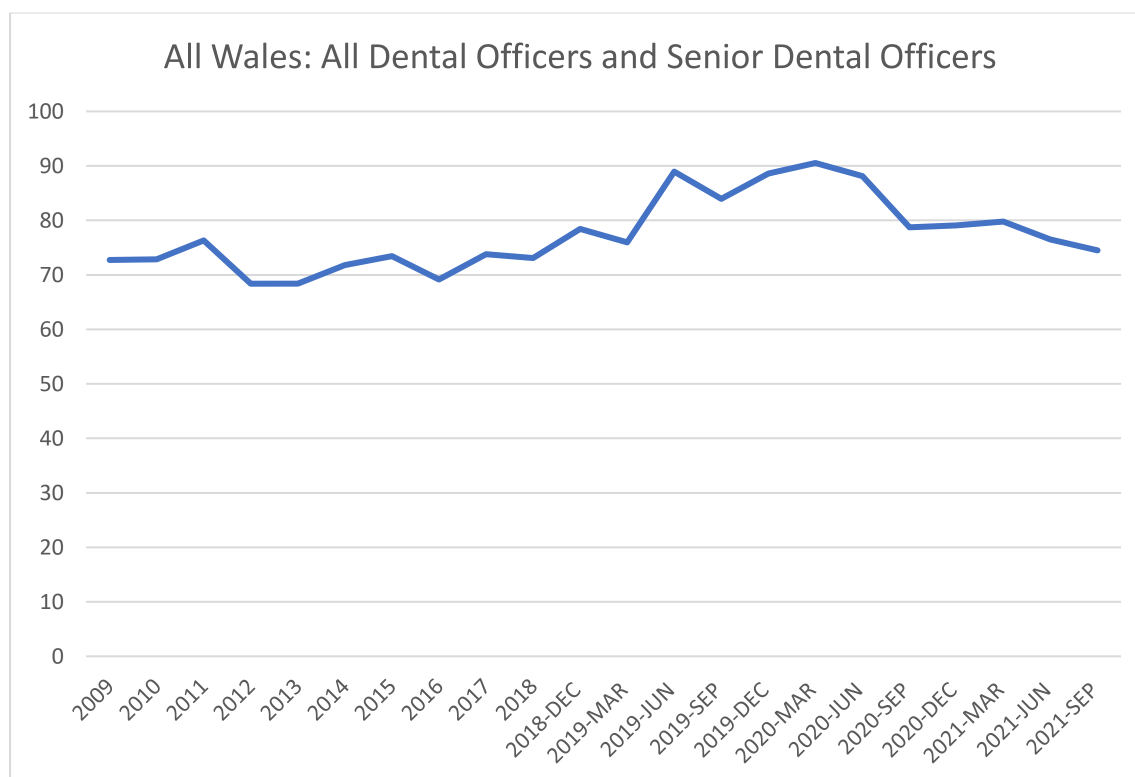
Overall, the WTE of Senior Dental Officers in Wales has increased since 2009, from 17.5 to 24.1. However, the WTE of Dental Officers has decreased, from 55.2 to 47.6 since 2009. This has led to an overall increase in all Dental Officers and Senior Dental Officers of just 1.7.

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.

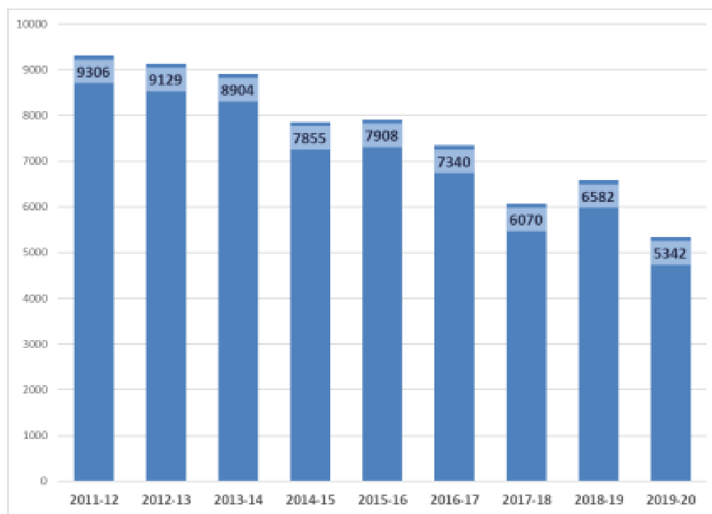
The oral health of children in Wales improved across all social groups, with the most deprived WIMD quintile seeing the largest reduction in decay prevalence (by 15%) and mean dmft score (by 0.6).

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



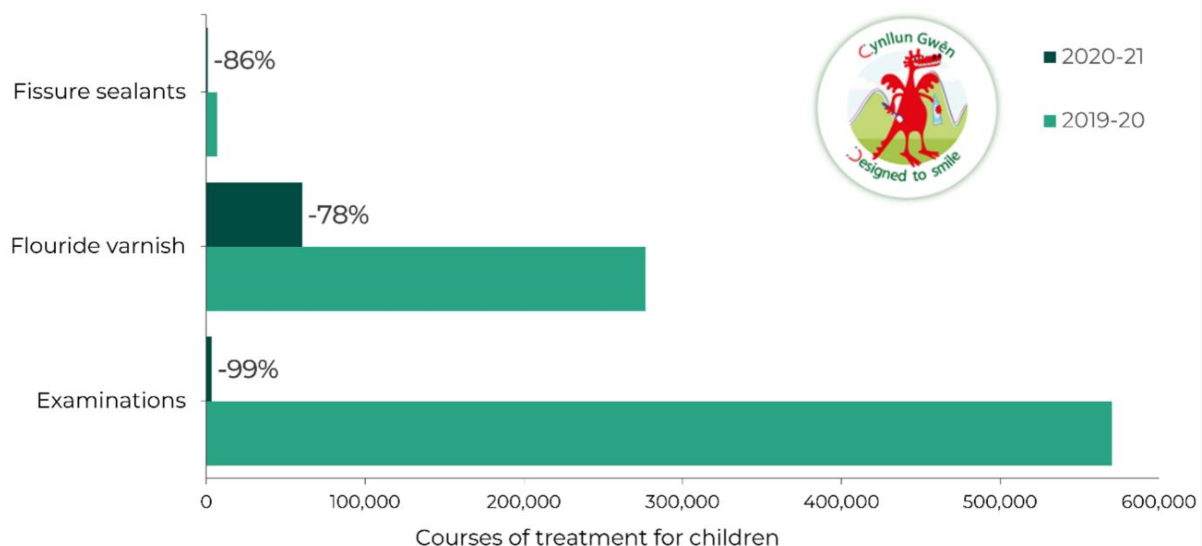
A total of 5,342 dental GAs were performed in Wales during 2019-20… This equates to 0.85% of the under 18 population receiving a dental GA in Wales during 2019-20. Or one in every 117 children across Wales receives a GA for dental treatment… The number of GAs for dental treatment in 2019-20 was 1,240 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

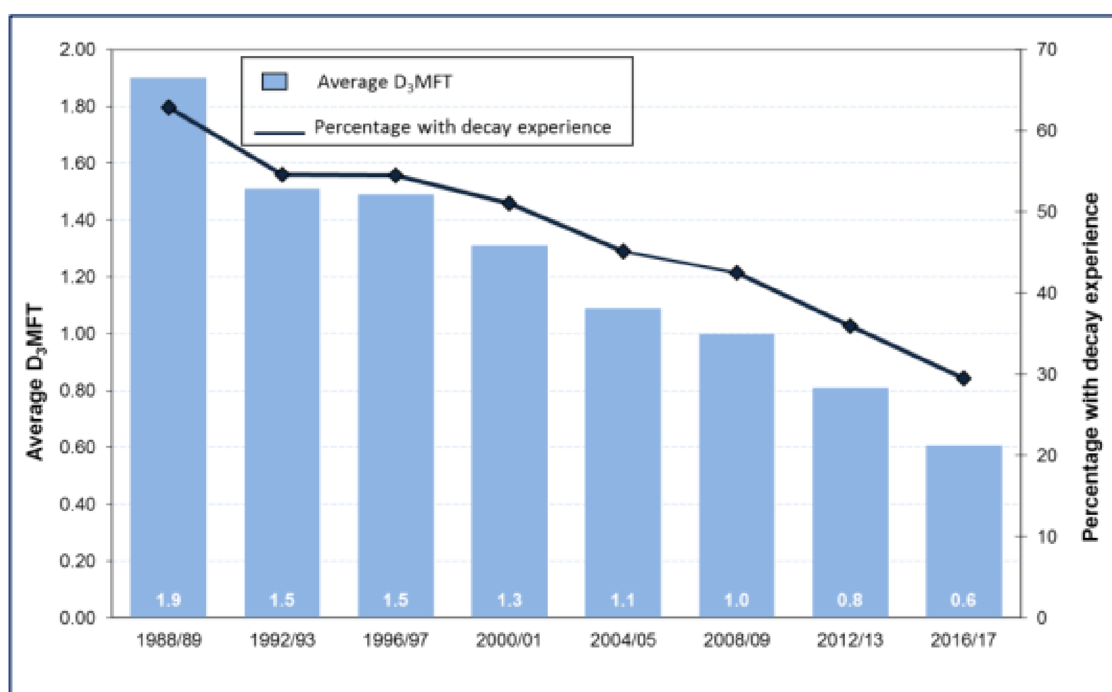
5.3 Understanding the oral health needs of people aged 12-21

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.

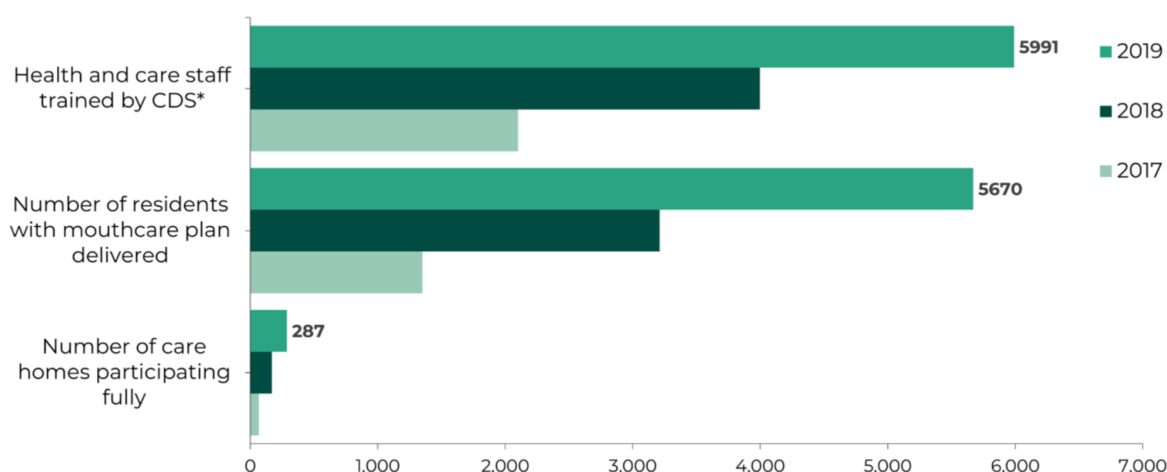
The last Welsh Health Circular about oral care of older people was published in 2015. The aim of the programme was to improve oral hygiene and mouth care for older people living in care homes through the development of a consistent all-Wales approach. There is no recent data on the oral health of care 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 – Up to 26 weeks	26 to 36 weeks	Over 36 weeks	All
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

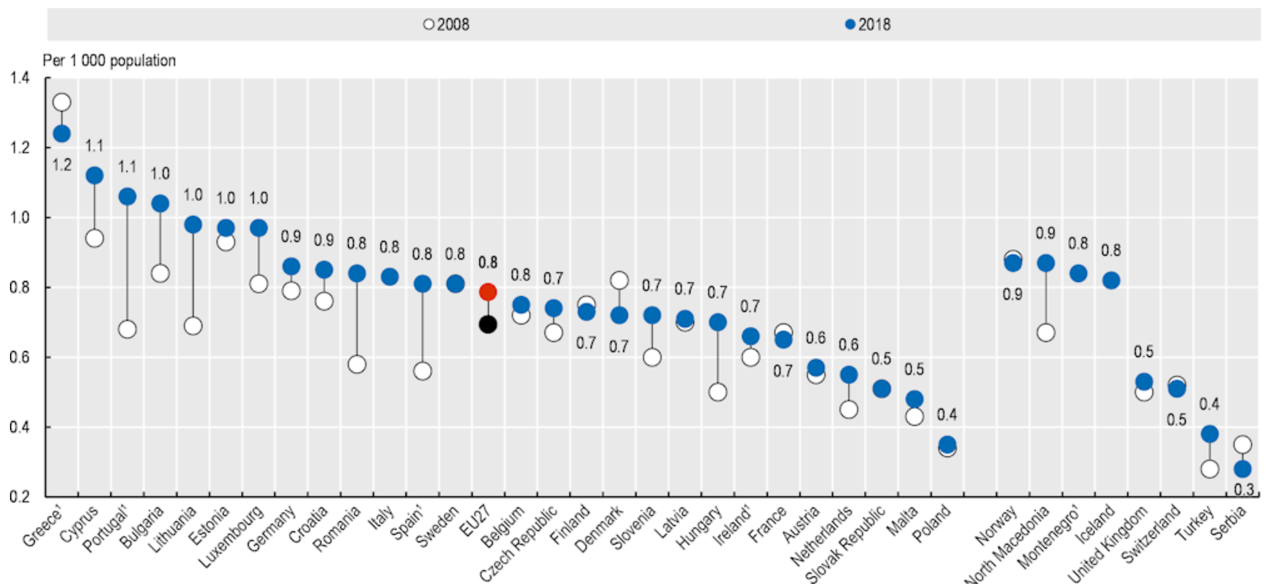
Total of each category of registrants shown – no distinction between NHS or private worker

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.

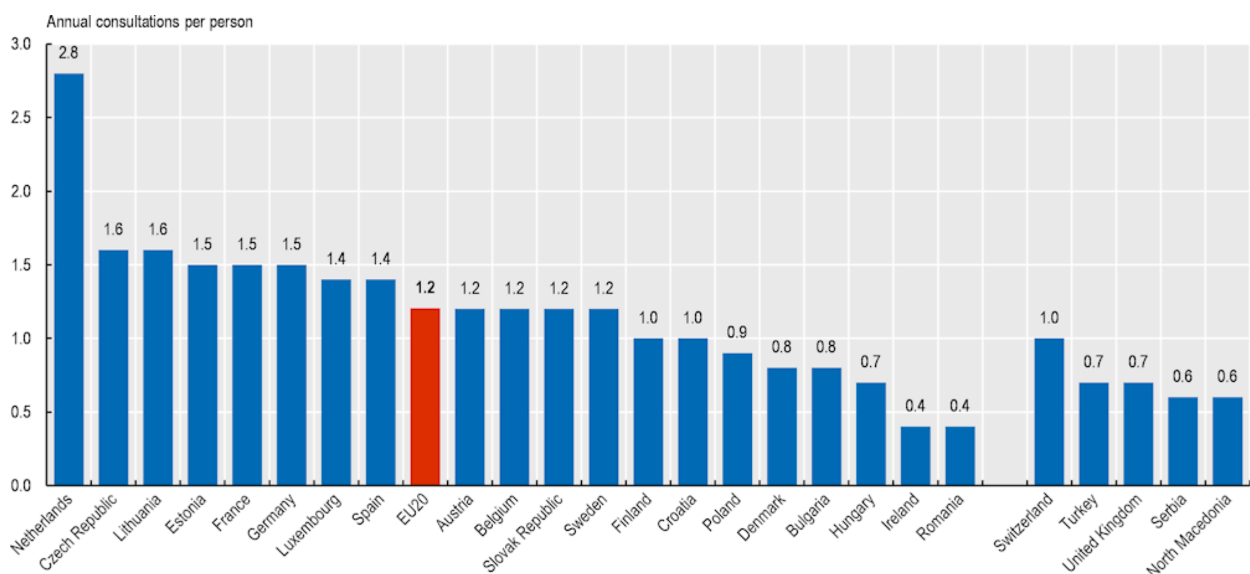
OECD: Health at a Glance: Europe 2020: State of Health in the EU Cycle [Data from OECD iLibrary]

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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Contract reform - the BDA's view
Tom King & Shawn Charlwood
British Dental Journal volume 233, pages382–385 (2022)

Workforce: Mental Health

The impact of the COVID-19 pandemic on the mental health of dentists in Wales
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Christie Owen BDJ In Practice volume 35, pages24–25 (2022)

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Julian Tudor Hart, Glyncorrwg Health Centre, Port Talbot, Glamorgan, Wales
The Lancet: Saturday 27 February 1971

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

Welsh Government. WHC: *Re-focussing of the Designed to Smile child oral health improvement programme.* Welsh Government, 2017.

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Gwên am Byth: a programme introduced to improve the oral health of older people living in care homes in Wales - from anecdote, through policy into action
E P Howells, R Davies, V Jones, M Morgan
Br Dent J 2020 Dec; 229(12):793-799 2020

British Orthodontic Society (BOS) Submission to the Sixth Senedd Health and Social Care Committee Inquiry into Dentistry in Wales

Author: Mr. Benjamin R.K. Lewis, Consultant Orthodontist.

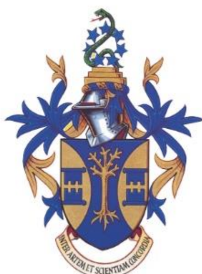
Background

1 The British Orthodontic Society (BOS) is a charity that aims to promote the study and practice of orthodontics, maintain and improve professional standards in orthodontics, and encourage research and education in orthodontics.

2 The BOS is also a representative body of all branches of general dentists and specialist orthodontists in the UK who provide orthodontic care. The Groups within the Society are the Orthodontic Specialists Group, Practitioner Group, Community Group, Consultant Orthodontist Group, University Teachers Group and the Training Grades Group.

3 Orthodontics is the dental specialty concerned with facial growth; the development of the dentition and occlusion; and the assessment, diagnosis and treatment of malocclusions and facial anomalies.

4 Orthodontic treatment provided by the National Health Service (NHS) is undertaken according to clinical need as determined by the Index of Orthodontic Treatment Need (IOTN). Patients are objectively assessed via a dental health component and allocated into one of five categories with NHS treatment being potentially available to grades 4 (great need) and 5 (very great need). Those patients deemed have a borderline severity of malocclusion to justify having treatment on the NHS on dental health grounds (Grade 3) are also assessed via an aesthetic component with only those with the most unaesthetic dental appearance, in addition to their borderline dental health need, would then be eligible for subsequent NHS orthodontic treatment.



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5 Orthodontic treatment is recognised to have a range of dental health benefits including reducing the risk of dental trauma from prominent teeth; reducing the risk of root resorption of adjacent teeth from impacted teeth; recreation of space for the replacement of missing teeth or eliminating the space completely to reduce the restorative burden in the future; improving the ability to clean the teeth and reducing the risk of dental caries; improving dental function; and correcting dento-facial deformity.

6 One must consider the definition of health in its entirety as promoted by the World Health Organisation: "Health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity."

7 With this in mind, in addition to the dental health benefits highlighted above, there is also an improvement in the appearance, self-esteem and psychological well-being, which can be especially important during the formative years of adolescence.

8 Orthodontic provision in Wales is undertaken by a range of professionals including orthodontic therapists (under supervision), dentists with enhanced skills (DES)/dentists with special interest (DwSI) in orthodontics; and specialists. These orthodontic professionals work in a range of clinical environments including General Dental Practice; Specialist Orthodontic Practice; Community Dental Clinics; District General Hospitals; and Cardiff University Dental Hospital. Who undertakes an individual's orthodontic treatment is determined by the complexity of the malocclusion and the treatment required; any additional dental, medical and social needs of the individual; and the availability of the required expertise within the geographical area.

9 To date there have been five major documents produced with regards to orthodontic provision by the National Assembly for Wales:

- National Assembly for Wales Health, Wellbeing and Local Government Committee – Orthodontic Services in Wales, February 2011
- National Assembly for Wales Health and Social Care Committee – Orthodontic Services in Wales, July 2014
- "Review of the Orthodontic Services in Wales 2008-09 to 2015-16." (Professor Richmond 14/12/16). This document supersedes the Professor Richmond's previous "Review of the Orthodontic Services in Wales 2013-14. Technical Report" (Professor Richmond 06/02/15)
- "Review of the Orthodontic Waiting Lists in Wales, 2017. Technical Report" (Professor Richmond, Oct 2017)
- National Assembly for Wales Health, Social Care and Sport Committee's Inquiry into Dentistry in Wales, September 2018, published as "A fresh start: Inquiry into dentistry in Wales" May 2019.

10 The Welsh Government's Sixth Senedd Health and Social Care Committee is considering whether the Welsh Government is doing enough to bridge the gap in oral health inequalities and rebuild dentistry in Wales following the COVID-19 pandemic and in the context of rising costs of living.

11 The Welsh Government's Sixth Senedd Health and Social Care Committee has asked the BOS to submit both written and verbal evidence to their inquiry. This document is the BOS's written evidence.

Comments on the recommendations from the last inquiry:

12 The most recent inquiry into dentistry in Wales "A fresh start: Inquiry into dentistry in Wales" May 2019, made a number of recommendations:

13 Recommendation 1. We recommend that the Welsh Government replaces the current Unit of Dental Activity targets with a new, more appropriate and more flexible system for monitoring outcomes to include a focus on prevention and quality of treatment, and to provide an update on the progress of these considerations to this Committee in six months.

14 The General Dental Services Contract reform was introduced in Wales for the new financial year in 2022. This was preceded by a series of pilots across Wales. Unfortunately, the nation wide introduction seemed to have occurred with a limited amount of notice and consultation with the dental profession and has reportedly led to a large degree of consternation within the profession due to the significant contractual non-tapered penalties included within the latest contract if the practice as a whole does not meet its performance obligations.

15 Recommendation 2. We recommend that the Welsh Government ensures and monitors the consistent reinvestment of clawback money recovered by health boards back into dentistry services until a new system for monitoring outcomes is in place (as referred to in recommendation 1).

16 The BOS is unaware to the extent to which this has happened.

17 Recommendation 3. We recommend that the Welsh Government undertakes an evaluation to determine if the UK wide recruitment system effectively supports a strategy to increase the recruitment of those who are Welsh domiciled and the levels of retention of students generally following training.

18 The BOS is not aware that this has been undertaken.

19 Recommendation 4. We recommend that the Welsh Government works with health boards to develop a clear strategy to ensure that the e-referral system for orthodontic services in Wales has a positive impact on ensuring appropriate referrals, prioritising patients and reducing waiting times.

20 In the immediate recovery phase of the Covid-19 pandemic, the Office of the Chief Dental Officer of Wales issued a guidance to the profession with the expectation that orthodontic provision is targeted to those with the greatest clinical priority rather than the length of time served on a waiting list. This is a clinically sensible allocation of limited resources, however, this has inadvertently resulted in individuals who do not fall into one of the clinical priority groups, but who would still qualify for NHS orthodontic treatment, waiting an indeterminate amount of time to access orthodontic care. This has anecdotally resulted in an increased demand for non-NHS treatment options which potentially results in inequities in accessing timely orthodontic provision.

21 Recommendation 5. We recommend that the Welsh Government funds the Designed to Smile programme sufficiently to enable children over 5 years old to receive the same benefits of inclusion as they did prior to the refocus of the programme.

22 The BOS is unaware to the extent to which this has happened.

23 Recommendation 6. We recommend that the Welsh Government builds upon existing oral health improvement programmes to address and improve the oral health of older children and young teenagers in Wales.

24 The BOS is unaware to the extent to which this has happened.

BOS comments on the areas of interest highlighted (in bold) by the Committee for the current inquiry:

25 • 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.

26 The pandemic has exacerbated the already significant waiting times to access orthodontic care within Wales. The orthodontic recovery has been hampered by capacity issues within interconnected disciplines including general dental services – such as accessing timely restorative and periodontal treatment, as well as arranging extractions; to specialist dental services included minor oral surgery for the management of impacted teeth which can be 1-2 years; and to maxillofacial surgery for the treatment of jaw deformities which can be 12-18 months.

27 During the pandemic and in the immediate recovery period, the reduced clinical capacity was focused on those individuals who were in active treatment. As the available capacity has increased then the number of patients who can be treated has also increased. However, there are a number of providers who are still reporting significant pandemic legacy issues which are restricting their ability to efficiently manage both their case load and new patient referrals. For those in treatment, this has resulted in appointment intervals increasing from 6-8 weeks to 4-5 months which as a result can double the overall treatment time which carries with it the risk of adverse outcomes.

28 The BOS supports the latest guidance to prioritise orthodontic care to those with the greatest clinical need, however, it highlights the consequences for those who do not fall into one of the priority groups which include an uncertain waiting time to access care and the unquantifiable dental and psychological effects on the individuals which was highlighted in the Board of Community Health Councils in Wales report published in December 2020 entitled “Orthodontic services in Wales – Hearing about the experiences of young people”.

29 Orthodontic services within Wales are based on a team approach with orthodontic specialists providing treatment plans and supervision for NHS orthodontic activity undertaken by non-specialists including DwSIs and orthodontic therapists. The shift in providing expedited access to assessment and treatment for those with greatest clinical need has resulted in a reduced capacity to provide treatment plans for DwSIs to undertake some orthodontic cases, as these are often less complicated cases and the treatment plans are provided by hospital based consultants where the DwSI originally gained their clinical training. This risks the DwSI being unable to fulfil their orthodontic contractual requirements as well as lost clinical activity in often more geographically remote areas. There would be merits in the Health Boards looking at providing a range of treatment planning provision options to increase the resilience of the current system.

30 Addressing the waiting list backlogs will require significant investment. Due to the nature of orthodontic treatment, which is usually undertaken over the course of 24 months, the use of “waiting list initiatives” is too simplistic and a more holistic approach will be required. A number of options are available and there will need to be flexibility to allow the Health Boards to be able to address their own individual needs and that of their population. However, it would be sensible for there to be a national steer along with guidance regarding the targeting of funds to individual patient groups. This could include a nationally agreed assessment tool for those patients who report a significant psychological impact from their orthodontic related problem. Wales has been proactive in the formation of Strategic Advisory Forums in a number of dental specialties with the Strategic Advisory Forum in Orthodontics being one of the first established. Unfortunately, this group has not met since prior to the pandemic and as such the strategic direction of the orthodontic services within Wales has been more limited in its focus.

31 One of the biggest limiting factors to reducing the orthodontic backlog is the ability to successfully expand the NHS orthodontic workforce. The current workforce is under a

significant amount of strain and this is influencing individuals' decisions on their working patterns going forward with an increasing number of individuals considering reducing their clinical time as a way to best ensure their resilience and longer working life. Unless the workforce can be increased it is very unlikely that the treatment capacity can be increased in a sustainable way.

32 **• Improved oral health intelligence, including the uptake of NHS primary dental care across Wales following the resumption of services, and the need for a government funded campaign to reassure the public that dental practices are safe environments.**

33 The BOS supports any interventions to reduce oral health inequalities and improve the oral health of both children and adults. Dental caries is preventable, unlike orthodontic problems which are usually developmental in nature, although orthodontic problems can be exacerbated by early loss of deciduous teeth as a consequence of dental caries. Initiatives to improve dental health education have the potential to reduce the long-term dental health needs of the public and the associated cost to both them and the NHS.

34 The recent implementation of General Dental Services Contract Reform has placed a contractual emphasis on dental practitioners/practices seeing "new patients". Although this seems to be a good method of improving access to dental services, as there is only a limited amount of capacity within the general dental service, the increased new patient activity will be at the expense of those patients who were routinely seen by the practitioner/practice. This has resulted in the existing practitioner/practice patient base having to wait longer to access treatment, which has reportedly led to patient frustration. From an orthodontic perspective, this has resulted in orthodontic patients having to wait a significant amount of time to complete the required dental treatment prior to commencing their orthodontic treatment. E.g. patients having to wait 6 months to undertake dental extractions following an orthodontic assessment. In addition to delaying the patient's treatment journey, it also introduces inefficiencies into the orthodontic care pathway, which may mean that orthodontic practitioners are unable to meet their contractual obligations.

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

36 Recruitment and retention of clinical and administrative staff is likely to prove to be the biggest challenge in addressing dental inequities within Wales. The negative effect of the pandemic on the dental workforce should not be underestimated. There have been multiple reports of long-standing experienced administrative staff deciding that they cannot continue within their role. This will be due to combination of factors, but seems to be significantly influenced by the increase in bureaucracy and complaints being made to practices about wating time to access care and the inability of these individuals to address these concerns due to capacity issues within the services. This has been made worse with the ramping up of

orthodontic contractual expectations to 100% whilst the supporting wider dental infrastructure remains limited.

37 Monitoring the dental workforce within Wales is challenging due to the fact that dental commissioned activity is agreed between the Health Boards and “Contractors” who then employ independent dental performers to fulfil that contract. This is made more complicated by the fact that many dental practitioners work across multiple sites. As such, the Health Boards do not usually have an accurate contemporaneous list of all dental providers working within their Health Board.

38 A comprehensive Welsh NHS orthodontic workforce assessment was undertaken for the first time at the end of 2021. This revealed a Welsh NHS orthodontic workforce of 112 individuals working in the general dental service, community dental service, primary care specialist practice and secondary care settings. A recent survey of NHS orthodontic practitioners operating within Wales received a response rate of 70.5% and indicated that 25% of respondents, which amounted to 20 individuals, were planning to cease providing orthodontic care within the next 5 years. Considering the timescale to train orthodontic practitioners, this will pose a significant risk to the provision of orthodontic services within Wales and is most likely to disproportionately affect individuals living in the more geographically remote parts of Wales.

39 It is recognised that throughout the UK, the more rural the environment, the harder it is to recruit suitably trained professionals. This is due to a number of factors, with two of the most important being where an individual’s family/social connections are based, and secondly, that professionals tend to “settle down” near to where they trained due to the personal and professional links they established during their training period. Wales has additional challenges due to its topography, transport links and ignorance and misperception surrounding potential linguistic challenges.

40 The training environment within Wales needs to be re-evaluated. It is noted that the trainee pay scales within Wales is significantly less than those within England. This puts Wales at a disadvantage when it comes to attracting candidates to take up training positions within Wales. This is having even greater an impact with the combination of increased student debt and the current cost of living crisis. National (UK) recruitment is used for dental recruitment within Wales. The appropriateness of this needs to be looked at as it may be that reverting back to a local recruitment process to allow local talent to be retained within an area could improve recruitment and retention in the long term.

41 Health Boards and independent businesses/contractors need to be more focused on timely succession planning. The timeline of the orthodontic training pathway dictates that to train a replacement orthodontic specialist will take a minimum of three years and a replacement consultant a minimum of 5 years. Replacement of non-specialists including orthodontic therapists and DwSI will also take time and a suitable training environment. Only considering succession once the incumbent has handed in their notice will inevitably result in significant disruption to clinical services and potential clinical risks to patients.

42 The importance of a supportive training environment cannot be overstated. It is also very important to recognise the essential role that clinical trainers and educational supervisors have in this process and the burden a training role places on these individuals on top of their personal clinical commitments.

43 The use of incentives to encourage individuals to come to live and work in Wales would be worth investigating. It would be unwise to think of this in purely financial terms as job satisfaction is multifactorial and in addition to remuneration, it also includes working environment, workload, development opportunities, work/life balance etc. Further evidence would need to be gathered about what the future workforce desires as is it recognised that the attitudes and preferences of the established workforce is likely to be significantly different from the newly qualified entrants.

44 **• Oral health inequalities, including 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; the capacity of dental domiciliary services for older people and those living in care homes (the 'Gwên am Byth' programme); and the extent to which patients (particularly low risk patients) are opting to see private practitioners, and whether there is a risk of creating a two-tiered dental health service. Workforce well-being and morale.**

45 The BOS is unable to comment on the effectiveness of the Welsh programmes implemented with the aim for reducing oral health inequities. However, one of the implications of improved oral health is that it would potentially result in a greater number of children sustaining a dental health foundation, which would make them suitable to undertake orthodontic treatment.

46 • The scope for further expansion of the Community Dental Service.

47 The Community Dental Service has always had a "safety net" role rather than replicating services which can, and should, be provided more effectively in the general dental service. However, the geography of Wales means that rural communities can struggle to access both general dental as well as specialist dental services locally. The Community Dental Service potentially has the workforce and infrastructure to help address this. However, as with other areas of dentistry, recruitment and retention to fulfil the roles required will be challenging.

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

49 NHS orthodontic activity within Wales has been significantly under resourced. A recent investigation found that in 2021 primary care orthodontic commissioned activity was approximately 76% of the orthodontic need. This is a legacy of the "New Dental Contract"

which was introduced in 2006 which eliminated "fee per item" payment method within dentistry and overnight put a limit on clinical activity.

50 The imbalance between the commissioned activity and the need has resulted in the generation of waiting lists to access NHS orthodontic care. The waiting time to access treatment varies across Wales, both between Health Boards and between providers ranging from 1-5 years prior to the pandemic, with the pandemic only exacerbated the problem.

51 Procurement of clinical services needs to be undertaken in a holistic manner taking into account the geographical location, challenges with recruitment and long-term sustainability. Orthodontic contracts are time limited and so the re-procurement cycle needs to be considered in good time to allow all stakeholders to plan the for the future. This includes investment in both staff and equipment/infrastructure as it is recognised that business investment reduced towards the end of the contracted timeline. It is essential that clinical advice is obtained during the procurement process to ensure that there is minimum disruption to patient services.

52 • The impact of the cost-of-living crisis on the provision of and access to dentistry services in Wales.

53 The cost of living is likely to have a significant impact on everyone. From an orthodontic perspective, it will result in higher overheads for those providing treatment. This will include increased staff wages, utility costs, equipment/infrastructure costs, and materials. This is even more important as the cases currently being prioritised, due to their level of clinical need, are often the more complex and thus more time consuming and expensive to treat. If the contractual payments provided for orthodontic treatment does not keep pace then it could mean that the practices are uneconomical to run. Not only would the closure of a practice result in the disruption of patient care, which is significant in longitudinal care pathways such as orthodontics, but also in the loss of a local business and employer, with the associated social implications.

54 For patients, accessing treatment may become impractical due to cost and time to get to appointments. Due to the population spread and geography of Wales, along with the more centralised locations of orthodontic services within Wales, many patients will have to spend 60 to 90 minutes to travel to an appointment and the same to get back home. This means missed time in education or work which will have its own consequences. The patients/parents will also have the transportation costs – either in privately own vehicles or relying on public transport networks.

Conclusions

55 NHS dental provision within Wales is at a crossroads. There needs to be a collaborative approach to the design and implementation of clinical services. Reforms which are instigated with little or no consultation with the profession are likely to be unsuccessful as they will lead to unintended consequences including loss of a proportion of the workforce from the NHS which would paradoxically reduce access to dental care.

56 NHS orthodontic services within Wales is in a similar position. After years of underfunding and lack of holistic strategic direction, orthodontic provision is in a dire state. The workforce is under a significant amount of personal and professional strain attempting to keep the current system functioning. The evidence suggest that many orthodontic practitioners are looking to cease practicing within the next five years and this is going to disproportionally affect those on the specialist list. As it is these individuals who provide the treatment planning and supervision for the other members of the dental team, the loss of this cohort of individuals, without suitable replacement, will result in significant instability within the orthodontic care model and additional strain on those specialists remaining.

57 The BOS believes that there need to be a comprehensive assessment of the risks to the orthodontic clinical services within Wales so that, once fully identified, mitigation steps can be implemented. This needs to be undertaken in conjunction with the whole profession to ensure that all stakeholders are involved and feel that their voices and concerns are being heard.

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

Health and Social Care Committee Consultation on Dentistry: RCPCH evidence

About the Royal College of Paediatrics and Child Health (RCPCH)

The RCPCH works to transform child health through knowledge, innovation and expertise. We have over 500 members in Wales, 14,000 across the UK and over 17,000 worldwide. The RCPCH is responsible for training and examining paediatricians. We also advocate on behalf of members, represent their views and draw upon their expertise to inform policy development and the maintenance of professional standards.

For further information please contact Gethin Matthews-Jones, Head of Devolved Nations via .

Our views on actions needed to address the issues under consideration and what the solutions might be:

- Welsh Government should commission a review into the factors affecting access to primary, secondary and emergency dental care, with a view to addressing inequalities in Wales.
- We welcome Designed to Smile, which provides support programmes for children and families to enable them take up positive oral health habits (e.g. through supervised tooth brushing schemes). Welsh Government should ensure funding and resource for Designed to Smile to continue; and provide 'catchup' resource if that is required to enable the programme to recover from the impact of the pandemic and associated school closures.
- The Welsh Government and partners such as Designed to Smile should provide a public health campaign to raise awareness of factors contributing to poor oral health (ie diet / tooth brushing) and to ensure that parents and carers know when their children should access dental services (by one year) and how to do so.

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- Welsh Government should review and publish clear targets and timescales for children's access to dentistry services as part of its programme to reduce waiting times and transform services – and report against these annually.
- The Welsh Government, working with partners, should provide resource to ensure annual capture and publication of data on children's dental health including tooth decay and hospital treatment including general anaesthesia. These data should be comparable over time and broken down to enable analysis of what is working and the impact of inequalities.
- NHS Wales, Welsh Government and Health Education and Improvement Wales (HEIW) should ensure that all health care professionals, including dentists, can make every contact count by having conversations with their patients (whatever their age) about reducing and replacing high-sugar foods and drinks.
- To reduce economic inequality in oral health, Welsh Government should resource and support fluoridation of public water supplies, particularly for areas where there is a high prevalence of tooth decay.

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.

A recent BBC investigation highlighted the scale of the problem in accessing NHS dentistry across the UK. Their investigation found that, UK-wide, 80% of dental practices were not taking on children, 10% of local authorities did not have any practices taking on under-16s for NHS treatment and about 200 practices said they would take on a child under the NHS only if a parent signed up as a private patient. It is unclear how these figures align or differ across the UK's nations. However, if access to adult services provide any guide to access for children, Wales would appear to have a particularly acute challenge. The report noted that "Scotland had significantly better access to NHS dentistry for adults than the other UK nations, with 18% of practices taking on new health-service patients. Wales, England and Northern Ireland had…7%, 9% and 10% respectively"[1]. We therefore believe that the Welsh Government should commission a review into the factors affecting access to primary, secondary and emergency dental care, with a view to addressing inequalities in Wales.

The Welsh Government's recent 'Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales' notes some of the challenges and outlines the approach being taken.

"We are making steady progress with recovery of dental services and as dentists respond to new ways of working, activity is still 50% compared to the same period pre-pandemic… Priority is being placed on those with highest risk and needs, this includes children who are in high risk groups, particularly those from disadvantaged socioeconomic backgrounds. More routine care will be provided as we move through recovery phases where throughput

[1] Green, R; Agerholm, H; and Rogers, L; 2022 *Full extent of NHS dentistry shortage revealed by far-reaching BBC research*. BBC. Available at: https://www.bbc.co.uk/news/health-62253893

is able to increase safely and provide services in the community to support people's needs closer to home"[2].

There is much in the statement on dentistry in the plan that we welcome, including the focus on children and young people; and on reducing heath inequalities. However, given the ongoing disruption to dentistry services resulting on only half of pre-pandemic activity being delivered at the point of the plan's publication, the Welsh Government should urgently provide a more detailed explanation of these 'recovery phases' and set out a plan for ensuring that its own targets and ambitions for children being seen by dentists are being met.

In 2018, the Welsh Government's 'Dental Care and Treatment for Very Young Children' guidance[3] stated that "we want all children to be taken to the dentist before the age of 1 - ideally as soon as deciduous teeth erupt. We want dental teams to see children routinely before there is a problem, provide preventive care and advice and support parents to keep their child's teeth sound". The Welsh Government's 'A Healthier Wales: The oral health and dental services response' identified as a key priority for 2018-2021, a "year-on-year increase in the proportion of people who have seen an NHS dental practitioner in the last 2 years (1 year for children) in all Health Boards"[4]. In its recent changes to frequency of dental check-ups in Wales, the Welsh Government confirmed that children and young people under 18 should continue to have check ups every six months[5]. We are unclear as to whether these commitments are being met and if not, what actions are being taken to ensure they are met as quickly as possible. It would be helpful for the Welsh Government to review and reaffirm these commitments for 2022 and beyond, setting out clearly its expectations and targets for children accessing dental services and reporting against this annually (with inequalities measured), to enable better understanding of access and the success of measures put in place to improve it.

We are also not aware of data on the provision of hospital based dentistry including extractions. The British Society of Paediatric Dentistry (BSPD) recently highlighted their concerns around children waiting for a long time for dental care under general anaesthesia and commented on plans to tackle long waiting lists[6]. Committee members may wish to consider whether it would be helpful for the Welsh Government to address this in the context of the dentistry 'recovery phases' mentioned in their plan to transform care and reduce waiting lists; and to publish data and timelines as part of operationalising that plan.

Given the scale and impact of tooth decay; and the extent to which it is preventable, it is surprising that there is little in 'Programme for Transforming and Modernising Planned

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[2] Welsh Government (2022). *Our programme for transforming and modernising planned care and reducing waiting lists in Wales*, p23. Available at: https://gov.wales/sites/default/files/publications/2022-04/our-programme-for-transforming--and-modernising-planned-care-and-reducing-waiting-lists-in-wales.pdf

[3] Welsh Government (2018) *Preventive dental advice, care and treatment for children from 0-3 Years*. Available at: https://gov.wales/sites/default/files/publications/2019-03/preventive-dental-advice-care-and-treatment-for-children-from-0-3-years.pdf

[4] Welsh Government (2018). *A Healthier Wales: The oral health and dental services response*. Available at: https://gov.wales/sites/default/files/publications/2019-03/the-oral-health-and-dental-services-response.pdf

[5] Welsh Government (2022) *Move to yearly dental check-ups to improve access to NHS dentistry in Wales*. Available at: https://gov.wales/move-yearly-dental-check-ups-improve-access-nhs-dentistry-wales

[6] British Society of Paediatric Dentistry (2022). *BSPD responds to reports of pandemic child tooth extractions data*. Available at: https://www.bspd.co.uk/Portals/0/Press%20Releases/2022/Statement%20BSPD%2013%20May%2022%20FINAL.pdf

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Care and Reducing Waiting Lists in Wales' on preventing tooth decay in children in the sections of the plan dealing with prevention of ill health, which would obviously have a long-term benefit for children themselves and for dentistry services.

In State of Child Health and elsewhere we recommended ensuring sufficient funding and resource for Designed to Smile; and that Welsh Government should resource and support fluoridation of public water supplies, particularly for areas where there is a high prevalence of tooth decay[7]. The evidence for the role of water fluoridation in preventing tooth decay was set out last year by the UK's four Chief Medical Officers in their independent *Statement on water fluoridation from the UK Chief Medical Officers*, which noted that:

"There is evidence that water fluoridation can help narrow differences in dental health between more and less deprived communities, with people living in fluoridated areas suffering less tooth decay compared to those living in non-fluoridated areas. It has its greatest positive effect in children who do not get fluoride through regular toothbrushing or dental interventions…

…There is strong scientific evidence that water fluoridation is an effective public health intervention for reducing the prevalence of tooth decay and improving dental health equality across the UK." [8]

Improved oral health intelligence, including the uptake of NHS primary dental care across Wales following the resumption of services, and the need for a government funded campaign to reassure the public that dental practices are safe environments.

Before the pandemic, we called on the Welsh Government and its partners to deliver a public health campaign to ensure children and families are aware of factors contributing to poor oral health (i.e. diet / tooth brushing) and to ensure that parents and carers know when their children should access dental services (by one year) and how to do so.

As noted previously, it would be helpful for the Welsh Government to publish clear and updated targets and expectations; and to publish reporting against this annually (with inequalities measured), to enable better understanding of access and the success of measures put in place to improve it.

Oral health inequalities, including 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

Despite tooth decay being largely preventable, it is the leading reason why children aged five to nine require admission to hospital. Multiple tooth extractions can also result in the need for a child to go under general anaesthetic. In pre-pandemic years, our State of Child Health report showed that children from lower socioeconomic groups were significantly more likely to be at risk of tooth decay prevalence and severity.

The good news is that between 2008 and 2016, prevalence of visually obvious tooth decay among 5 year old children in Wales fell from 47.6% to 35.4%. From 2014/15 to 2017/18, among

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[7] RCPCH (2020). *State of Child Health*. Available at: https://stateofchildhealth.rcpch.ac.uk/evidence/prevention-of-ill-health/oral-health/

[8] UK Government Chief Medical Officers (2021). *Statement on water fluoridation from the UK Chief Medical Officers*. Available at: https://www.gov.uk/government/publications/water-fluoridation-statement-from-the-uk-chief-medical-officers/statement-on-water-fluoridation-from-the-uk-chief-medical-officers#impact-of-water-fluoridation-in-areas-of-deprivation

0 to 2 year olds in Wales, the rate of general anaesthetics performed for dental reasons fell from 2.8 to 1.7 per 1,000. It should be noted that this still placed Wales as having a significant problem compared to Scotland and England. In his written statement in 2017[9], the then Health Minister noted a "reduction in the proportion of children with decay between 2007-08 (47.6%) and 2015-16 (34.2%)... represents continuing improvement of the proportion of children who have no obvious decay experience by age 5". However, our State of Child Health report notes that the proportion of children aged 5 years with obvious tooth decay in Scotland in 2016 of 26.5% and in England of 23.4%[10], significantly lower than the (improved) picture in Wales.

Nonetheless, the last available survey results Welsh Oral Health Information Unit[11] indicate progress in Wales in the years before the pandemic. In addition to the data on five year olds, we note that 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.

Given school closures in recent years and disruption to the Designed to Smile programme, which the Welsh Government believes has driven much of this improvement[12], it is important that we have up-to-date data on the prevalence of tooth decay on children in Wales and what this means for hospital admission and waiting lists for children requiring dental extractions and other treatment.

Welsh Oral Health Information Unit data doesn't give us an up to date picture, nor enable us to understand the impact of school closures, or measure the impact of the disruption to Designed to Smile and the wider impacts of the pandemic; or indeed of the current cost of living crisis. Furthermore, these data are snapshots of different age groups in different years (for example 12 year olds in 2012-13 and 2016-17; 5 year olds in 2011-12, 2014-15 and 2015-16).

To understand both the impact of tooth decay on children and young people and the inequalities that exist in children's oral health, we would recommend that the Welsh Government reviews its data collection and reporting structures. These should provide readily available consistent, easily comparable, contemporary data on tooth decay and outcomes including hospital treatment and general anaesthetic rates in children and young people. Data should be broken down to enable us to understand the adverse effect of inequality better. Consistent reporting of oral health by each age group annually would identify trends and enable better comprehension of whether policies are working quickly enough in producing improvements in oral health.

The most recent Designed to Smile Monitoring report currently published on the Welsh Oral Health Information Unit website is for 2018/19. We note the previous success of this programme and are concerned that varnishing rates and tooth brushing may have decreased during the pandemic due to school closures and disruption to it. Given that Welsh Government evaluation largely attributes these improvements to Designed to Smile, Committee members may wish to consider whether additional resource is required

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[9] Welsh Government (2017). *Written Statement - Picture of Oral Health 2017 – Dental caries in 5 year-olds (2015-16) Update*. Available at: https://gov.wales/written-statement-picture-oral-health-2017-dental-caries-5-year-olds-2015-16-update

[10] RCPCH (2020) *State of Child Health*. Available at: https://stateofchildhealth.rcpch.ac.uk/evidence/prevention-of-ill-health/oral-health/#page-section-4

[11] Cardiff University (accessed 2022). *Welsh Oral Health Information Unit*. Available at: https://www.cardiff.ac.uk/research/explore/research-units/welsh-oral-health-information-unit

[12] See Welsh Government (2019) *Welsh Government scheme puts a smile on Children's faces*, available at: https://gov.wales/welsh-government-scheme-puts-smile-childrens-faces

The Royal College of Paediatrics and Child Health is a registered charity in England and Wales (1057744) and in Scotland (SCO38299)

for that programme to recover and catch up and whether the Welsh Government is taking steps to ensure this is made available. Universal Water fluoridation may also reduce these inequalities in areas of low tooth brushing or inadequate natural fluoridation.

The extent to which patients (particularly low risk patients) are opting to see private practitioners, and whether there is a risk of creating a two-tiered dental health service.

On the issue of a two-tier service, we do not hold data on the number of parents accessing private dental treatment for their children but following the recent BBC report, this is something we are concerned about[13]. It would be unacceptable for parents to feel they have no option other than to pay for private dentistry services for their child. This would create a two-tier oral health system where those from lower income families are forced to remain on waiting lists, or worse, go without dental check-ups and procedures entirely.

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

Although we have no formal evidence at the time of writing, we have heard anecdotal reports from paediatricians of patients not attending appointments because of the cost of travel. If this is happening in paediatrics, it could well be something that dental colleagues are experiencing. We note this as an emerging concern the Committee may wish to investigate further.

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[13] RCPCH (2022). *RCPCH responds to BBC investigation on NHS dentistry shortage for children*. Available at: https://www.rcpch.ac.uk/news-events/news/rcpch-responds-bbc-investigation-nhs-dentistry-shortage-children

Consultation Response

Access to dentistry inquiry

Senedd Health and Social Care Committee

September 2022

Age Cymru is the leading national charity working to improve the lives of all older people in Wales. We believe older people should be able to lead healthy and fulfilled lives, have adequate income, access to high quality services and the opportunity to shape their own future. We seek to provide a strong voice for all older people in Wales and to raise awareness of the issues of importance to them.

We are pleased to respond to the Senedd Health and Social Care Committee's inquiry into access to dentistry as this is an area where we are increasingly hearing concerns from older people on availability of NHS services and how it is affecting them. In developing this response, we have looked in depth at feedback from older people from our annual surveys, gained feedback from our information, advice and support services, and listened to older people's concerns through our ongoing community-based engagement events across Wales on experiences of access to dentistry in Wales. Themes that have emerged through our analysis include:

- An increase in the number of older people that have told us they have had to seek private dental care as they can no longer wait for their NHS dentist (if they have been able to register with an NHS dentist at all), as they need dental work immediately
- Poor or no communication from dental practices on treatment availability and how moves to private practice replacing NHS services are communicated
- An increase in the number of older people telling us the negative effects a lack of ongoing dental care is having on their oral and wider health.

1. How limitations in NHS dentistry are affecting older people

Limitations in availability of NHS dentistry services existed prior to the pandemic and the situation has been vastly exacerbated for older people as a result of delays in ongoing checks and treatment throughout the pandemic.

A British Dental Journal article on the Gwên am Byth programme[1] highlights how improvements in dentistry in the 20th century now mean that more older people have retained their teeth than their predecessors. In 1968, 37% of adults in Wales had dentures compared with 10% in 2009. Original or restored teeth require more complex dental care than dentures, which has implications for the delivery of prevention and dental care to the older population. As such, access to NHS dental services affect older people more than before. With an ageing population, this trend is set to continue unless steps are taken to address this issue.

Over the last 3 years Age Cymru have conducted an annual survey on older people's experiences of the pandemic. For each year we have run this older people have told us of increasing issues in access to dental care. For our 2022 survey[2], more people than before told us specifically of their experiences of access to NHS dentistry care.

Responses highlight the worry older people experience with delays in access to necessary dental care:

"I didn't see a dentist for 2 years and I am permanently worried about my deteriorating teeth." (Vale of Glamorgan)

"Everything is now delayed check-up appts for dentist […] are now at least months longer" (Caerphilly)

"General dentistry like check-ups have been stopped by my dentist" (Caerphilly)

Separately, older people have told us they cannot understand why the services they have paid into all their lives through income tax and national insurance contributions don't seem to be available when they need them. They feel the NHS need to understand that earlier intervention and prevention is much better than dealing with chronic issues: if routine checks were maintained and delays were not happening their oral health would be much improved. As one survey respondent said,

"*Dentists need to get back to normal - I had to demand a check-up after having emergency treatment 3 times. If the dentist was accessible, I should have had treatment sooner and would not be left with the extent of problems now."* (Bridgend)

Where people are able to access check-ups and treatment, feedback is almost wholly positive. One respondent said,

"My dentist has been amazing as I have an auto immune oral condition and he has always video called me and had the support when needed" (Blaenau Gwent).

We have broken down responses by area as a means of seeing if there are regional differences in access to dental care and quality of care. Table 1 shows our results.

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[1] 2020, Gwên am Byth: a programme introduced to improve the oral health of older people living in care homes in Wales - from anecdote, through policy into action https://www.nature.com/articles/s41415-020-2400-2

[2] https://www.ageuk.org.uk/cymru/get-involved/covid-19-survey/

Further information on how we have analysed results is included in the foot notes.[3] Overall, 74% told us of negative experiences and 26% told us of positive experiences. This was an improvement over the previous year's survey where 84% told us of negative experiences and 14% told us of positive experiences of the responses that discussed dentistry access at all. This improvement is likely to be linked to the resumption of dental services over the last year.

Table 1: Breakdown of responses by local authority area

Local Authority area	Positive experience	Negative experience
Blaenau Gwent	1 (100%)	0 (0%)
Bridgend	1 (10%)	9 (90%)
Caerphilly	0 (0%)	5 (100%)
Cardiff	7 (39%)	11 (61%)
Carmarthenshire	6 (33%)	12 (66%)
Ceredigion	1 (20%)	4 (80%)
Conwy	2 (29%)	5 (71%)
Denbighshire	2 (33%)	4 (66%)
Flintshire	2 (22%)	7 (78%)
Gwynedd	3 (30%)	7 (70%)
Isle of Anglesey	1 (11%)	8 89%)
Merthyr	0 (0%)	3 (100%)
Monmouthshire	0 (0%)	9 (100%)
Neath Port Talbot	0 (0%)	4 (100%)
Newport	2 (50%)	2 (50%)
Pembrokeshire	5 (36%)	9 (64%)
Powys	3 (20%)	12 (80%)
Rhondda Cynon Taff	5 (38%)	8 (62%)
Swansea	2 (18%)	9 (82%)
Torfaen	1 (50%)	1 (50%)
Vale of Glamorgan	2 (40%)	3 (60%)
Wrexham	1 (25%)	3 (75%)
Total	**47 (25.8%)**	**135 (74.2%)**

It is important to note that the volume of responses by region are not sufficient to be statistically reliable. We do hope, however, that the above allows some indication of which local authority areas may require an additional focus. For example, more rural counties and areas with known high levels of deprivation appear to be suffering more than some other areas. A wider scale study may capture sufficient information with which to target areas that require an additional focus.

[3] Information has been included where it is possible to identify which area respondents reside in and where it was clear from their response that they felt that their experience was positive or negative. The number of responses may not necessarily reflect overall experiences of the wider population due to Where it was unclear those responses have not been included in the table. Experiences have been categorised as positive in cases where the respondent included that they had been able to access NHS dentistry at all - as opposed to responses that included specific details of how good their service had been. As such a positive experience may be overstated.

The 2019 A Fresh Start: Inquiry into dentistry in Wales[4] report highlights issues with contacting arrangements that dissuade the registration of patients that may require a considerable amount of dental work. It is highly possible that these contracting arrangements are contributing to increasing inequalities of provision and given the increase in the volume of people that require remedial work following the main pandemic period, are likely to widen inequalities further. One of our survey respondents said,

“Dentist won’t make an appointment for me, yet a few weeks ago they advertised that they were taking on private patients.” (Bridgend)

Case study 2 further down in this response demonstrates how these arrangements affect older people’s access to NHS dentistry.

The case study below demonstrates how a lack of access to dental care affects older people.

Case Study 1: Effects of lack of dentistry throughout the pandemic, July 2022

An older man sought help from Age Cymru’s dementia advocacy service to help him access dentistry and podiatry care, as well as access to some other support he needs. One of the issues he faced amongst a range of health concerns was having been struck off from his NHS dentist practice shortly before lockdown when they say that he failed to attend an appointment, which he distinctly remembers cancelling. As a result of this, he has been without dentures for the entire pandemic period. He has been surviving on liquid food as he cannot chew. He says he sometimes tries to eat solid food, but he knows he is at risk of choking if he does. He told us that he doesn’t like to smile or laugh ‘because people can see the state of my mouth.’ He says he looks older than his years without teeth his confidence is affected. His speech sounds slurred so people may get the wrong impression of him.

Since getting support through our project, he has been able to get his appointments restarted, although there have been delays whilst his dentist was off work sick. At the time of this discussion he was still without teeth and so was still only able to eat liquid food. He required numerous dental appointments to get to the stage where he will be able to have dentures fitted.

He told us he feels let down by the same system that was happy for him to provide unpaid care to his late wife for 25 years and is upset that the care he needs hasn’t been available at the time he needed it.

The delays in access to dentistry are having a profound impact on older people. Whilst we understand that the pandemic’s infection control measures impacted delivery of dentistry more than some other areas of health services, when this is coupled with a reduction in the availability of NHS dentists, issues are vastly

[4] 2019, A Fresh Start: Inquiry into dentistry in Wales report for the Senedd Health and Social Care Committee https://senedd.wales/laid%20documents/cr-ld12528/cr-ld12528-e.pdf

compounded. We also understand that other age groups have also been impacted greatly by a lack of access, but for older people on fixed incomes it is vital that NHS services are maintained as there simply is not another option for the majority of older people that they can afford.

2. **Creation of a two-tier system**

Though many responses to our survey spoke of delays, it was clear that even with delays in access, people feel that not having to worry about how much treatment will cost is a major benefit of living in the UK that does have public health care, despite capacity issues. As one respondent told us,

"I'm worried about not getting a dentist appointment, although at least I haven't got to worry about the cost of the treatment I know I need."

This year we have heard from more older people who have sought private treatment in the absence of NHS dental prevention and treatment services than in previous surveys. Responses included:

"It's totally impossible to access our NHS dentist for a routine dental appointment unless urgent. I've phoned numerous times but dentist doesn't call back. I had to make appt with private dentist for 1st check up in nearly 3yrs since before Covid began. Had to pay over £400 total for check up, hygienist & filling which as a pensioner is not sustainable each year. Neither my husband nor I know if we're still registered with our NHS dentist as he's not seen us for over 12 months & might therefore have unregistered us - we don't know. We feel abandoned by our NHS Dentist." (Cardiff)

"I have never in 15 years been able to access an NHS dentist." (Pembrokeshire)

"Dentistry collapsed, I have had to sign up for Denplan" (Gwynedd)

"There are no NHS dentists available in my area and I am forced to pay private. I had to find £500 to have 4 teeth extracted." (Powys)

"Used private services of dentistry as impossible to access NHS" (Ynys Mon)

Many respondents to our survey spoke of how even though they pay for private treatment, this is no guarantee that they can get the preventative care and treatment they need at the time they need it. In addition, costs of both NHS private treatment appear to be increasing. As one respondent told us,

"Dentist very difficult to access and much more expensive."

This year more calls have come into our information, advice and support projects for help with finding an NHS dentist. This coincides with a marked increase in the number of older people approaching us to check that they are in receipt of all their financial entitlements. Our advice team has received many calls from older people in distress at the increased cost of living and uncertainties how they will manage over the winter months. Those of pensionable age usually rely on the fixed income from

pensions and related benefits and are unable to find additional income to cover the increased costs people across the UK now face. Funding private dental care is beyond the means of the majority of older people.

Older people with co morbidities are also likely to face additional challenges from services they have historically received for free through the NHS now moving to paid for services. For example, we have seen an increase in requests for help with access from older people with high risk medical conditions who used to receive free podiatry care through the NHS but now have to pay for this service themselves. The case study below demonstrates how the lack of access to dentistry can affect older people with comorbidities disproportionately to other groups of the population.

<u>Case study 2: Privatisation of dental care, Summer 2022</u>

A caller to Age Cymru Advice contacted us after receiving a letter from the dental practice she had been with for 60 years that said that her latest dentist was moving to private practice only. Until recently she had no problems with dentists retiring and being passed on to their successors at the same dental practice. However, this most recent letter has come only 6 months after she had received a similar letter, saying that her dentist at that time was also moving to private practice. At the time of the call, she was waiting to have a series of appointments arranged for vital treatment as her teeth that had deteriorated over the last two years.

The letter included an offer of private dental insurance and some information about the insurance. There was a deadline to apply for this at a discounted rate. The letter said that further information on the dental plan could be found on the internet, which our caller did not have access to. She called on help from her daughter to help with internet searches of where she could register with an NHS dentist and what the dental plan covered. The cover she was offered simply covered the cost of 2 checks a year, with any dental work needed having to be paid or privately.

Any NHS dentistry close enough to her had very long waiting lists. She does not drive so in the event that loved ones cannot give her lifts she would have to rely on public transport, so it is vital that she has dental care close to home. She told us that she feels she has no choice about having to pay for private health care.

This experience has left her with no faith in NHS services. She told us that the arrival of this letter felt like 'the straw that broke the camel's back' after two years of the pandemic where she has had to deal with a whole range of health conditions and had worked as hard as she could to keep herself fit and healthy. She feels that she and her family have done everything they were told to do through the pandemic and does not understand why she can no longer get NHS care. Her husband also said that he had worked all his life and cannot understand why their working contributions are no longer enough to support them through the system they have paid into all their lives. Having saved over many years for their retirement, increased living costs have destroyed their savings and they no longer have a safety net. Our caller said, "I feel like I'm between a rock and a hard place […] They have us over a barrel and we are losing our independence," she said.

Later communication with our caller showed that the letter was not entirely accurate. The dentist that had sent the letter was moving to private work, but another at the practice was not. As such she was told she would be able to move to another NHS dentist for now. However, when asked whether it was likely that this would happen again and whether it was likely that other dentists would be going to private patients only, she was told this is very likely because they struggle to get financial recompense from the government for NHS patients. So, whilst she can get the dental care she needs for now, she expects to be in a similar position in the very near future.

From this case study it appears that the default position of some dental practices where a practitioner moved to private practice is to offer private treatment first and NHS care as a last resort. Given the fixed income and other financial pressures facing older people, it is vital that efforts to increase access to NHS dentistry happens at pace. It is vital that urgent consideration is given to changes in contracting arrangements that inadvertently limit NHS availability of care.

Discussions through our engagement events have illustrated some views on what could improve access to dentistry in the future. During a discussion at one of our recent engagement events several older people suggested that those who train through the NHS should be required to stay working full time within the NHS for a fixed period of time after completing their training.

Given the stress that is caused by miscommunication over changes as seen in the above case study, we call for a review of how changes in practice are communicated. An equalities impact assessment should be completed on changes in practice in order to help mitigate against changes. Given the reliance that older people on fixed incomes have on NHS dentistry, with no opportunity to have planned for the current situation, it is vital that older people on fixed incomes are protected from moves to private practice.

3. Access to dentistry in care homes

Dental care for care home residents relies on a combination of continuing with existing dental care arrangements made prior to the resident moving to the care home, and domiciliary dental treatment provision and preventative dental care provided through the Gwên am Byth programme. This Welsh initiative is a vital service welcomed by Age Cymru to care home residents who have not had access to the dental care they need. The crisis in recruitment of carers will affect the ability of care homes to provide the oral care that care home residents need – just as much as other aspects of personal and daily care. Good oral health is a foundation for a person’s ability to eat healthily and so any decline in this has a large effect on a person’s overall health.

As older people’s access to community dentistry diminishes, this may put additional pressure on the Gwên am Byth resources fill that gap. We are concerned that a lack of access to community dentistry and gaps in domiciliary dentistry may mean that the

preventative focus of Gwên am Byth may be reduced in order to address critical dental care needs. Further, with high levels of care staff turnover in care homes there is an increased level of training on oral care that needs to be resourced.

Annual reports on Gwên am Byth demonstrate that not all care homes are participating in the programme. Whilst a lack of engagement from some care homes may ne related to pandemic pressures, it is vital that all care home residents across all of Wales have access to the vital dental care they need.

Where a care home residents was already registered with a dentist prior to the move to the care home, the expectation is that in most cases family members will take the care home resident to their community dentist appointments. With the cost of living crisis it is highly likely that family members' ability to continue to do this will reduce when they are unable to cover the costs. This also comes at a time where care homes ability to escort residents to external appointments is limited through the staffing crisis.

The range of treatments available through domiciliary dentistry are limited due to the practicalities of transporting all dentistry equipment, e.g. Xray equipment and the volume of resources needed to provide domiciliary services is greater per patient than community dentistry services with increased travel, time and capital requirements.

Currently the use of fluoride varnish as a preventative dental care initiative is limited to younger children. Studies have shown how this initiative has reduced the number of cavies needing treatment in children. Given the preventative focus of the Gwên am Byth programme it seems that this initiative could be extended to care homes as a means of reducing the level of need for dental treatment in the short term.

As we have demonstrated in this response, older people are vastly impacted by the lack of access to NHS dentistry services and the majority do not have the financial means to pay for private care. As age is a protected characteristic, further consideration is needed of the disproportionate impact the paucity of dental services has on older people.

We urge Welsh NHS services to ensure that older people's enhanced need for dental care is fully considered in pandemic recovery plans in terms of both volume of NHS dental services available and projected future demand of an ageing population. Consideration is also needed of the support that increasing numbers of older people need to navigate changing systems and how changes in service are meaningfully and clearly communicated to the older Welsh population.

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Comisiynydd Pobl Hŷn Cymru
Older People's Commissioner for Wales

Response to the Health and Social Care Committee Inquiry into Dentistry

September 2022

Introduction

The Older People's Commissioner for Wales (OPCW) welcomes the opportunity to respond to the Health and Social Care Committee Inquiry into Dentistry.

Dental health is an important part of older people's quality of life. Maintaining a functional, comfortable, presentable set of teeth - natural, artificial, or a combination of the two - helps older people to eat a balanced diet and maintain their health and wellbeing in later life.

The number of people who retain at least some of their natural teeth into old age has been rising steadily in recent decades.[1] This means that the oral health needs of older people are changing and becoming increasingly complex. Complex needs and co-morbidities in later life can make basic care, such as brushing teeth, a challenge. Many older people now need regular maintenance and restoration of natural teeth and individually designed partial dentures, where previous generations would have needed a full set of dentures to replace all their teeth.

The Royal College of Surgeons' report "Improving dental health is essential to improving overall health"[2], demonstrates the impact of poor oral health on older people's physical and mental wellbeing, causing pain and making it difficult to speak, eat and take medication. Poor oral health is also linked to conditions such as malnutrition and aspiration pneumonia. The Commissioner has heard recently from an older person who said they had almost given up eating because they were afraid of losing their teeth. Another said they would not go out without the denture which was no longer functional.

The OPCW Care Homes Review report, "A Place to Call Home"[3] published in 2014, identified a lack of oral hygiene and access to dentistry services in care homes. The Welsh Government responded to the Commissioner's report in 2015 with additional funding and a programme, "Improving Oral Health for Older People Living in Care Homes"[4] delivered by

the Community Dental Service as Gwên am Byth (A Lasting Smile). In 2017 the Royal College of Surgeons' report highlighted an urgent need to improve oral healthcare for all older people, called for greater disaggregation of data on older adults and pointed out that demand for dental services will increase as the population ages.

Dental services have been severely curtailed by the Covid-19 pandemic and oral health programmes including Gwên am Byth have been suspended. Dental professionals are concerned that the decrease in dental capacity has probably (in the absence of data) mainly affected those who are extremely clinically vulnerable to Covid-19, people unable to afford dental treatment, and older people,[5] and that the backlog of vulnerable people waiting for dental appointments is even greater than that of the general population.[6] As older people are at higher risk from Covid-19 and as almost one in five older people in Wales lives in relative income poverty,[7] older people are likely to represent a significant proportion of the appointments backlog.

Since the beginning of the pandemic, the number of older people contacting the Commissioner's Advice and Assistance Team for help in accessing dental services has increased. Older people and their families have told the Commissioner's office that being unable to access the dental care they need makes their lives miserable. People have reported suffering daily discomfort and pain, and in one case, a risk of sepsis, a life-threatening condition. Older people say they are frustrated at feeling their teeth becoming loose while they are unable to access dental care, and that they afraid and upset at the prospect of losing teeth, a crown or an implant

Older people who have been trying to access dental care and know that their oral health is deteriorating say they feel vulnerable, let down and desperate at being left on their own in their distress to deal with the problem of finding a dentist to help them. One inquirer said, "It has taken almost three years to have a dentist appointment and I have now been advised that I have gum disease and likely to loose all my teeth. I am annoyed that due to being an older NHS patient we are considered to be unimportant. I am hoping that by bringing this to your attention it will mean that other people won't have to go through this experience."

The extent to which access to NHS dentistry continues to be limited

Older people contacting the Commissioner's office for help report difficulty in finding an NHS dentist, difficulty in booking appointments and in one case an appointment being cancelled at short notice.

Some older people also experience poor communication and lack of information from dental practices. One person said they had been calling the practice every day to ask for a cancellation, then finding out at a late stage that their dentist worked only two days a week. Another had been left sitting in the waiting room for a long time with no explanation. Other older people said they had had no replies to emails and requests for advice from the practice. When one inquirer had asked about the practice's complaints procedure, the receptionist had told them not to expect a quick response.

Some older people have been surprised and dismayed at being refused the routine services they were used to, because of the new prevention-led dental contract[8] and the prudent healthcare-based move away from interventions such as the six-monthly scale and polish, that had become the norm. Changes in dental practice should be communicated clearly, in a timely, careful and sensitive way, so that older people know what to expect.

Improved oral health intelligence

The Commissioner has previously highlighted that older people are in danger of being rendered 'invisible' to policy- and decision-makers due to a lack of meaningful data in key areas about people's experiences of growing older in Wales.[9] The Commissioner is very concerned that it is not known which population groups are getting regular check-ups and which groups are struggling to access services and treatment.[10]

The Commissioner agrees with the Royal College of Surgeons' recommendation that more data is needed both on the oral health of the older population and on older people's access to dental services, and that data on the older people's cohort should be further disaggregated by age band in Wales. Data on oral health should be collected at population level regardless of whether someone accesses NHS or private dental services.

The need for a government funded campaign to reassure the public that dental practices are safe environments

Some older people whose physical and mental health have been impacted by the Covid-19 pandemic have not yet come forward for health care and some are still afraid to leave the house at all. The Commissioner believes that a publicity campaign on dental practices as safe environments, while helpful, will not be sufficient to overcome the problems that older people face in coming forward for dental services.

Some older people have said that, because of the constantly changing situation during the pandemic and the impact of staffing shortages on dental services, they lack the information

about what services are available at any one time, which would enable them to make an appointment. One inquirer suggested that updates on the availability of dental services should be broadcast on television, as other methods of communication would not reach them.

Other inquirers report difficulty in getting transport to dental appointments, pointing out that the introduction of a local Fflecsi bus service means that, although they can book an outward journey by telephone from home, they are unable to book a return journey from town because they do not use the Fflecsi app, do not have a mobile phone, or cannot hear to use it due to traffic noise. The Commissioner understands that Transport for Wales is setting up a facility so that medical and educational establishments, supermarkets and other destinations can access the system to make return bookings for customers.[11] It will be essential to include dentists in this facility.

The capacity of dental domiciliary services for older people and those living in care homes

The OPCW report "A Place to Call Home" found that many older people living in care homes rarely or never had access to a dentist, which resulted in a significant deterioration of people's oral health, and that care staff rarely received training on oral hygiene and were therefore unable to maintain the oral health needs of older people effectively or were unaware of how to identify a problem that needed to be referred to a dentist.

A 2015 study in the British Dental Journal[12] found that 72.8% of care home residents in Wales had tooth decay. Compared to older adults examined in the Adult Dental Health Survey, residents were less likely to brush their teeth or dentures twice a day (37% *vs* 63%), more likely to attend a dentist only when they had a problem (63% *vs* 26%), had more teeth with active decay (3.1% *vs* 0.9%), more had current dental pain (13% *vs* 5%) and other morbidity (open pulp, ulceration, fistulae, abscess 27% *vs* 10%). High decay was present in both recently admitted and longer-term residents. There was some regional variation in levels of oral hygiene.

The Gwên am Byth (A Lasting Smile) oral health improvement programme was running in just over half of all care homes in Wales by 2020.[13] The programme was integrated with Improvement Cymru's Care Home Cymru programme and from 1 January 2020 the Welsh Government increased the total funding to health boards from £249,500 to £500,000, with the expectation that the programme would be running in all care homes for older people in Wales.

However, face to face contact in care homes was suspended at the beginning of the pandemic. Relatives of older people in care homes have told the Commissioner's office that care homes had difficulty arranging appointments for residents while community dental staff were redeployed to the Covid-19 booster vaccination programme. This included, for example, an appointment for a resident who had sustained an unobserved tooth injury. The injury had been filled but the filling had become loose and the home had not been able to arrange a repair.

In one very concerning case, a care home resident's dental plate was slipping, cutting her tooth and gums. A doctor had attended, prescribed antibiotics and requested an urgent dental appointment. However, the resident was registered with a private dental practice which was not insured for visits outside the practice premises. The NHS emergency dentist would not attend because of the Covid-19 situation and because the resident did not fit their criteria. The resident's family member stated that travel outside the care home was dangerous for the resident because of her medical condition, so she was left with a plate which caused injury and put her at risk of sepsis.

It is not acceptable that any older person should be left to fall into the gap between NHS and private dentistry in this way, when they are experiencing injury and are at risk of serious illness and death. Health Boards should work with dental practices to identify older people in their areas who are in this position and ensure that they are able to receive the services they need.

On a more positive note, the Commissioner's office recently heard from an inquirer whose husband, a care home resident, had received a visit from an NHS dentist and dental nurse, who used the chair and reading light in his room to carry out a dental consultation. However, the inquirer managed to secure this visit only by contacting her MP. The Commissioner is very concerned about access to services for older people who have no-one able to advocate for them in this way.

In addition, in its implementation report for 2019-20, the Welsh Government had already identified the poor pay levels and insecure contracts of care workers and the fragmentation of the care homes sector as impediments to the programme. System pressures have only increased since then. Capacity issues in dental services in care homes will not be addressed by focussing on the capacity of dental services alone. The wider social care system must also have the resources it needs to support the delivery of dental services to older people in care homes.

The Commissioner believes that it is essential that the Gwên am Byth programme should be reinstated as soon as possible. If Community Dental Service staff are to be redeployed again to the Covid-19 vaccination programme, the Welsh Government should examine the possibility of combining vaccination and dental checks in care homes.

The extent to which patients (particularly low risk patients) are opting to see private practitioners

Several older people who contacted the Commissioner's office have said that they have ended up having private treatment because they were unable to access NHS services. Some report difficulty in finding information about local private practices, as the health board does not provide a list.

The range of NHS dental services available to older people needs to keep pace with older people's increasing need for more complex partial dentures and associated maintenance. The Commissioner has heard from one older person, for example, with dental implants funded through a hybrid arrangement, who had been unable to find a dentist who would maintain the implant after she had moved house. The inquirer had extensive tooth loss and had paid for the materials and manufacture of her implant, while her NHS dentist had provided the fitting without charge. She had not considered at the time whether by doing this she was "going private". The inquirer and her husband subsequently moved closer to their children but within the same Health Board area. She now found herself outside the scope of the NHS and facing a 130-mile round trip for regular servicing and re-alignment because neither she nor the Health Board had been able to find a dentist to undertake the work closer to home. The inquirer was worried about the future, with the journey becoming more difficult as she and her husband grew older. She was afraid of what would happen when her dentist retired, and there was no-one to help. She did not understand why the Health Board did not appear to have a duty of care and continuity of service and had "no sense from the Health Board that there is a vulnerable, elderly human being at the centre of all this." She thought that the solution should lie with the NHS and not with the patient.

The Commissioner agrees. The Welsh Government should ensure that the range of NHS dental services is keeping pace with older people's changing needs. In the meantime, it should not be acceptable for a Health Board to fail to provide an older person with the care she needs within a reasonable travelling distance when she is not able to obtain it for herself. This is especially so when the work was carried out by an NHS dentist and the inquirer did not understand at the time whether her treatment was NHS or private, and when she did not understand the long-term implications of a particular arrangement. Health boards should work with dental practices to identify any other older people within their areas who may find themselves in this situation and offer them a solution.

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

The Commissioner knows that many older people throughout Wales are deeply worried about the cost-of-living crisis and the ways this will impact on their lives.

Several inquirers have raised the affordability of private dental treatment with the Commissioner's office. One said that they paid £47 for periodontal cleaning on the NHS, and that the fee for private cleaning was £120. One inquirer had been dismayed to find that someone else in another town had paid less for the same treatment at a different private practice.

Another inquirer was eligible for free dental care as she was receiving Pension Credit. Her NHS dentist had suspended routine care due to the pandemic but had said that she could be seen as a private patient for a minimum of £15 a month. As a recipient of Pension Credit this was beyond her reach. The Commissioner believes that suspending dental care for the poorest in society and making it available to others who can afford a fee is inequitable and serves only to widen health inequalities.

As well as the cost of dental care itself, inquirers also complained that they had discovered late that the 0300 telephone number to book a Fflecsi bus to get to their appointment was not free. Inquirers pointed out that, with the scheduled bus service, they simply kept to the timetable and used their free bus pass.

The Commissioner has called on the UK Government to provide additional financial support for older people and to deliver longer-term structural change to ensure that the State Pension and other financial entitlements keep pace with rising costs and inflation and provide a sufficient level of income for older people. She has also called on the Welsh Government to take action to tackle the wider determinants of poverty and to provide funding to community groups and charities to deliver support, in particular through identifying and reaching out to older people who may need help, to make sure that they do not go without nourishing food and opportunities for social interaction. In the Commissioner's view, good dental health and care are prerequisites for enjoying a healthy diet and for presenting oneself confidently to others, and must be made available according to need, not ability to pay.

Conclusion and recommendations

Dental health and care are essential to older people's quality of life. The Commissioner has seen that the number of inquiries she receives from older people unable to access the care

they need has risen since the Covid-19 pandemic. Older people should not be left alone, in pain and discomfort, because of a lack of NHS dentistry for which they personally are unable to find any practicable solution.

The Commissioner recommends that:

- The Welsh Government should collect population-level data on the oral health of older people, regardless of whether they use NHS or private dental services, or no service at all. The data should be disaggregated by age band within the overall cohort of older people in Wales;
- The Welsh Government should ensure that the range of NHS dental services available to older people is keeping pace with their changing needs for more complex dentures and associated maintenance;
- The Welsh Government should ensure that all older people are able to access appropriate, affordable, good quality dental treatment, based on need and not on ability to pay, and that no-one falls through the gap between NHS and private dental service provision in the future;
- The Welsh Government should provide funding to community groups and charities to deliver support, in particular through identifying and reaching out to older people who may need help, to make sure that they do not go without the dental health and care they need to enjoy a healthy diet and confident social interaction;
- The Welsh Government and Transport for Wales should ensure that lack of access to transport is not a barrier to older people accessing dental services. Transport for Wales should include dental practices in any new facility for booking return journeys on Fflecsi buses for older people visiting the dentist;
- The Welsh Government and the Community Dental Service should reinstate the Gwên am Byth programme as soon as possible and ensure that care homes themselves are sufficiently resourced to support the delivery of the programme. If Community Dental Service staff are redeployed to the vaccination programme, the Welsh Government should explore the possibility of combining the two;
- Health Boards should work with dental practices to identify anyone in their areas who is unable to secure the dental services they need for themselves and offer them a permanent resolution of their difficulty as close as possible to where they live;
- Health Boards should ensure that older people have reliable, up to date information about dental service availability;
- Health Boards and dental practices should communicate and explain the shift to prevention-led, prudent dental care and what people should expect from their dental practice in a timely, careful and sensitive way;
- Dental practices should communicate with and provide information to older people in a timely, clear and helpful way, recognising the diversity of their communication needs.

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The Older People's Commissioner for Wales

The Older People's Commissioner for Wales protects and promotes the rights of older people throughout Wales, scrutinising and influencing a wide range of policy and practice to improve their lives. She provides help and support directly to older people through her casework team and works to empower older people and ensure that their voices are heard and acted upon. The Commissioner's role is underpinned by a set of unique legal powers to support her in reviewing the work of public bodies and holding them to account when necessary.

The Commissioner is taking action to end ageism and age discrimination, stop the abuse of older people and enable everyone to age well.

The Commissioner wants a Wales where older people are valued, rights are upheld and no-one is left behind.

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Y Pwyllgor Iechyd a Gofal Cymdeithasol
—
Health and Social Care Committee

Y Pwyllgor Plant, Pobl Ifanc ac Addysg
—
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Lynne Neagle MS
Deputy Minister for Mental Health and Wellbeing
Welsh Government

11 July 2022

Dear Lynne

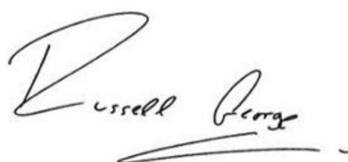
Mental health and wellbeing: Committee recommendations

During the Fifth Senedd, the Health, Social Care and Sport, and Children, Young People and Education Committees did significant and substantial work on the mental health and wellbeing of people in Wales. We plan, through the work of our Sixth Senedd committees, to build on our predecessors' work on these important matters.

As the remits of our Committees overlap in respect of the mental health and wellbeing of children and young people, we are writing jointly to seek an update on our predecessors' recommendations.

We would be grateful if you could respond to the issues raised in the annex by 1 September 2022.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Jayne Bryant MS
Chair, Children, Young People and Education Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Senedd Cymru
Welsh Parliament

Annex: Request for information

To inform our Committees' work on mental health and wellbeing, for each of the reports listed below, we would welcome:

1. An indication of which recommendations the Welsh Government considers still to be outstanding and where further action is needed, whether there are any barriers to implementing these, and if so, what those barriers are.

2. How the Welsh Government's work to implement the recommendations is contributing to tackling mental health inequalities.

We would be grateful to receive your response by 1 September 2022.

Health, Social Care and Sport Committee reports

The Fifth Senedd's Health, Social Care and Sport Committee maintained a determined focus on mental health. In addition to exploring issues relating to mental health throughout its scrutiny of Welsh Government budgets, general scrutiny of health and social care Ministers, and its other inquiry work, the Committee undertook inquiries on:

- Loneliness and isolation (December 2017)
  The report made six recommendations, including: the timescales for developing a loneliness and isolation strategy; a cross-departmental approach (especially in relation to dementia and carers); assessing the impact of loneliness and isolation on mental health and the subsequent impact on public services; working with the voluntary sector to secure funding stability; evaluating the impact of intergenerational contact; and an awareness-raising campaign to change attitudes and address stigma. In its February 2018 response, the Welsh Government accepted four recommendations, and partially accepted two.

- Use of antipsychotic medication in care homes (May 2018)
  The report made eleven recommendations, including: improving data collection and publication; compliance with NICE guidelines; person-centred care assessments for people with dementia; issues relating to medication reviews; access to allied health professionals; dementia care training; and a review of the levels and appropriateness of the use of antipsychotic medication for people with dementia in secondary care. In its July 2018 response, the Welsh Government accepted, or accepted in principle, ten of the recommendations, and rejected one. The Cabinet Secretary provided further information later the same month.

- Suicide prevention "Everybody's Business" (December 2018)
  The report made 31 recommendations, including: suicide prevention training and promotion of existing resources; evaluation and rollout of suicide prevention initiatives and

referral pathways; parity of mental and physical health; an all-Wales triage model locating community psychiatric nurses in police control rooms; follow up care after discharge; waiting times for psychological therapies; a postvention suicide strategy and pathway; engagement with people with personal experience of suicide ideation, survivors of suicide attempts and people bereaved by suicide; targeted actions for at risk groups, including men, farmers, students and prisoners; considerations for planning authorities; media reporting; online safety; governance; and funding. The report also supported recommendations made by the CYPE Committee in its Mind Over Matter inquiry. In its January 2019 response, the Welsh Government accepted 21 recommendations in full, and accepted eight more in principle. Of the remaining two recommendations, some elements were accepted in full, and others in principle.

- Mental health in policing and police custody (October 2019)
  The report made eleven recommendations, including: detentions under the Mental Health Act; partnership working between police and health services; early intervention, mental health crisis and out of hours care; data collection and publication; care and treatment planning; conveyance; and the Mental Health Crisis Care Concordat Assurance Group. In its December 2019 response, the Welsh Government accepted seven recommendations in full, three in principle, and rejected one.

- Impact of the COVID-19 outbreak, and its management, on health and social care in Wales: impact on mental health and wellbeing (December 2020)
  The report made 15 recommendations, including: planning for the short and long term mental health impact on the population and the health and social care workforce; monitoring the impact on self-harm and suicide; disconnects between health boards' assurances and patients' experiences; the mental health core dataset; a bereavement care framework; and urgently evaluating remote digital mental health service provision. The report also reiterated recommendations made in Everybody's Business and the CYPE Committee's Mind Over Matter reports on children and young people's mental health and wellbeing. In its February 2021 response, the Welsh Government accepted twelve recommendations in full, and three in principle. The then Minister for Mental Health, Wellbeing and the Welsh Language wrote to the Fifth Senedd HSCS Committee in March 2021 to provide a detailed update on progress against the recommendations made in the Everybody's Business report.

Children, Young People and Education Committee reports

In a Plenary statement in January 2017, the chair of the Fifth Senedd's Children, Young People and Education Committee, Lynne Neagle MS, stated that members of the Committee were "incredibly passionate about the quality and provision of mental health services for young people". The

Committee carried out work relating to the mental health of children and young people and their families throughout the Fifth Senedd, including as part of the following inquiries:

- Perinatal mental health in Wales (October 2017) and Perinatal mental health – Follow up
  The report made 27 recommendations, including that the Welsh Government: establishes a clinician-led managed clinical network; ensures that robust data is collected and monitored to understand the ongoing level of need for perinatal mental health support; creates a Mother and Baby Unit in south Wales; and explores with NHS England options for the creation of a centre in north east Wales. In its response, the Welsh Government rejected four recommendations, accepted four "in principle", and accepted 19. The Committee carried out follow-up work to monitor the Welsh Government's implementation of those recommendations between November 2018 and March 2021.

- Mind over matter (October 2018) and Mind over matter: Two years on (October 2020)
  The Committee's influential Mind over matter report made 28 recommendations. Its "key recommendation" was that the Welsh Government make the emotional and mental well-being and resilience of children and young people a stated national priority. Other recommendations considered issues such as support for mental health in schools, primary mental health support services, CAMHS services, suicide prevention, inpatient care, advocacy services and expenditure on emotional and mental health services. In its response, the Welsh Government rejected four recommendations, and partially or wholly accepted the others. The Welsh Government's progress against those recommendations two years on from the original report's publication is addressed in the Committee's follow-up report Mind over matter: Two years on.

HSC(6)-06-22 - PTN 2

Lynne Neagle AS/MS
Y Dirprwy Weinidog Iechyd Meddwl a Llesiant
Deputy Minister for Mental Health and Wellbeing

Llywodraeth Cymru
Welsh Government

Jayne Bryant MS, Chair
Chair of Children, Young People and Education Committee

23 September 2022

Dear Jayne,

Update on perinatal mental health inquiry recommendations

Please find attached the latest update in response to the Perinatal Mental Health in Wales report. The then Minister for Mental Health, Wellbeing and Welsh Language provided you with a substantive update on progress against all the recommendations in March 2021, and in January I wrote to you responding to some specific queries from the Committee at that time.

In our previous full update, we confirmed that recommendations 1, 3 and 11 were considered complete. Within the same update we also provided high level responses to those that were previously rejected to provide assurance that this work was factored in as stated within that original response. As part of this we confirmed that we would not expect future updates to report on these recommendations (13, 22, 23 and 24 specifically). Therefore, these seven recommendations are not included in the updated table.

We are expecting to make progress on major milestones within these recommendations in the coming months, this includes receiving the report on the operation of the South Wales Mother and Baby Unit, progress on developing timescales for the commissioning of access to a Mother and Baby Unit for people living in North Wales, and progress on developing the dataset for ongoing monitoring. We will provide more information on these developments in due course.

The next update will also include further detail on how we will be incorporating perinatal mental health into the successor strategy to Together for Mental Health.

Yours sincerely,

Lynne Neagle AS/MS
Y Dirprwy Weinidog Iechyd Meddwl a Llesiant
Deputy Minister for Mental Health and Wellbeing

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

Recommendation - 2. The Committee recommends that the Welsh Government ensure one of the new MCN's first tasks is to agree and publish outcome-based performance measurements for perinatal mental health services. Once these are developed, the Welsh government should collect and publish national and local data on the measures, with service provision, activity and improvement monitored by a named associated body (e.g. Public Health Wales) so that further levers for improvement can be identified and implemented.

Recommendation 4. That the Welsh Government ensure, once the urgent work to establish the level of demand for MBU services is completed as requested by WHSSC, more robust data collection and monitoring methods are maintained across the perinatal mental health pathway in order to understand the ongoing level of need and demand for support and to provide a stronger evidence base for future service development.

Welsh Government has continued to collect data relating to service provision and activity within perinatal services, and the level of demand for placements in Mother and Baby Unit's (MBU) in order to monitor services.

Welsh Government and the National Perinatal Network are now prioritising data collection to ensure the collation of high-level data appropriate for publication. In collaboration with the NHS Wales Health Collaborative, a Perinatal Mental Health (PNMH) Task and Finish Group has been working to prioritise the development and agreement of a Wales Perinatal Mental Health Dataset which will support the publication of this data.

The perinatal mental health data requirements have now been built into the draft core mental health dataset. This has been circulated to health boards to impact test and to understand which elements are already recorded by health boards and which elements would need to be added. This has helped identify any elements which would be difficult to record. The report on this impact testing has now been received by the NHS Collaborative and Welsh Government. The draft core mental health dataset is being considered by the Welsh Informatics Standards Board, and Welsh Government will write out to stakeholders to formally mandate this work when agreed.

In terms of outcome measures for mental health, training and resources to embed the use of patient reported outcome and experience measures in all mental health teams in Wales began in June 2021 and this work will continue to be supported until March 2023. Work to look at performance indicators/ data and outcome measures across the 10 Wales Perinatal Mental Health Pathways has been identified as a priority within the 2022-23 work programme. Further work to agree outcome measures being used across the whole pathway needs to be completed and the Perinatal Mental Health Outcome Measures Framework finalised. This work will be taken through the Mental Health Data and Outcomes Measures Board and will be reported through Together for Mental Health (and successor document).

Recommendation - 5. That the new managed clinical network (see recommendation 1) prioritises the production of guidance for professionals and information for patients on the evidence-based benefits admission to an MBU can have for mothers, babies, and their families so that more informed decisions about treatment options can be taken.

The Royal College of Psychiatrists Wales has produced this guidance; this can be obtained at the following link.

One of the key themes arising from the benchmarking exercise regarding the RCPsych Standards is the continued and updated provision of information / leaflets. Permission has been given to use content from RCPsych leaflets and plans are in place to adapt and adopt for the Welsh context, this includes being available in Welsh and English. The leaflets being developed will include information on - Mental Health in Pregnancy, what Specialist Perinatal Services are, Planning a Pregnancy, Postnatal Depression & Anxiety, Postnatal Depression & Anxiety for Carers, Perinatal OCD, Perinatal OCD for Carers, Post-Partum Psychosis, Post-Partum Psychosis Information for Carers, MBU and Rights, Infant Welfare & Safeguarding/Carers & The Mental Health Act. All leaflets will be available to access online and download from the NHS Wales Health Collaborative website. It is expected that resources will be available from October 2022. This work will remain in the work programme of the Perinatal Clinical Lead.

Recommendations 6. That the Welsh Government, based on the evidence received, establish an MBU in south Wales, commissioned and funded on a national basis to provide all-Wales services, staffed adequately in terms of numbers and disciplines, and to act as a central hub of knowledge and evidence-based learning for perinatal mental health services in Wales.

We have previously confirmed that the Mother and Baby Unit (Uned Gobaith) in south Wales, based at Tonna Hospital was opened in April 2021. There was also a positive event held in June which looked at the achievements and challenges during its first year, which will be used to inform the next steps for the unit. This webinar was hosted by NSPCC Cymru/Wales, the Maternal Mental Health Alliance, Uned Gobaith, and Swansea Bay University Health Board.

As referenced in recommendation 8 we have committed to undertake a review of unit after it had been open for 12 months to ensure that any lessons learnt over this period could be considered to inform future practice. As referenced within the cover letter, we are expecting a report on the operation of the South Wales Mother and Baby Unit in the coming months and this will be reported through recommendation 8. This recommendation is therefore considered closed.

Recommendation - 7. That the Welsh Government, in light of the fact that an MBU in south Wales will not necessarily be suitable for mothers and families in mid and north Wales, engage as a matter of urgency with NHS England to discuss options for the creation of a centre in north east Wales that could serve the populations of both sides of the border. More certainty should also be established by the Welsh Government in relation to the ability of the Welsh NHS to commission MBU beds in centres in England where those are deemed clinically necessary.

There has been significant engagement between Betsi Cadwaladr University Health Board, WHSSC and colleagues in NHS England and the decision is that the development of a joint 8-bedded mother and baby unit in the northwest of England with good access from north Wales is the preferred model to meet needs in Wales . Work is ongoing to further develop this model and WHSSC have confirmed that the current demand / capacity indicates the requirement to fund two beds, and a third on a needs basis. This has been factored into WHSSC's current commissioning plans.

Work is ongoing to develop a business case, and it is expected that the service would be operational around 18 months after final approval. Officials are working with WHSCC to identify any opportunities to accelerate these timescales if possible. We are also working with the provider to support the Welsh language needs of our patients when developing the unit.

Recommendation - 8. That the Welsh Government deliver a clear action plan to ensure that centres providing MBU beds, wherever they are located (in England or in Wales), are closely integrated with specialist community perinatal mental health teams and that these beds are managed, co-ordinated and funded on an all-Wales, national basis to ensure efficient use and equitable access, especially as they are often needed quickly in crisis situations.

We previously committed to undertake a review of the South Wales MBU after it had been open for 12 months to ensure that any lessons learnt over this period could be considered to inform future practice. As part of this process, all specialist teams in Wales were invited to attend a reflection session with MBU colleagues. Team members unable to attend or those needing more time to reflect on the last year have been given an open invitation to provide feedback on their experiences of what has worked well and suggestions for improvements. There are also plans in place for MBU colleagues to meet regularly with all specialist team colleagues. The learning from the South Wales MBU will also be utilised as we develop the provision for those living in mid and north Wales.

Recommendation - 9. That, on the basis of an 'invest to save' argument and following analysis of the forthcoming evaluation of services and Mind-NSPCC-NMHC research results, the Welsh Government provide additional funding to Health Boards to better address variation so that service development and quality improvement can be achieved by expanding existing teams. To enable all community perinatal mental health services to be brought up to the standard of the best, the mechanism adopted by the Welsh Government to allocate additional funding should have as its primary aim the need to address the disparity in provision between Health Boards in Wales

All health boards are now signed up to the Perinatal Quality Network (PQN). This will enable us to ensure teams are working in a consistent manner and to be assured that services are of appropriate standard.

Over the coming months, all health boards will be preparing and participating in their next PQN reviews. Reports received following the review will highlight the strengths and provide advice on any challenges that teams may have.

The National Clinical Lead is working closely with the specialist team leads in the health boards to support and ensure a strong focus on the implementation of the national standards. This will include identifying gaps and actions to be taken to meet the standards, the sharing of good practice and learning and a collaborative, solution-focussed approach to any challenges identified. All of which is shared with the PNMH Board**.**

As part of the additional funding made available to health boards through service improvement funding allocated from this year, we continued to make perinatal mental health services a priority. Welsh Government set out in the terms of funding that submissions should reflect the staffing requirements within the Royal College of Psychiatrist's Perinatal Community Standards (Type 1-3) It is expected that teams will;

- Meet all type 1 standards (by March 2023).
- Meet 80% of type 2 standards and 60% of type 3 standards (by March 2024).

We also confirmed that in line with the Senedd's Perinatal Mental Health Committee Inquiry, that we expected to see each health board have a specialist perinatal mental health midwife.

As part of the additional funding there was an expectation that even if proposals were not submitted in respect to perinatal mental health, there is still an expectation to adhere to the standards as referenced above. In the latest reporting it was indicated that three health boards are fully meeting type 1 staffing standards currently. 3 health boards have the appropriate staff roles in place but do not yet meet the required whole time equivalent staff resourcing. One health board is still working towards having all staff roles in place by March 2023. An additional £500,000 of recurring funding has now been earmarked through this process for perinatal mental health community provision, which builds on previous recurrent investment.

Recommendation - 10. That the Welsh Government ensure work underway on improving access to psychological therapies for perinatal women (and men where necessary) is prioritised given the established link between perinatal ill health and a child's health and development. Priority should be given to ensuring pregnant and postnatal women with mental health problems have rapid and timely access to talking therapies or psychological services (at primary and secondary care level), with waiting times monitored and published. We request an update on progress in relation to improving access to psychological therapies for perinatal women (and men where necessary) within 12 months of this report's publication.

The National Clinical Lead has been involved in discussions regarding the need to review and agree the model of psychological support being offered to parents and families within neonatal units across Wales. This work will be ongoing throughout 2022-23.

The Welsh Government are working with HEIW and Improvement Cymru to continue to develop the infrastructure to support health boards to improve access to psychological therapies. This work will ensure that we have a robust process to consider the evidence base of interventions that underpin Matrics Cymru and Matrics Plant.

We remain committed to publish waiting time data on specialist psychological therapies, but this work has been delayed during the pandemic. Whilst the data is not yet robust enough to publish, operational data is reported by all health boards and used by the Welsh Government to hold services to account. The waiting time data that will be published only reflects one element of access to psychological therapies – the specialist services. Data is already published for Local Primary Mental Health Services, which includes psychological therapies and we have strengthened low level support, for instance through the introduction of online Cognitive Behavioural Therapy (Silvercloud) – another form of psychological therapy**.** A pilot of the new Silver Cloud Space for Perinatal Health & Wellbeing Programme has also recently started in Powys. In order to gain an accurate understanding of activity and waiting lists, the Welsh Government has recently commissioned the NHS Delivery Unit to undertake a review of Psychological Therapy delivery across Wales.

The Women's Health Implementation Group recognised in 2021 there was an opportunity to partner with the Perinatal Mental Health Network. Amongst the 107 recommendations of the WHIG Programme, there were 6 specific references to mental health and wellbeing within the recommendations for both the woman and the man during the perinatal period.

The Women's Health Implementation Group and the Perinatal Mental Health Network have been leading a project to support women and their families during the perinatal period. WHIG & PNMH will develop and create resources co-productively, that are Wales specific to encourage discussions about perinatal wellbeing in a home and clinical environment, for families and their supporters. The project has reached out to people throughout Wales to gather their views, experiences and hear people's stories with regards to physical and mental health and wellbeing during the perinatal period. Interviews with people; both people who are contemplating pregnancy, are currently pregnant or have been pregnant, and their supporters; whether husband, wife, partner, parents or siblings - have been conducted in Welsh and English. The project will be analysing all findings to showcase insights that will lead to the resources being branded and created, to share via focus groups with community members throughout Wales.

In addition to this project, significant activity has been led by the Perinatal Mental Health Network to review and redesign the pathways across Perinatal Mental Health, with partner stakeholders, third sector organisations and members of the community.

Recommendation - 12. That the Welsh Government ensure that the new all-Wales clinical care pathway for perinatal mental health services requires consistency of outcomes (including referral windows and waiting times) but enables Health Boards to retain the level of flexibility around delivery methods necessary to manage and meet local need. The priority should be to develop and implement within the next 12 months an evidence-based, integrated all-Wales clinical care pathway (with some local differences). The pathway should help to deliver integrated services and incentivise early intervention and holistic approaches to care and recovery.

The 10 Wales PNMH Care Pathways, programme and animation were shared in June at the Wales Perinatal Mental Health Community of Practice. The pathways have initially been shared with colleagues to allow them the opportunity to familiarise themselves with them and to 'test the change' for a period of 6 months. An evaluation form has been developed to enable colleagues across Wales to offer feedback, with any necessary changes being made before launching more formally at the beginning of 2023. Awareness raising and testing of the pathways is being supported by Perinatal Mental Health Champions.

A clinical resource guide has also been developed to support the embedding of the ASK, ASSESS and ACT model and this is in the process of being translated into Welsh before being shared with midwifery, health visiting and primary care teams.

Further work to identify the data required to demonstrate the difference these pathways will make has commenced. This will ensure that the right care is being provided at the right time and by the right people and will include identifying and agreeing key performance indicators, outcome measure tools, secondary/ branch pathways, awareness raising and any additional training required. This work has been highlighted and included in the 2022-23 delivery plan.

The pathways, programme and animation are hosted on the NHS Wales Collaborative website - Perinatal Mental Health Programme and Pathways - NHS Wales Health Collaborative

Recommendation - 14. That the Welsh Government review information provided in standard pre- and post-natal packs given to women in Wales to ensure that it includes the necessary details about emotional well-being, perinatal mental health and where to seek help and support.

Public Health Wales colleagues are currently reviewing and updating the Bump, Baby and Beyond resource and planning their next steps in delivering the new pregnancy and birth resource. They are currently sharing with members of the quality assurance group and National Clinical Lead, to ensure that feedback given previously still reflects guidance and best practice. Digital Health and Care Wales have undertaken a scoping exercise for Digital Maternity Cymru, around the development of a once for Wales maternity information system that will provide women with access to their notes and public health information. This is currently awaiting confirmation to progress into programme stage.

Recommendation - 15. That the Welsh Government design and provide for all Health Boards a national framework for antenatal classes and require Health Boards to do more to encourage attendance. The framework should include conversations about emotional wellbeing and the realities of parenthood in order to break down the significant and damaging stigma surrounding perinatal mental illness.

In July 2019 the Minister for Health and Social Services, published a Future Vision for Maternity services strategy (2019 to 2024). This Vision has been the result of many people coming together to refresh our model of maternity care-based on the current available evidence, best practice and feedback from families and frontline staff to design and further improve existing services.

Within the Vision, it confirmed that health boards will work in conjunction with Public Health Wales and local public health teams to develop, implement and evaluate evidence-based programmes that engage women in a number of areas such as improving parental and infant health and wellbeing, including mental health. This will include a commitment to delivering pre-pregnancy counselling (where appropriate),

Work streams are being led by the Maternity and Neonatal Network to understand the current status of provision in each health board and develop models of provision in various formats (virtual and face-to-face). This work has included the Perinatal Mental Health Network as key stakeholders to inform development of provision. This work is informing the ongoing work of health boards in developing both online and face-to-face materials which are accessible to women. This work will be a key element incorporated into the Digital Maternity Cymru model. Welsh Government are undertaking a review of the Vision as part of the maternity and neonatal safety support programme which has commenced a phase 1 diagnostic element together with Improvement Cymru to identify key issues impacting on safety and positive outcomes for families.

Recommendation - 16. That the Welsh Government works with the relevant bodies to ensure that perinatal mental health is included in the pre-registration training and continuous professional development (CPD) of all health professionals and clinicians who are likely to come across perinatal women. The Welsh Government should ensure coverage of perinatal mental health as a discrete topic within midwifery and health visiting education is improved and forms part of the pre-registration mental health nursing programme. The Royal College of General Practitioners' core curriculum for general practice training also needs to better equip GPs to deal with perinatal mental health problems.

It has been agreed by the PNMH Task & Finish Group that the Scottish Competency Framework, Training Plan and online modules will be used in Wales. Having received NHS Education Scotland (NES) agreement a memorandum of understanding for the seven introductory level modules from NES has now been signed for the modules to be hosted on the 'Learning@Wales' platform. Work to adapt all for the Welsh context is underway, with a plan to complete this work and have it ready for a 6-month testing period with the specialist perinatal mental health teams in autumn 2022.

Once the modules are ready, there will be a 'test the change' for 6-months, making any necessary adaptations, with a view to sharing formally across Wales at the beginning of 2023.

Work continues to improve uptake of the Institute of Health Visiting (IHV) training modules package to ensure all colleagues have the opportunity to access appropriate perinatal and infant mental health training. This training is also reflected in the new Wales PMH training programme.

The Wales Perinatal Mental Health Network, with input from working GPs, continues to explore how to provide training and education to support GP colleagues in caring for patients with perinatal mental health difficulties. A short survey was undertaken to help identify GP training needs and preferences. Colleagues have started to shape training content and work is happening with colleagues in HEIW and NHS England to explore the introduction of a GP Champion model across Wales.

The National Clinical Lead has also met with the Lead Midwives for Education to think more about how training is offered to pre-registration students and PMH Champions have linked with universities and are providing updates, information and training when requested. Plans are now in place to undertake scoping work which support us to get a clearer understanding of who is linking with what universities and what is being offered. This will allow the network to then think about what a Wales-wide plan could be to provide a consistent approach to pre-registration PMH education.

Recommendation - 17. That the Welsh Government undertake work to develop and deliver a workforce strategy/competency framework to build capacity and competency across the specialist workforce, looking to experience in England and Scotland's Managed Clinical Networks (MCNs) which take responsibility for training as part of their leadership and co-ordination role.

Welsh Government commissioned Social Care Wales (SCW) and Health, Education and Improvement Wales (HEIW) to develop a mental health workforce plan, which includes NHS, local authorities and the voluntary sector. HEIW and SCW engaged extensively with stakeholders to develop the draft plan which ran from 1 February to 28 March 2022. HEIW /SCW have now provided a costed plan to the Welsh Government for formal consideration. It is anticipated that the plan will be formally published in the autumn. HEIW are developing a more detailed implementation plan as well establishing a number of steering groups and workstreams following the launch of the plan, to oversee and support its delivery. Alongside this they have also undertaken specific work in relation to perinatal, as referenced in the previous update.

Recommendation - 18. That the Welsh Government ensure every Health Board has a specialist perinatal mental health midwife in post to encourage better communication between professionals to enable women who are unwell to get the very best care and support they need.

All health boards now have funding and posts for the Specialist Perinatal Mental Health role. All health boards now have specialist perinatal midwives in place. The National Clinical Lead facilitates a specialist perinatal mental health midwifery forum, which provides midwifery colleagues working within specialist perinatal mental roles with the opportunity to come together to reflect, learn, share best practice, and identify challenges and solutions.

We now consider this recommendation closed and will be monitored as part of 'business as usual' arrangements.

Recommendation - 19. That the Welsh Government ensure all Health Boards work towards a situation in which every woman has a continued relationship with either a midwife or health visitor. While meeting with the same individual may not be possible on all occasions, continuity of care should be an aspiration to which all Health Boards actively commit resources, with a named lead responsible for each woman's perinatal care.

The 'Future Vision for Maternity Services in Wales' was published in July 2019 and lays out the vision for the next five years. Continuity of care and perinatal health are core elements of the Vision. Work streams led by the maternity and neonatal network are developing work to further enhance the services provided to women and families.

WG have commissioned a review of the Birthrate plus acuity tool which is reaching a conclusion and is due to report in autumn 2022 and will provide modelling of future staffing requirements to deliver the Vision in Wales. The Minister for Health and Social services also launched in January 2022 the Maternity and Neonatal Safety support programme which during the discovery phase will review all aspects of service provision including perinatal and midwifery support, led by Improvement Cymru this will provide recommendations for future improvements in delivery. The development of Digital Maternity Cymru will provide data on all aspects of care including continuity.

In respect to Health Visiting, we continue the commitment in the national strategy "to create a more joined up, responsive system that puts the unique needs of each child at its heart", work has continued throughout the pandemic on the programme of work to explore how we create an early years' system, both locally and nationally, working with health boards and local authorities on pathfinder projects and more recently a phased expansion of Flying Start. Our aim is to develop a coordinated single approach to early years, which will ensure that services are delivered in a more collaborative and integrated way. This programme of work has underlined the key role the health visiting service has in supporting families, especially in identifying those in need of extra help. Associated with this work is the development of a workforce acuity tool for health visiting to determine appropriate caseload levels and associated workforce requirements according to identified needs of families. This work is progressing and supporting an assessment of future workforce needs.

The Healthy Child Wales Programme provides a universal range of health visitor contacts for families with children aged 0-7 irrespective of location in Wales, with enhanced and intensive interventions delivered to those families and children with increased levels of need.

During the course of the pandemic the health visiting service (Flying Start and general services) have worked together to issue regular guidance setting out clearly what its expectation was in terms of delivery of the programme, emphasising that certain core contacts should be maintained and that where families were identified as needing more support, or where there were safeguarding concerns.

Recommendation - 20. That the Welsh Government work with Health Boards to ensure appropriate levels of third sector provision are properly funded, especially where referrals are being made to and from statutory services. A directory of third sector services should be made available to increase awareness of their availability and relevant third sector providers should be invited as a matter of course to attend training jointly with statutory services.

The PNMH network continue to deliver the third sector and voluntary organisation coffee and catch ups, with new members been identified and invited on a regular basis. To strengthen service user and family voice and ensure services user voices are represented across and within the Wales Perinatal Clinical Network, the National Clinical Lead is working in collaboration with the Maternal Mental Health Alliance (MMHA's) Champion Network to increase the number of Welsh Champions. All specialist PNMH midwives have been encouraged to link with their Maternity Service Liaison Committees and Communications and Engagement colleagues.

The National Clinical Lead is working with partners to consider the need of third sector provision for parents with mild-moderate mental health difficulties. A scoping exercise to further understand what community services are available for this level of need is underway.

From the early findings of the National Collaborative Commissioning Unit's (NCCU) mapping work in primary care (part of the Strategic Programme for Primary Care Mental Health) and the analysis of data from SilverCloud and CALL we are aware that demand for tier 0/1 continues to increase, especially for those with anxiety and depression and other common mental health issues.

We have therefore strengthened our arrangements to support voluntary sector provision and from October the following arrangements will apply
- We will have a central budget to commission national, all Wales support based on need and evidence to fill gaps in provision.
- Increased funding to health boards explicitly for third sector provided mental health support. This includes allocating additional funding for tier 0/1 support and support in primary care.
- Providing increased and recurrent investment for priority work for health boards in partnership with third sector, for instance alternatives to admission, including sanctuaries.
- Providing additional funding for a small grants scheme for suicide and self-harm prevention work. This will be led by the National Suicide and Self-Harm Prevention Co-ordinator and more details will follow on this shortly.

National opportunities for funding will be advertised widely to enable organisations who wish to register their interest and with sufficient notice to allow smaller organisations to collaborate.

As stated within the Programme for Government, in order to provide effective, high quality and sustainable healthcare, we are developing an all-Wales framework to support local action to mainstream social prescribing. The framework will outline what best practice looks like in terms of an accepted Welsh model of social prescribing but will not dictate how that is delivered in different communities. We are aiming to understand what the framework can do to add value to social prescribing in Wales and identify what work we in Welsh Government might be able to do to support once-for-Wales activity, for example this might be through supporting use of technology. Co-producing the framework is also key in developing the model to ensure solutions are developed at a regional level and making sure that whatever is developed is fit for purpose and doesn't inadvertently widen health inequalities.

Recommendation - 21. That the Welsh Government outline within six months of this report's publication how it expects the lack of psychological support for neonatal and bereaved parents to be addressed and standards to be met, and what steps it will take if compliance with the standards is not achieved. The third edition of the neonatal standards should be published as a matter of priority.

The All-Wales Neonatal Standards outline the requirements for delivery of high quality, person centred, safe and effective care. They are designed to provide a framework for units to assess quality service provision at local level and also to benchmark across other units in Wales. The 3rd edition of the standards were published in 2018.

In 2019 the Wales Neonatal Network developed neonatal peer review quality indicators which followed the six domains of quality healthcare. They were developed using the Wales Neonatal Standards 3rd Edition; British Association of Perinatal Medicine (BAPM) Neonatal Service Quality Indicators 2017; Bliss Baby Charter, Toolkit for High Quality Neonatal Services 2009 and the

Neonatal Critical Care Quality Indicators, Quality Surveillance Team (NHS England). An updated set of Quality Indicators is being developed that will consolidate these documents into a best practice document.

The National Bereavement Steering Group chaired by Dr Idris Baker, the national clinical lead for end of life care is well established and comprises of a wide variety of third sector organisations providing bereavement support to children, young people and adults, those affected by baby loss, sudden death, suicide and all types of bereavement. The National Framework for the Delivery of Bereavement Care in Wales, published in October 2021 sets out how in Wales we can respond to those who are facing, or have experienced, a bereavement. The framework includes core principles, minimum bereavement care standards and a range of actions to support regional and local planning. It also includes a section on learning from COVID-19 and the distress felt by many people who lost loved ones during the pandemic. It is written for those responsible for commissioning and providing bereavement support, as well as for bereaved people themselves.

We have made significant investments in bereavement services during and since the pandemic and driven a number of activities to improve bereavement care across Wales. A £3m Bereavement Support Grant for third sector organisations is being provided over the three-year period 2021-24 with 21 organisations receiving funding, including organisations such as 2 Wish, Sands and Bliss who work hard on a daily basis to support families who suffer the heartache of losing a baby, child or young person. An additional £420k (£60k each) is also being made available to local health boards (LHBs) in 2022-23 and 2023-24 to help with bereavement co-ordination and we are now working closely with recently identified named bereavement leads in each LHB.

As part of our work to implement the framework we are working with LHBs and a number of partners to develop a national bereavement pathway for Wales. These pathways will provide information and guidance to LHBs and everyone involved in bereavement support provision, to promote a consistent approach for accessing bereavement support across Wales. We have developed an “overarching” pathway and the first of our specific pathways relating to sudden and traumatic death for children and young people, with the next pathway being developed relating to pregnancy and baby loss. This should ensure that anyone who experiences a bereavement, wherever and whenever it happens, will be provided with information on how to obtain further support should they need it, whether that is practical, financial or emotional support. Once these pathways are embedded, a range of bereavement care standards will be implemented and monitored.

The National Clinical Lead has encouraged colleagues in the Specialist PNMH teams to link in with bereavement midwives and the work that is being undertaken across health boards and made links/ met with colleagues lead on the development of the national bereavement pathways.

Work will be undertaken through both the bereavement pathway provision and the further development of psychological therapies work streams and thus consider that this separate recommendation can now be closed.

Recommendation - 25. That the Welsh Government ensure all workforce planning for perinatal mental health service provision considers - and provides for - the Welsh language needs of the population.

The Welsh Government recognises that receiving services through the medium of Welsh is a key component of care, especially for the more vulnerable and in key services such as mental health. *More than just words* is the Welsh Government’s strategic framework to strengthen Welsh language provision in health and social care.

A new *More than just words* plan 2022-27 was published on 2 August 2022. Its aim is to support Welsh speakers to receive care in their first language. According to our research, for many Welsh speakers being able to access services in Welsh significantly improved their overall experience and, in many cases, improved their health and wellbeing outcomes.

At the core of the strategy is the principle of the Active Offer. It places a responsibility on health and social care providers to offer services in Welsh, rather than on the patient or service user to have to request them. The plan has been developed by an expert group, following an independent evaluation of the first *More than just words* five-year plan. Implementing the new *More than just words plan* is the responsibility of everyone in their respective fields. Progress against the actions will be monitored by a new advisory board.

Welsh language services provision is also a theme of the HEIW / SCW workforce plan referenced above. As this recommendation is being delivered as business as usual, we now consider this recommendation closed.

Recommendation – 26 That the Welsh Government require Health Boards to report on the extent to which their perinatal mental health teams are engaging - and undertaking joint work - with other services such as CAMHS, Community Addiction Units (CAUs) and primary and secondary care mental health teams

This is being taken forward as part of the development of the Perinatal Mental Health pathway outlined in recommendation 12, as part of the engagement undertaken in relation to this work additional areas of need were highlighted. We are currently working with colleagues supporting individuals in areas including learning disabilities/ neurodiversity/ CAMHS/ alcohol and substance misuse/ primary and secondary care to enable pathways to be put in place to ensure equitable access across Wales.

The NCL has facilitated the development of pathways between Eating Disorder and CAMHs services. Further work needs to be undertaken to do the same for other services e.g. Community Mental Health Teams, Crisis Resolution and Home Treatment Teams and Psychiatric Liaison. Recent links and discussion has also taken place with Substance Use Policy Leads, CASCADE and Parent-Infant Mental Health Network Cymru.

Recommendation - 27 That the Welsh Government undertake further work on the link between health inequalities and perinatal mental health, focusing in particular on the best mechanisms for the early identification and treatment of those populations in greatest need.

The Together for Mental Health Ministerial Delivery and Oversight Board for Wales continues to consider and take account of the latest evidence in its work. The forthcoming Welsh Health Equity Solutions Platform of the Welsh Health Equity Status Report initiative will provide another tool to assist the Board in its work on health inequalities. The Solutions Platform is a cross-sector multidisciplinary online portal which will bring expertise, evidence, stakeholder insights, good practice, tools and sustainable approaches together, informing solutions and accelerating action to help reduce health inequities and improve health and well-being. This information will be used to inform our new mental health strategy. We also recognise that the Health and Social Care committee inquiry into mental health inequalities is ongoing and will also inform future direction.

We now consider this recommendation closed.