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

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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.

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.

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

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.