	Abertawe Bro Morgannwg University Health Board [ABMU] response to the Health, Social Care and Sport Committee's inquiry into dentistry in Wales
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Date created	30 August 2018

Introduction

1. Abertawe Bro Morgannwg University Health Board [ABMU] welcomes the opportunity to respond to the Health, Social Care and Sport Committee's enquiry into dentistry in Wales. The information and views set out below have already informed inform the Wales-wide report from the Welsh NHS Confederation but are provided in full to reflect a perspective on oral health care services provided and commissioned in the Swansea, Neath Port Talbot and Bridgend county areas. The submission comprises responses on the specific issues the Committee requested in 39, numbered paragraphs across 9 pages.

Welsh Government's Dental Contract Reform

2. In 2017 four of 95 general dental contractors in the ABMU area volunteered and met the locally developed criteria to test out a Wales-revised version of the 2005 General Dental contract which aims to reduce the disincentives to providing holistic, preventive care that are inherent in the original. The problems associated with the 2005 contract are described in other submissions to the Committee. They were so significant that pilots of three alternative models were being piloted across Wales within three years of its inception. By 2011 only ABMU was content to pursue a more effective alternative and continued to support two practices operating without an 'activity' target with very positive results in terms of treatment and access. These two 'Prototype' practices are now providing both a helpful foundation and in-built control test for the dental contract reform programme introduced from September 2017. The six reforming practices (four Contract Reform and the two Prototypes) have, for the past year, formed a ABMU Contract Reform group, supported by the Health Board, Public Health Wales and Chief Dental Officer to share learning, and views on the proposed programme, its benefits, potential pitfalls and how it can be taken forward. ABMU is represented on the Chief Dental Officer's national contract reform group through the Dental Director and Primary Care Manager who has driven and supported much of this work locally.

3. The ABMU pre-2017 legacy is that, from 2011 onwards the two Prototype practices had their standard Unit of Dental Activity [UDA] target removed from their contract and were instead paid on a Capitation and Quality Payment which focused on patient numbers and promoting prevention. Recording of activity on a UDA basis continued as a background check. The practices introduced a new Dental Care Assessment service, increased the focus on prevention, recalled patients based on NICE clinical guidance (rather than fixed 6 month periods) and scored

patients' oral health cards as Red/Amber/Green to give clear indicators of the patients' journey and facilitate a genuinely co-produced plan. Five stages of treatment were identified following assessment and planning: Urgent care, Risk Reduction, Stabilisation, Restoration of Function and Advanced Care. This allowed Practice teams to review the patient's progress with them before committing to providing advanced care, e.g.crowns, implants. The Prototypes also tested a more equitable system for patient charge revenue and allayed fears associated with that aspect of the pilot. By 2017 it had been demonstrated successfully that removing the UDA as a driver from these practices gave clinicians more freedom to make decisions, using their own clinical judgement about what was in the best interests of their patients. Once established, it became evident that more new patients were being seen and the proportion of patients provided with advanced treatment had reduced.

4. The national dental contract reform programme launched in 2017 built upon the Prototypes as well as experience introduced from elsewhere in the UK. They were joined by four other practices in ABMU (14 across Wales) to test a 'blended' contract methodology which comprises a compromise between the GDS contract and the prototype described above. Phase 1 of the contract reform programme (September 2017 – March 2018) reduced, but did not eliminate, the UDA target by 10%, easing the time/financial pressures on practices to enable them to complete and submit clinical profiles on all patients assessed and treated.

5. The six, very different, practices who comprise the Phase 1 Contract Reform group hold a total contract value of approximately £2.2 million to deliver almost 87,000 UDAs or equivalent. The UDA rates per practice varied from £23.13 - £38 (average £26) for contracts ranging from 5,800 to 34,500 UDAs. Between them, they can provide a true test of what might be deliverable with contract restrictions lifted to varying degrees.

6. In June 2018 Public Health Wales colleagues produced and shared the initial draft of the practice-based patient and practice profiles drawn from the data collected by the practices. Further, more detailed profile information that will support decision making, factoring in practice size, contract value etc., is awaited from year-end returns. However that available to date indicates that the Health Board and Practices can be confident in reducing further UDA targets in return for specific quality initiatives to secure greater, more appropriate, patient access to General Dental Services with improved health outcomes.

7. The reform programme has, as an aim, that 10% of Wales' practices will be testing the blended contract by 31 March 2019. The current thinking within ABMU is that the next phase of the reform project, from October 2018, will seek to reduce the contract targets by 10% in at least two more practices* and drop further the UDA target in the phase 1 practices in return for specific quality initiatives, some of which are already being explored. Some examples discussed within the Primary Care team and/or contract reform group to date include initiatives that could:

    - improve practice sustainability and retain Dental Foundation trainees in struggling practices
    - improve patient access to general dental services with demonstrable increases in unique patient numbers (in contrast to current high levels of repeat attenders) and/or
    - support enhanced skills training of General Dentists to help reduce what are currently secondary care waiting times for treatment which could be delivered out of hospital.

    *NB 10% of contractors in Swansea and Neath Port Talbot = 8. There are currently no contract reforming practices in Bridgend county.

8. ABMU is aware that not all practices are in a position to embrace the multi-disciplinary approach upon which a holistic model of service depends. This is particularly the case in those who are single-handed and/or operating in small premises that cannot accommodate additional staff, e.g. hygienists, therapists, dental nurses. As an integral part of its service planning and development in 2018/19 ABMU will undertake a survey, jointly with the Local Dental Committee, of practice staffing and facilities to help gauge the extent to which practices are in a position to remodel the services they provide.

9. It is the view in this Health Board, based on experience to date with the Prototype Practices and the wider contract reform, that the changes have resulted in improved access, especially for the most vulnerable, and the nature of the care provided has been driven more by individual need than a contract target. However, as the programme is rolled out it is important that it is underpinned by robust governance and that changes for individual practices are based on the needs of the local population and not simply an 'all-Wales' framework. Experience from the Prototype practices should be shared nationally and these practices should continue to drive and test innovation. Local management teams will need to ensure they have the resources and the capabilities to support the changes and provide reassurance to Health Boards and Welsh Government.

How 'Claw back' money from Health Boards is being used

10. Since February 2017, investment of all ABMU's funding for primary and community dental services has been guided by a three-year oral health service and financial framework. Now known locally as the Oral Health Delivery plan, its broad plans and progress to invest an increasing amount of the ring-fenced budget up to the full allocation in 2020/1, including contractual recovery monies, referred to above as 'claw backs' - is summarized from 12. below. The reasons why a three-year approach to budget setting and management was both necessary and beneficial lie in the constraints imposed by the General Dental Services [GDS] Contract and local circumstances.

11. The GDS Contract requires Health Boards to pay practices 100% of their contract if they have delivered at least 95% of contractual activity, as expressed in Units of Dental Activity [UDAs]. It is also at Health Boards' discretion to pay contractors for over-performance of up to 105% against their contract. ABMU chose not to recognize over-performance in 2016, primarily because concerns had emerged in the preceding two years about inappropriate contracting practice by a significant number of dental contractors. However the removal of the potential reward for over-performance was a disincentive for many contractors to achieve more than 95%. Many achieved significantly less than this with consequent 'claw backs' required.

12. In 2016/17 ABMU's underspend of the Welsh Government [WG] ring-fenced general dental budget reached almost 7% for a variety of reasons *including* the recovery of monies from contractors who had delivered less than 95% of their contract at year end. A decision made in 2016 to commission all dental activity in ABMU HB via a formal procurement process to improve governance meant that it was not feasible to offer out the recovered funds to contractors willing to undertake additional activity in-year. The formal procurement process replaced an informal arrangement whereby the primary care management team wrote to dentists who met particular criteria (eg location, performance) to gauge interest in undertaking more activity on a non-recurring basis, then awarded it. Delivery of a formal procurement process requires significantly more investment of primary care and procurement management time. Consequently, the whole

of the 2016/17 underspend contributed to supporting the Health Board's overall financial position.

13. Action to prevent a recurrence of this situation was taken from early 2017 to prevent. The offer to pay over-performing contractors who met specific criteria was reinstated, and a three-year investment plan, informed by contract monitoring returns and trends, was developed and agreed within the Health Board in February 2017. This proposed increasing expenditure on dental services in three large steps to ensure the whole dental allocation was invested in oral health care by 2020/1. It was not feasible to achieve this sooner within the existing management resource.

14. The plan was revised in June 2017 when, as a consequence of ABMU's level of underspend, Welsh Government withheld contract uplift monies and increased the patient income target. This had the result of halving the additional monies available to invest in dental services. The revised plan demonstrated how the Health Board would succeed in spending the additional monies that remained and received approval within ABMU (June) and Welsh Government in September 2017. The plan includes a range of service and financial of initiatives to achieve the following broad objectives:

    1. Improve the Oral Health of vulnerable groups, e.g. children, adults in care homes,
    2. Improve equity of access to general dentistry
    3. Reduce variation in dental pathways
    4. Improve access to special care dentistry
    5. Reduce referral to treatment times in restorative dentistry
    6. Improve governance and leadership
    7. Improve compliance with key legislation

15. Through a mixture of schemes, ABMU made significant progress on a range of improvements against objectives that had been prioritized for years 1 and 2:

    - Increased UDA value to £25 for 43 practices who agreed to a range of quality initiatives
    - Commissioned additional activity (30,000 UDAs) in 7 practices in high need areas including new practice in Port Talbot from 2018/19
    - Halved children-only contracts, rewarding practitioners who 'converted' to full range of patients with a higher UDA rate
    - Introduced Referral Management Centre [RMC] and new paediatric pathway to support referrals for treatment under a General Anaesthetic, savings from reduction in latter being reinvested in building alternative pathway
    - Transferred resources to the Community Dental Service recognizing its contribution to providing domiciliary dental services in Bridgend county (only) and to support the new paediatric pathway
    - Enhanced Clinical leadership and management, investing in additional Dental Practitioner sessions, Clinical Leadership roles in Community and Restorative Dentistry and primary care management support.
    - Supported practices to comply with the Equality Act through award of improvement grants to introduce hearing loops, disabled access; commissioned bariatric waiting and toilet facilities in Port Talbot Resource Centre.

16. At 2017/18 year end, it was confirmed that the ring-fenced GDS budget had underspent by less than 2%. The Health Board's overall underspend on dental services (inclusive of General, Community and Restorative Dental services) was also less than 2% and demonstrated an

increase in expenditure towards full investment by 2020/21. ABMU had achieved the twin aim of investing in dental services, whilst also containing plans to ensure they were affordable to the Health Board.

17. In 2018/19, Welsh Government increased the dental allocation to restore the element withheld in 2017/18 on the basis of the demonstrable investment in dental services. However ABMU is not complacent: the advice received in July from Welsh Government colleagues that there needed to be an increase in expenditure in GDS from the level evident at the end of June is taken seriously. The Health Board is confident, and has provided assurance, that the further roll out of its Oral Health Delivery Plan will increase expenditure of the ring-fenced allocation and overall oral health service budget, as a consequence of the full year effect of the initiatives summarized above plus the following:

    - Introduction of an enhanced new dental service for HMP Swansea
    - Further development of new dental service to improve access by asylum seekers
    - Completion and introduction of a new, integrated, pathway and associated service specification for domiciliary care
    - Additional investment and reinvestment in paediatric pathways as consequence of changes made to date and impact of WHC(18)009
    - Remodeling of Restorative Dentistry service, creating intermediate care model with support of additional Dentists with Enhanced Skills

18. Additionally, the plans to invest the dental allocation in 2018/19 (inclusive of contractual recoveries) will include initiatives that did not feature in the original plan but which are considered appropriate to reflect emerging service issues. Notably, concerns about long-term primary care sustainability (referenced at 8. above and 22 below) have resulted in the development of General Dental Practice Fellowship to retain and train young dentists.

19. ABMU will be recovering more monies from contractors for 2017/18 than in the previous year, but this is as a direct result of significant underperformances in a few large contracts, reported by the providers as being the result of vacant dental posts. Proactive contract management, reducing the traditionally underperforming contracts for restricted groups (e.g. children only) if the contractor would not accept all groups of patients also had an impact. It is hoped that increasing intelligence around practice prescribing profiles, local population needs and regular engagement will reduce the need for 'claw back' will reduce in future years. It is also considered that the lines between General, Community and Hospital Dental Services will become less distinct than the historical position. ABMU is actively engaged in integrating the delivery of services and pathways across these areas. This is enhancing scope to deploy specialists to work alongside General Dental Practitioners in primary/community settings, and the development of intermediary services means that dental budgets will need to be considered as a whole rather than ring-fenced to service areas.

Issues with the Training, Recruitment and Retention of dentists in Wales

20. Although some corporate practices have reported that they experience problems recruiting dentists, recruitment is not yet felt to be a major problem in the majority of dental practices in ABMU. However, there is increasing awareness that this is changing in dentistry as in other areas of healthcare. Retention issues amongst the young is now seen as a problem, and the impact of likely retirements amongst senior dentists will need to be quantified and tackled. For example, the 14 training practices have all reported difficulties retaining their Dental Foundation trainees

and, particularly as this problem has been common to all types of practice, including the Prototypes last year, it is felt that this is a consequence of the disincentives associated with the UDA Target-driven GDS contract but also the UK-based allocation of training places. There is also a perception that many young dentists no longer aspire to take on the responsibilities of running a practice. ABMU's Post Graduate Training Unit at Port Talbot has trained 35 postgraduate dentists since completion of its first course in 2010, of which 9 are still working in the ABMU area (two within the Community Dental Service). Work is ongoing to confirm the retention rate for those trained in ABMU's 13 other training practices that would help gauge whether this should be considered a cause for concern, but it is understood that the retention rate generally is significantly less than at the Training Unit and is reducing.

21. ABMU was therefore keen to work with the Deanery to introduce, in September 2015, a 'longitudinal' training programme based around ABMU and Cwm Taf's Dental training units with rotations into practices that provided intermediate care (oral surgery) and the Community Dental Service. The hope was that a two-year training period would provide sufficient time and incentive to encourage trainees to establish roots in the area. However, this proved no more successful than the previous experience and, being as complex to undertake to deliver, the training programme reverted to one year's duration from September 2017.

22. As ABMU has concerns about this issue, it has developed and will pilot a three year General Dental Practitioner Fellowship from September 2018, linked with the Contract Reform programme. Expressions of interest were sought from individual practices and Dental Foundation Trainees themselves to receive funding which would support their placement and training as a Dentist with Enhanced Skills who could contribute to both the practice and the overall requirements of oral health services within ABMU. In 2018 the placement is being offered to train in the provision of Endodontic services (assessment and treatment of root canal disease) through the ABMU Restorative Dentistry-provided MSc course in endodontics and working alongside specialists in an intermediary setting. It is hoped that the chosen individual, as well as some of the annual cohort of six MSc-trained dentists, will be able to strengthen the skill-base of primary care dentistry and ensure that less patients need to be treated in hospital, with consequent reductions in waiting times. If successful, it is hoped that in subsequent years the scheme will attract dentists in other dental sub-specialties, e.g. oral surgery or oral medicine and allow a wider development of Dentists with Enhanced Skills.

23. The introduction of Dental Contract Reform and more use of a varied skill mix in dental practices requires the development of national and local workforce plans to ensure there is sufficient supply of these individuals to support dental practices. As indicated at 8. above, it is also important that practices also have the physical capacity in which they can work – hence the reference to review physical as well as staff capacity in general dental practices, lest it is a barrier to dentists wishing to adopt contract reform.

24. There continue to be difficulties in recruiting and retaining specialists and consultants in the recognized specialities – and some specialities do not exist outside the Dental Hospital in Cardiff. In ABMU it is considered that there is a need to develop more intermediary services as part of specialty-led managed clinical networks. This should be linked to opportunities for dentists and Dental Clinical Practitioners to upskill and eventually provide such care from their own practices. At the heart of this must be a sustainable specialist workforce to drive standards, innovation and quality. Welsh Government is recommended to invest in services that can demonstrate a commitment to provide primary and community based services, including the smaller specialties such as paediatric, restorative and special care dentistry and oral surgery. Resources for specialty training posts should target population need, access and impact rather than

historical criteria. Health Boards should be encouraged to develop specialist training programmes which should help retention of the workforce as well as service provision.

Orthodontic Services

25. ABMU commissions 7 Personal Dental Service Primary Care Orthodontic contracts, three General Dental Service Primary Care Orthodontic contracts (with an orthodontic element attached for a Dentist with Enhanced Skills and provides Secondary Care Orthodontic services from the Morriston Hospital site. Six of the seven orthodontic contractors are based in Swansea, the seventh in Bridgend. The three General Dental contractors (in Neath Port Talbot and Swansea) provide orthodontic services to patients to a treatment plan submitted to and approved by the hospital-based specialists. The remaining contractors and the hospital service provide the whole assessment and treatment pathway.

26. Orthodontic and Specialist contracts are subject to similar contract monitoring processes as standard general or personal dental contracts, although some of reports may differ due to their speciality. Any concerns are raised with the Health Board's Specialist Dental Advisor who grades the level of concern using a 'traffic light' system and appropriate action is then taken. Exception reports are not applicable to specialist Contracts and Orthodontic services and currently Dental Assurance Framework [DAF] reports are not available in Wales. If and when these become available, ABMU will aim to align with guidance in England to include these as part of the monitoring process of orthodontic services.

27. ABMU's primary care management team, with the support of the Orthodontic Managed Clinical Network (ABMU and Hywel Dda) continues to develop policies to improve the quality of orthodontic care to predominately:
    - Identify patterns of inappropriate referrals
    - Plan and deliver suitable targeted interventions
    - Improve waiting times
    - Identify robust waiting times monitoring arrangements.

28. The 7 Primary Care Orthodontic contracts account for approximately 10% of the GDS expenditure budget. They were re-commissioned and awarded in December 2016 and will expire on 30 November 2021. The opportunity was taken to standardise the Unit of Orthodontic Activity rate at £63.15 (now £64.06 pending national uplift). That paid to the DES providers is at a similar level and has yet to be reviewed.

29. The Primary Care Team collates waiting time lists from all orthodontic providers on a quarterly basis and issues this information to all dental practitioners following discussion with the Orthodontic Managed Clinical Network [OMCN] which was re-established in 2017. The information is circulated with the aim of influencing referral practice, particularly to reduce the number of inappropriate referrals, notably of children under 11 years old and those whose orthodontic condition, measured against IOTN1 score, does not meet NHS criteria.

[1] Index of Treatment Need – dental health score indicates a developmental anomaly that would offer health gain from correction

30. Despite the above, waiting times are still unacceptably variable and long with over 3000 patients awaiting consultation across ABMU. The Health Board will continue to work with the support of the OMCN to secure a reduction in inappropriate referrals in line with the recommendations of the Welsh Government's most recent national review by [redacted]. Access to an orthodontist across the Health Board ranges from one month (in one, General Dental practice only) to 36 months from referral to assessment. Waiting time remains at three years in Bridgend compared with 3 to 12 months between the Swansea providers. The team has been actively encouraging Bridgend dentists to send patients to Swansea, and requiring the orthodontists to tighten up on the application of their referral acceptance criteria. It is anticipated that significant improvement will follow the introduction of a new e-referral system across all dental specialties in Wales within the next 18 months; earlier in ABMU and Hywel Dda Health Boards who are designated 'early adoptors' .

31. It is considered that the resources are already in place to support the population needs but work is still necessary to ensure robust acceptance criteria are in place, especially for the under 12 year olds and cross boundary referrals. There is also a need to establish a national Dental Activity Review [DAR] for orthodontics and, as contracts are renewed, it will be essential to emphasise the need for a change in the model of delivering orthodontic specialist service.

The effectiveness of local and national oral health improvement programmes for children and young people

32. A Public Health Wales' dental survey in 2016/17 revealed the lowest levels of dental decay across Wales in young school children since records began, with a consistent decline in the number of children with missing or decayed teeth. Public Health Wales subsequently reported, earlier in 2018, that the proportion of 12 year olds with decayed or missing teeth had reduced significantly over the past five years to 29.6% from 45.1% across Wales. The achievement in the ABMU area was even more significant, reducing from 47% to 28.9% over the same period.

33. The survey of young school children showed that dental disease levels continued to improve across all social groups with most deprived areas seeing the largest reduction in decay. It is considered that the continued increase in the activity of the Designed to Smile team, (an NHS Dental programme funded by the Welsh Government helping children to have healthier teeth) working in schools and nurseries in the Health Board's most deprived areas has made a major contribution to this

34. However it was also confirmed that 16% of three year old children in ABMU were reported as having decayed, missing or filled teeth. With 28,000 of children being cared for by the Health Board's Health Visiting Team, 2016/7 saw the establishment of a Public Health Wales-led "Lift the Lip" campaign with one of ABMU's Health Visiting teams. This has been continued and extended across ABMU. The excellent joint working with the Designed to Smile team to *make every contact count*, now includes closer working with dentists, the Speech and Language Department and school nursing team to prevent dental decay in pre-school and primary school settings.

35. The publication of WHC(17)23 cemented the need for Designed to Smile to focus on the youngest children and ceased the fissure sealant element of the programme. The team continues to provide fluoride varnishing in the 300+ schools and nurseries in which it educates and treats children but was required by the same Welsh Health Circular to cease the education programme for the year 7 age group. The evidence base for the programme change is respected but there is one element of the change in specification with which the local Designed to Smile

team is uncomfortable: removing the oral health presentation to the older age group. Local experience is that doing so has already weakened the bond with the school staff who are now required to deliver the message formerly conveyed by the D2S team and advise that they – D2S – remain in a good position to deliver that message immediately following the application of the fluoride varnish before the children are able to have their lunch.

36. The number of nursery and school settings in which Designed to Smile is delivered continues to rise (exceeds 300) and change, with an additional 18 identified by the Welsh Oral Health Information Unit in 2017. The challenge for the team is securing 100% engagement, e.g. four of the new cohort actively sought their input, three did not engage and five 'actively' refused. Although this position improved subsequently it was not without considerable effort and engagement directly with the schools, through the Healthy Schools teams and others and this will continue to require engagement at senior partnership level to achieve 100% engagement in target areas.

37. Additional work is also ongoing and required within ABMU to strengthen the links from the Health Visiting and Designed to Smile teams to general dental practices to enable them to secure immediate access for children who need dental care. In the past, there was a direct route to the Community Dental Service [CDS]. However, particularly since the publication of WHC(16)9 emphasised the pressing need to ensure the CDS focused on patients with special care dentistry needs rather than healthy children, that route has not been appropriate. Work is therefore ongoing to ensure access to General Dentistry is readily available for these children in deprived areas.

38. In the interim, Designed to Smile is, as required by WHC(17)23, engaging specifically with the 14 Teaching Dental Practices within the ABMU area to ensure Dental Foundation Trainees and senior colleagues are briefed on latest oral health education advice and training and provided, where appropriate, with the means to provide more fluoride varnish treatments within General Dental Practice. The impact of the change in emphasis in the programme will emerge within the next few years.

39. It is considered that Designed to Smile, although still in its infancy is beginning to deliver on its intended outcomes. However, there is also a need to expand oral health education and support to other vulnerable groups such as teenagers and the older population possibly in conjunction with other programmes such as the care homes project which was established with WHC(15)1, *Improving Oral Health in Care Homes*.