

IMPROVING HEALTH IN WALES



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# ROUTES TO REFORM

## A Strategy for Primary Dental Care in Wales

a consultation  
document



Llywodraeth Cynulliad Cymru  
Welsh Assembly Government



# **A STRATEGY FOR PRIMARY DENTAL CARE IN WALES**

The purpose of this document is to set what we believe our strategy for primary dental care in Wales and what our aims should be to strengthen and develop dental services and to help support primary dental care teams in the work they undertake in providing dental care and improving oral health.

We hope that you will tell us what you think about the proposals in this document. In addition please give us your view on priorities and on what needs to be done to deal with the challenges we face.

We would like to publish the responses received. Please let us know if you want part or all of your response to be treated in confidence.

Please send your comments by Tuesday, 31 December 2002 to:

Rob Heaton-Jones  
Health and Well-Being Strategy and Planning Team  
Welsh Assembly Government  
Cathays Park  
Cardiff  
CF10 3NQ

E-mail: [rob.heaton-jones@wales.gsi.gov.uk](mailto:rob.heaton-jones@wales.gsi.gov.uk)

Further copies of this document can be obtained from:

Health and Well-Being Strategy and Planning Team  
Welsh Assembly Government  
Cathays Park  
Cardiff  
CF10 3NQ

Tel: 029 20801414  
E-mail: [suzanne.parfitt@wales.gsi.gov.uk](mailto:suzanne.parfitt@wales.gsi.gov.uk)  
Website: <http://www.wales.gov.uk>

# ROUTES TO REFORM

## A STRATEGY FOR PRIMARY DENTAL CARE IN WALES

### Foreword



It gives me great pleasure to present this primary dental care strategy for consultation. The strategy outlines an ambitious agenda for improvement in NHS dentistry. We recognise the essential contribution dental services make to general patient care and health. This strategy sets out proposals to meet the challenges facing NHS dentistry. It requires new approaches to the provision of dental care in Wales. To achieve our aims, over time, fundamental changes are required so that the people of Wales will continue to benefit from high quality dental services.

The skills, experience, and dedication of the dental workforce are and, will remain the essential pool upon which we will need to draw in the future. Your comments about the proposals contained within this document are therefore, vital to determining the future shape of NHS dentistry in Wales. We also seek the views of users of dental services and those of professionals from the wider fields of health and social care. Please distribute this document widely and encourage others to comment likewise.

A handwritten signature in black ink that reads "Jane Hutt". The signature is written in a cursive, flowing style.

**JANE HUTT AM**



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# INTRODUCTION

The purpose of this document is to outline a strategic way forward for NHS Primary Dental Care in Wales. *Improving Health in Wales – A Plan for the NHS with its Partners* (1) signals the renewal of NHS Wales and sets out an ambitious agenda for change and improvement. The prime aim of the Plan is to achieve wide scale improvements in patient services and the quality of care. The Plan presents challenges that will demand new approaches.

Poor oral health is blight on the quality of life of those affected and, failure to break this pattern can result in generation after generation suffering with its associated problems. Society and individuals pay a considerable price in terms of health, work, social, educational, and economic disruption. Good oral health is to be valued, it is a major contributor to good general health and therefore to the foundation of the quality of life for individuals and the nation.

We came to this task with the clear belief that Wales needs a comprehensive strategy for Primary Care Dentistry but also aware that dental services in Wales could not be developed in isolation from developments in other countries. The dental workforce is increasingly dynamic both in terms of the nature of the workplace practitioners choose and the flow of the workforce across national boundaries.

In Wales, however, we do have our own distinctive challenges to address and, the approach we have adopted embraces the need to meet these challenges whilst maintaining enough flexibility to account for wider influences.

We took, as our starting point for the development of this document, the collated responses received to the Future of Primary Care consultation. We built upon this through a series of meetings and interviews with representative members of the dental profession and others. These meetings proved invaluable in assuring that the wealth of different viewpoints were able to directly inform the production of the needs assessment which in turn informed the development of this strategy.

The existing systems of service delivery and remuneration cannot be changed overnight. Therefore this document identifies where short-term improvements can be made and also begins to signpost a path for later and more fundamental change.

We aimed to outline a dental strategy for Wales that:

- Benefits patients and assists in the improvement of their health
- Addresses health inequalities and while improving the health of the whole nation, prioritises health improvement for those who are worst off especially children
- Promotes access to services for patients and an integrated service approach to provision
- Provides flexibility in local delivery whilst ensuring high/measurable standards
- Cultivates an atmosphere of mutual support among professionals
- Is evidence based, effective and draws upon good practice both from within and outside Wales, (2).

- Takes short, mid and long term considerations of dental workforce planning
- Links with the work of the IM&T Development Plan setting out a way forward for Information and IM&T development in primary dental care
- Links with the Framework for Continuous Improvement developed by the Performance Management Task and Finish Group
- Is compatible with other health strategies,
- Provides value for money.

*Routes to Reform* is inextricably linked with the main Primary Care Strategy being developed for Wales (3) and complements the other important strategic work that is underway in primary and secondary care. The General Dental Service (GDS) contract is still, essentially, delivered on an U.K. basis. Any changes proposed by the Department of Health will impact on the proposals suggested in this strategy.

We have kept these factors in mind and we consider that our proposals are flexible and practical enough to inter-link intelligently with related developments.

As our work progressed we realised how complex this assignment was, but we became even more convinced of the need to put a strategy in place. We realised, too, that in many ways, poor dental health can be viewed as a symptom of a deeper malaise in society generally and that our approach must take account of other Government initiatives aimed at these underlying problems. Perhaps, most importantly of all, we soon came to the conclusion that no one service or single approach can tackle the problems on its own. We also recognised that, in order to stand close scrutiny, this service-orientated strategy could not stand completely divorced from general oral health considerations.

It would be wrong to paint a picture of dentistry in Wales that was totally gloomy. The best services in Wales stand comparison with the best anywhere but there is a need to systematically spread good practice and to tackle the acknowledged problems in the levels of dental disease, availability of services, and the system of remuneration in the GDS. This consultation paper sets out an ambitious agenda for change and improvement in NHS dentistry in Wales. It presents a range of proposals, upon which comments and views are invited.

# CHAPTER ONE – SETTING THE SCENE

## 1.1 Vision for the future

Our vision of the new NHS is - a NHS that offers people quality treatment that is prompt, convenient and where patients are central to the care process. We envisage that a well-trained and motivated workforce will deliver that to a consistently high standard and are reassured that the dental profession in Wales shares this vision. We seek to improve the links between dentistry and the wider primary care team and propose to develop models of care responsive to local need delivering quality evidence-based care, focused on preventing oral disease and addressing inequalities.

We appreciate that patients, especially children, older people and people with disabilities require access to dental care which meets their needs and enables them to enter into a partnership in the provision of that care. We believe that the proposals laid out in this consultation document will help ensure that this vision becomes a reality.

## 1.2 The current provision of dental service in Wales

Since its inception in 1948, the availability of NHS Dental Care has played a major part in the improvement of the general health of the population. There are two main components of primary care dental services the GDS and the Community Dental Service (CDS). Current arrangements for the delivery of Dental Care in Wales are as follows:-

### General Dental Services

Most NHS dentistry is delivered to patients through the General Dental Service. Currently health authorities are responsible, under Section 35 of the NHS Act 1977 (as amended), for the provision of General Dental Services in their area, (from April 2003 it will become the responsibility of Local Health Boards).

General dental practitioners, GDPs, the traditional family high street dentists who provide NHS dental treatment, are independent self-employed practitioners who are at liberty to choose whether they contract a proportion of their work time to provide NHS treatment. They are also free to decide how many and which patients they wish to have on their NHS list. As a consequence GDPs may provide only NHS care, work totally outside the NHS, or as is commonly the case, provide a mixture of NHS and private dental care.

The GDS operates within the terms of what is effectively a national contract that pays them under a complex system of fees and allowances. The GDS is funded from the centrally held, demand led, Family Health Services budget which is non-discretionary. They operate in the main from privately owned premises. They are also free to practice wherever they choose and the Welsh Assembly Government has no power to direct them into any particular part of Wales.

At the end of September 2001, the number of dentists working in the General Dental Service in Wales was 1011 and 61% of children and 47% of adults were registered with a NHS dentist, having visited them at least once during the preceding 15 months.

The number of courses of treatment for adults in Wales continues to increase year on year reaching 1.5 million treatments in 2000/2001. NHS spending on the General Dental Service rose by 4.5% in 1999/2000 to £62.6 m and by 6.8% in 2000/2001 to £66.9 m, and by a further 6 % in 2001/2002 to £70.8 m.

## **Community Dental Service**

The Community Dental Service is a salaried service provided by NHS Trusts. A 1989 Health Circular WHC (89) 28 defines its remit in Wales. In Wales the CDS has performed an essential role, especially in areas of low socio-economic status, providing dental care to schoolchildren. The CDS also cares for adults and children with special needs; provides a safety net service for those who are otherwise unable to gain access to NHS dental services; undertakes screening of school children, epidemiological surveys and provides oral health promotion services. It is a matter for each Health Authority to determine, in light of local circumstances, the appropriate level of CDS provision for its area and to fund it from its allocation.

## **CDS/GDS Interface**

This trial scheme was established under the Welsh Office Dental Initiative in 1995 to address areas of unmet need and strengthen the safety net function of the CDS. Under this scheme, salaried dentists employed by the CDS can work within the GDS arrangements and levy charges via the GDS funding mechanism. Fees are charged to those patients not exempt from payment and the service is housed in NHS Trust owned premises.

## **Personal Dental Services**

There are no PDS pilots running in Wales at present.

## **Independent (Private) Dental Practice**

Dentists working in the GDS are at liberty to provide dental care outwith the NHS. This may be provided by direct contract between the dentist and patient i.e. the patient "pays out of pocket". Alternatively, patients may elect to join an insurance scheme whereby they contribute on a regular basis to a third party who will cover routine care, on a capitation basis. Patients may also have to pay additional sums for more complex care e.g. items requiring construction in a dental laboratory (crowns and bridges).

## **Dental Bodies Corporate**

The oldest dental company on the Register was incorporated in 1900 and the legal status of corporate bodies was established in the 1921 Dentist Act. Their numbers were restricted by the 1956 Dentist Act.

## **Hospital Dental Services**

This service is salaried and provided by NHS Trusts. The Hospital Dental Service (HDS) provides specialist dental care and advice on referral from dentists, medical practitioners and other health care professionals. Specialist dental care is provided from community and district hospitals throughout the Principality, the University Hospital in Cardiff is major provider of HDS in Wales.

## The Dental Practice Board

The Dental Practice Board, DPB, is a statutory body set up originally under the National Health Service Act 1946 and now under the National Health Service Act 1977 as amended by the Health and Medicines Act 1988. The DPBs procedure is governed by the Dental Practice Board regulations 1992. It is a centrally financed service.

The DPBs principal functions covering Wales and England are:

- approval of payment applications
- calculating and transferring payments
- preventing and detecting fraud and abuse
- providing dental health information, see 2.1

It is the duty of the Dental Practice Board (DPB) to ensure that any dental treatment patients have is not only necessary but carried out to satisfactory standards. To achieve this, they examine over 80,000 randomly selected patients annually in Wales and England. The Dental Reference Service (DRS) is a team of experienced dentists that helps the DBP to monitor the quality of service provision, see 7.2.

### 1.3 The Need for Primary Care Dental Strategy and factors influencing change

Over the next 10 years it is highly probable that the delivery of dental care in Wales will, following the UK trend, increasingly be through a "mixed economy" of NHS and independent services. We recognise that patients will exercise their right to choose where and how they receive their dental care. We intend to assure that whomever they choose will provide care to an acceptable standard, and that accessible quality NHS dental services will set the benchmark. The Welsh Assembly Government is committed to providing NHS dentistry to all whom wish to access it.

We recognise the very different local and regional differences in the socio-economic profile of Wales. The conditions under which dental care has to be delivered in the Principality is far from homogeneous, and a variety of service delivery mechanisms will be needed to ensure that good quality NHS care is genuinely available in different communities and to different age groups.

Levels of tooth decay vary three-fold between the least and most affluent areas in Wales. In developing future dental services we must strive to ensure they are targeted appropriately to meet need, that good financial control is maintained, and that the emphasis on oral health promotion and preventive dental care is intensified.

At the beginning of the 21st Century, there is a necessity to set out a way forward for Primary Care Dental Services in Wales.

The need for change at this time is driven by many factors. These include:

- Inequalities in oral health

- Changing epidemiology of oral disease
- Inequalities in access to care
- Workforce issues
- The need to deliver evidence-based care
- The increased provision of dental care outwith the NHS
- Changing aspirations of young practitioners
- Changes in the structure of the National Health Service in Wales
- Changes in the provision of dental care in England

In March 2001, the Report of the Health Select Committee Inquiry into *Access to NHS Dentistry* (4) was published. The Committee's terms of reference related to the English dental strategy, *Modernising NHS Dentistry* (5) but, due to the similarities under which the GDS in Wales and England are delivered, the Reports recommendations have a direct relevance to service provision in Wales.

The main conclusions and recommendations were that:

- The current remuneration system in the GDS was at the heart of the access problem
- A review of the dental workforce was necessary
- Health Authorities have insufficient levers to assist them towards meeting the objectives of *Modernising NHS Dentistry*

The need to reform dental services is not a new concept. A decade ago the then Minister for Health suggested that the existing system was "complex and difficult both to understand and administer". Far-reaching ideas on changes to the arrangements for the delivery of dental care were outlined in a Fundamental Review of Dental Remuneration (6) carried out by Sir Kenneth Bloomfield in 1992. Ten years on, many of the suggestions outlined in that review are relevant to the restructuring of NHS dental services today.

**We acknowledge the need to examine new ways of commissioning Primary Dental Care and remunerating dental practitioners.**

It must, however, be recognised that the current system has served the public, the dental profession, and government well. The lessons learned from early 1990's following the introduction of the "New Contract" suggest that future change should be a phased and planned process.

The complexity of reforming the delivery of primary dental care is a major challenge. It is imperative that any change is introduced on an incremental basis, together with appropriate evaluation, before further rollout and *that this is done with the full support of the profession.*

## CHAPTER TWO - ORAL HEALTH IN WALES

### 2.1 Collecting the data on dental and oral health

Oral health is an important aspect of general health – it enables an individual to eat speak and socialise without painful disease, discomfort or embarrassment and contributes to general wellbeing.

The Welsh Assembly Government commissions annual epidemiological surveys co-ordinated by the British Society for the Study of Community Dentistry and conducted by the Community Dental Service that, together with the National decennial surveys of child and adult oral health, make it possible to identify patterns of disease and trends in oral health over time. Through these surveys the oral health of the Welsh population can be monitored and the data used to inform policy and commissioning. We also acknowledge the role of the Dental Practice Board (DPB) in providing detailed data on treatment carried out in the GDS and the work of the Welsh Oral Health Information Unit of the Dental Public Health Department University of Wales College of Medicine.

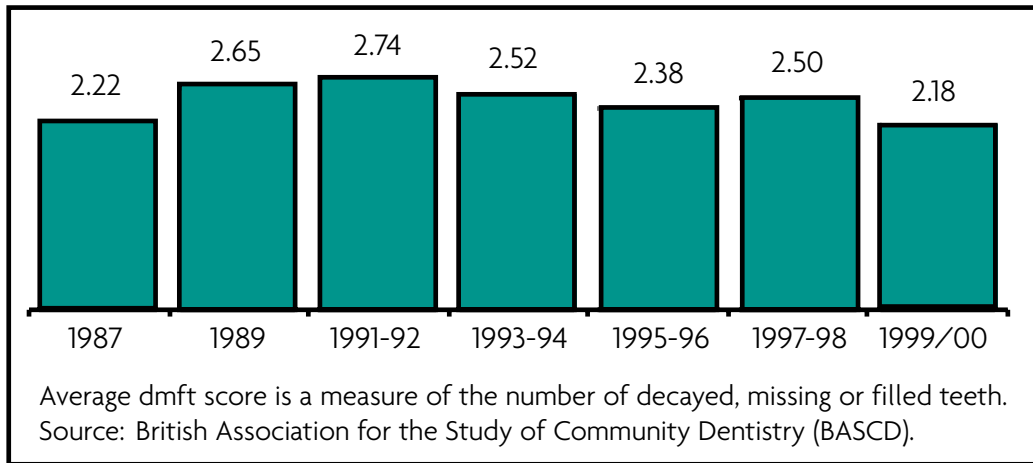
**These programmes are important in helping to inform the development of health policy agenda and we will continue to support them.**

### 2.2 Oral health in children.

Although oral health has improved markedly in the last three decades it is still the most prevalent disease affecting our children – a silent epidemic. There is a widely held perception that dentistry is undergoing rapid change, largely brought about by its successes in the prevention of dental caries. The perception, however, is both misleading in its generalisation and narrow in its view of contemporary oral disease and its consequences. Dental caries may be a diminished burden amongst certain groups of the population but it still impacts greatly on children and other vulnerable groups.

In Wales childhood dental data is collected annually as part of an epidemiological programme, in line with a protocol set out by the British Association for the Study of Community Dentistry (BASCD) that publishes annual reports. Surveys conducted by BASCD during the 1990's indicate a fluctuating trend in the number of decayed teeth in five year old children, (see chart 1). The Annual Report of the Chief Medical Officer for Wales (7), also using data from BASCD surveys, notes that the rate of decline in prevalence of tooth decay has been disappointing (see chart 1) and the oral health gain targets set for children have not been reached. The 1999-2000 BASCD survey showed that 52% of 5-year-old children in Wales had experienced tooth decay.

**Chart 1 : Tooth decay in 5 year old children (dmft)**



In 1999 -00 the average dmft of 5 year olds was 2.18, see Chart 1, but the impact of dental decay was greater amongst those children with experience of the disease. Table 1. below shows that these children, i.e. 52% of those surveyed, had an mean dmft of 4.23.

Health Authority	For dmft>0		
	dmft mean 1999/2000		
	Mean	LCI *	UCI *
Bro Taf	3.92	3.74	4.10
Dyfed Powys	4.19	3.98	4.40
Gwent	4.72	4.61	4.82
IMH	4.10	3.90	4.30
North Wales	4.06	3.91	4.21
<b>WALES</b>	<b>4.23</b>	<b>4.18</b>	<b>4.28</b>

\* LCI -lower confidence interval, UCI - upper confidence interval  
Source Welsh Oral Health Information Unit.

The inequalities that exist throughout Wales show that there is no single cause of poor oral health but a range of factors including unemployment, poverty, social deprivation and life style see 6.1. Such factors impact greatly on levels of tooth decay and the affects of this are often localised. At a health authority level Bro Taf had the lowest prevalence of dental decay amongst the Welsh health authorities with 48% of children affected. However, within that health authority area, Merthyr unitary authority (UA) had 62.8% of 5-year-olds with caries (second worst UA in Wales) compared with Cardiff unitary authority which had 40.5% (best UA in Wales). Additionally, at a more localised level within the bounds of Cardiff UA there were many pockets of high levels of dental disease on a par with the worst in Wales.

The existing health gain targets are being reviewed and a framework of new targets and indicators established to provide the focus and direction for improving health and reducing health inequalities, (8). It will be crucial that the framework links into local action and process.

## 2.3 Oral health in adults

The 1998 UK Adult Dental Health Survey Oral (9,10) showed that oral health is generally worse in Wales than in England but better than in Scotland or N. Ireland, largely reflecting socio-economic circumstances. Adult oral health in Wales is slightly worse than the U.K. average. The full report of the Adult Dental Health Survey 1998 contains a chapter specifically devoted to Wales. Below is a summary from the report of the key results for Wales: -

- Between 1978 and 1998, the proportion of adults in Wales with no natural teeth decreased from 37% to 17%.
- During the same period the proportion of adults in Wales with 21 or more natural teeth increased from 71% to 81%
- The average number of teeth increased in dentate adults (that is, adults with some or all of their natural teeth) from 22.9 in 1988 to 24.2 in 1998
- There has also been a marked increase since in the proportion of dentate adults with 18 or more sound and untreated teeth. The biggest improvements have occurred in the two youngest age groups
- There has been significant improvement in the proportion of adults with no natural teeth within each social class since 1978, but the gap between the different social classes has remained
- In 1998, 59% of dentate adults in Wales reported attending the dentist regularly for check-ups, compared with only 39% in 1978
- Dentate adults from non manual backgrounds were less likely to have decayed or unsound teeth than those from skilled and unskilled manual backgrounds.

Changes in total tooth loss between 1968 and 1998 show that people in Wales are keeping their natural teeth for longer, that there are more decayed teeth per person in Wales than England and more periodontal (gum) disease. The reason that many people are retaining their teeth into older age reflects advances in dental techniques, technology and changing attitudes on the part of the public, who no longer see tooth loss as an inevitable consequence of ageing. Thus, there is a significant cohort of middle aged and elderly people who have heavily restored dentitions and will in the future have a high treatment need. It is also important to recognise that it is not solely dental and periodontal disease that impact on oral health; there is also a wide range of other conditions and pathologies, including oral cancer.

## 2.4 The implications

In summary, the epidemiology of dental disease in Wales is as follows:

- Dental health in Wales is worse than in England
- The rate of decline in prevalence of tooth decay in children is disappointing
- There are marked inequalities in oral health

- Adults are retaining their teeth for longer
- Increased tooth retention has resulted not only from less decay but changes in public attitude to tooth loss and increased dental technology

The significance of these findings in the context of this Primary Care Dental Strategy is as follows:

- In future there will be a cohort of adults (the baby boomers) who have retained their teeth and will have a high restorative need
- New approaches are required to ensure that improvements in the dental health of young children seen in the 1970s and 1980s continue
- Actions will need to be taken to address inequalities across socio-economic groups
- Fluoridation of water supplies offers Wales a proven public health measure for reducing levels of dental decay, see 6.2.

# CHAPTER THREE - WORKFORCE ISSUES TRAINING, RECRUITMENT AND RETENTION

## 3.1 The Primary Care Dental Workforce

The number of dental practitioners in the Wales GDS at 30th September 2001 was as shown in the Table 2. For reasons indicated earlier the proportion of time devoted to NHS activity cannot be quantified accurately.

**Table 2 Dental practitioners in the GDS Wales at 30th September 2001.**

Principal	Assistant	Vocational Dental Practitioner	Total
931	29	51	1011

A much smaller number of dentists, 102, are employed in the CDS representing a whole time equivalent of 82.6 dentists.

## 3.2 The Review of the Dental Workforce

The Human Resource chapter of the NHS Plan "Improving Health in Wales" (1) reaffirms the commitment in the Human Resource Strategy for Wales to undertake a full review of the workforce planning process in consultation with NHS Wales, other interested organisations, and the Department of Health. It also outlines the need to put in place an agreed process for integrated workforce planning.

The Welsh Assembly Government commissioned a review of the Dental Workforce in Wales. The Dental Workforce Development and Advisory Group has made a series of recommendations and suggestions see annex 1. A detailed review of the findings is not presented here. However, the implications of the report as they impinge on the development of this strategy are recorded below. We were also able to utilise information from a draft report by the Eastman Dental Institute into recruitment and retention issues affecting Wales that was commissioned by the Department of Postgraduate Dental Education.

## 3.3 Issues facing Wales

Many areas of Wales, particularly North Wales and other rural areas, have been historically 'short' of NHS dental provision often because the local population is too sparse to comfortably support a GDS practice. In these areas the departure of a long established dentist through retirement or other reason can be catastrophic for service provision.

Age profiles of the dental workforce dentists in many areas of Wales show a worrying picture. Retirement profiles suggest that there will be a need to recruit more dentists into these areas. The challenge facing Wales is both the number of dentists predicted to retire in the next ten years and the inability to recruit dentists to parts of North and West Wales in particular.

Data recently made available by the Nuffield Trust shows Wales lagging some way behind in dentist to population ratio when compared with England, Scotland and Northern Ireland. Wales currently has a ratio of one dentist per 3005 population heads compared with 2846 in England, 2619 in Scotland and 2417 in Northern Ireland. There is a strong case to bring Wales more in line with other

UK countries with the Scotland ratio at one dentist per 2619 a realistic target. Currently that would mean Wales needing to recruit an extra forty-four dentists to its workforce. Additionally, both Scotland and NI train more dentists per head of population see 3.4.

In the last few years a high proportion of dentists registering with the General Dental Council have qualified outside the United Kingdom. In 1995 for instance the proportion was approximately a third but by last year it had risen to just over 50%. The numbers have been split evenly between dentists from inside and outside the European Economic Area. Many of those from within the EEA come from Sweden or the Republic of Ireland. Of dentists registering from outside the EEA many have come from South Africa.

This suggests that, in the past few years, the UK dental services have to an extent relied on dentists who are not "home-grown". This may present something of a problem because if factors influencing the demand for dental workforce in these source countries change the numbers of incoming dentists from these countries may start to fall. Furthermore, this year has seen the introduction of the International Qualifying Examination (IQE) for dentists from outside the EEA who wish to practise inside it. The effect of this is likely to reduce the rate of increase in dentist numbers.

A survey was commissioned by the Department of Health to examine the need for improvements in employment opportunities for women dentists in the National Health Service for England. The review was undertaken in the light of the widespread perception that women find it difficult to return to dentistry after taking a career break and that 50% of women in dentistry work no more than the equivalent of two days per week for the NHS. The findings were reported in Better Opportunities for Women Dentists (11). Many of the findings are worthy of consideration within the context of dentistry in Wales. In October 2000, just over 50% of new entrants to dental undergraduate courses in the UK were female. Women now make up 32% of the Dentists Register. Throughout the UK there are almost a third more women in the General Dental Service today, compared with five years ago and 60 per cent more compared with ten years ago. This year half of all new students to enter dental school are female and by 2005 more women than men will be graduating from dentistry for the first time.

We recognise that many female dentists take career breaks, for example to look after their children, and research indicates that 64 per cent of these women ultimately intend to return to the dental workforce. However, loss of confidence and feeling out of touch with the profession are cited by women as obstacles to return. We also recognise that this is not solely a problem for female practitioners and with the changing aspirations of young practitioners an increasing number of male dentists may adopt such career/lifestyle patterns. "Back to Practice/Keeping-In-Touch Courses" courses have run for sometime in Wales. We believe that a fresh and more flexible approach is now required see 3.7. We have recently announced an initiative to encourage dentists to return to work in the GDS see 5.2.

### 3.4 Undergraduate Dental Education in Wales

Wales has a world class teaching institution in the Cardiff Dental School. The dental workforce review report **recommended an increase in the number of undergraduate dental students from 55 to 76 per year**. There is evidence that a significant proportion of dentists choose to practice close to where they trained. The inference is that an expansion of dental student numbers in Wales would help address the current shortage of dentists.

Other arguments for expansion of dental training include:

- age profile of the dental workforce in Wales
- the increased numbers of females entering the profession
- Scotland and Northern Ireland have better dentist to population ratios than Wales and relative to their populations train proportionally more dentists.
- Probable decrease in the numbers of incoming dentists qualified outside of the UK

**We will commission a feasibility study into expanding the number of dental undergraduates trained in Wales.**

The length of training for the dental team owes much to history and the gradual increase in training time reflects a desire for training institutions to cover the subject in as much depth as possible and ensure educational quality. However, there is a need to consider whether the dental degree programme best prepares dentists' for working in primary care and meeting the needs of patients. The General Dental Council recently published a second edition of, *The First Five Years*, the Council's requirements that provides a framework for undergraduate dental education.

As the professions complementary to dentistry begin to contribute more widely to the provision of dental care, an impact can be anticipated upon the content of dentists' training. Education may need to be focused on developing professionals who are able to provide appropriate, high quality patient care through a team approach see 3.10. Increasingly there may be a need for curriculum planning to be undertaken on a dentistry-wide basis to ensure skills learned by different team members are truly complementary.

There is a need to develop selection procedures that better identify individuals who will be most able to meet the specific demands that a successful and productive career in dentistry imposes. Such an approach could be refined so that a more considered assessment of applicants allows the undergraduate intake to better match the desired outcome in the percentage of graduates estimated to be needed in primary care, secondary care, public health and academia. Indeed, government and the profession must consider exploring innovative qualification/training routes into and within dentistry. There is a need to ensure that education and training is designed to develop sufficient numbers of dental professionals who are well suited to working in primary care. Such a need argues for an increased use of primary care outreach schemes throughout training see 3.5, 3.10.

### 3.5 Primary Care Dental Education Units

The majority of dentists work in the primary sector yet traditionally basic training has been centred in secondary care environments. Increasingly clinical teaching across all health professions is shifting into community locations under the direction of academic departments. This has raised questions about the appropriateness of current dental training arrangements. We are therefore, reassured to see that outreach teaching is beginning to become an established feature of the undergraduate curriculum of the Cardiff Dental School. Undergraduates, outside the protected surroundings of the dental school, have the opportunity to develop not only their clinical abilities but also a wider range of "real-world" social and profession skills. We believe that there is potential for developing the concept for the whole dental team, (see 3.10).

Undergraduates receive outreach training within the CDS at locations in both North and South Wales. However, the St. David's Primary Dental Care Education Unit, recently developed in Cardiff is

the only major purpose built establishment providing primary/community based training in Wales. The workforce report proposed the establishment of a similar unit in Northwest Wales. The development of such units have obvious resource and training implications, but have the added potential to help address the fundamental issues facing NHS primary dental care, namely access, recruitment and retention. Additionally, there will be a significant service impact since dental students and professionals complementary to dentistry (PCDs) in training treat large numbers of children and adults.

**The terms of reference of the feasibility study into the expansion in the number of dental undergraduates trained in Wales will embrace the concept of further educational initiatives within the primary care setting.**

### 3.6 The changing aspirations of young dentists

During the work of the needs assessment and dental workforce review group it became apparent that the aspirations and attitudes to work of young dentists are different from those of their predecessors. Some have aspirations to work in the private sector rather than the NHS because of the perceived better working conditions, increased clinical opportunities and financial reward. For an increasing number the prospect of a lifetime career in the GDS is not a preferred option and for many running any business of their own is no longer singularly attractive. Many undergraduates expressed preference for working in an employed status and this was cited as a reason why corporate bodies are currently proving an attractive option for young practitioners. The majority desired greater flexibility in working patterns.

### 3.7 Postgraduate Training

Over the past 2 years we have provided increased levels of funding for Postgraduate Dental Education in Wales. We recognise the great advances made in this field.

The need for dentists to systematically identify their educational needs under the umbrella of Continuing Professional Development, CPD, is acknowledged. We have provided funding for the appointment of CPD tutors to assist and support practitioners in the development of their personal development plans.

At present, most courses are provided by NHS consultants and academics, as well as GDPs. Each of these groups are under considerable time pressures to provide treatment to patients, teach, or undertake research. If course based activity remains the main educational approach future increases in postgraduate courses will increasingly encroach on these tasks. Computer based interactive learning offers a means to increase the scope and range of postgraduate courses for all members of the dental team. It could also play a role in undergraduate teaching and potentially offers scope for links between educational institutions and training centres outside of dental schools, see 3.5, 4.8, 4.10, 8.2.

Given the changes, identified by the workforce report, in the make-up of the Primary Dental Care workforce, the increase in career breaks and the wider clinical demands being placed on the CDS, the need for the more a more flexible approach to supporting dentists wishing to refresh, update or develop their clinical skills is required. " Back to Practice/Keeping In Touch Courses" courses have run for sometime in Wales. We have encouraged the Dental Postgraduate Department of the

University of Wales College of Medicine to develop a new modular approach to providing such support to dentists. A series of modular clinical skills courses linked with the existing distance learning courses, developing hands-on facilities and teledentistry systems will give Wales a flexible package.

**We will continue to work with the Department of Dental Postgraduate Education on the development of modular clinical skills courses.**

**Recently, in Stage 3 of the Dental Initiative we have introduced grants to support dentists who successfully undergo refresher training and return to work in the Wales GDS.**

### 3.8 Vocational Training

The introduction of mandatory Dental Vocational Training in 1993 is seen as a constructive development and accepted as a positive aspect of developing the workforce. There are 6 VT schemes in Wales.

The Committee for Vocational Dental Training for England and Wales, (CVT), has recently reviewed wide aspects of vocational training and reported to the Chief Dental Officers of both countries. The restructuring of the NHS in both Wales and England, combined with the increasing development of specifically Wales focused health policy, has radically altered the environment in which CVT operates.

**We will consider the implications of the CVT Report and review the advisory structure for dental vocational training in Wales.**

The workforce review report recognised the value of VT in encouraging young practitioners into "under dentisted" areas of Wales.

**Recently, in Stage 3 of the Dental Initiative we have introduced grants to support practices working towards obtaining VT Training Practice status and for attracting vocational dental practitioners to areas of high need and demand.**

Other means of attracting vocational trainees to rural and remote practices may also be effective. North Wales Health Authority introduced a Bursary scheme in 1995. We have requested that North Wales Health Authority provide the Welsh Assembly Government with a report on the effectiveness of their scheme thus far.

### 3.9 General Professional Training

General Professional Training (GPT) is voluntary. The first GPT scheme in Wales has been operating for three years. It has provided a useful tool in assisting career choice particularly for those graduates intending to pursue a career outside of general practice. A second GPT scheme commenced this summer and, includes a dental public health component, a speciality of dentistry in which Wales is under strength in suitably qualified and experienced personnel.

### 3.10 Professionals Complementary to Dentistry

There are currently several classes of Professionals Complementary to Dentistry, (PCD`s), dental therapists; dental hygienists; dental technicians; maxillofacial prosthetists and technologists; orthodontic therapists and dental nurses.

The concept of skill-mix in an expanded **dental team** has been well debated. Recent changes in primary legislation and the work of the GDC introducing universal registration and a new regulatory framework for PCDs, now allow PCDs to be employed in more areas of the NHS and to widen the scope of their work. PCDs will be regulated through educational and ethical guidance, rather than a prescriptive list of duties, (see 3.11). The University of Wales College of Medicine has responded rapidly to the changes by putting on training courses for dental therapists and dental hygienists so that they can take advantage of training for extended duties.

The increased opportunities for other members of the dental team to provide clinical care will create prospects for dentists as team leaders. This presents us with a vision of working where diagnosis is the responsibility of the dentist who then prescribes and delegates preventive and less complicated operative tasks to PCDs. In theory, this leaves the dentist free to concentrate on more complex cases requiring more advanced operative interventions. It must be recognised that this vision of the dental team is one that will need to take an evolutionary path towards fulfilling its potential, not least because the numbers of PCDs currently available dictates a graduated development. We have also been made aware that there may also a problem in the recruitment and retention of Dental Technicians. We will explore this as work resulting from the Workforce Review develops.

Although dental hygienists are an established part of the GDS team, the extent to which dental therapists will be deployed in the GDS, as it is currently constituted, is difficult to assess.

The CDS already experiences difficulties in recruiting and retaining therapists because the income which dental therapists can presently command working as dental hygienists in the GDS make NHS salaried posts unattractive. The Community Dental Service in North Wales and Gwent, rely heavily on the use of dental therapists and local commissioners should note and support the critical contribution dental therapists make to CDS provision in certain areas of Wales.

In the short to medium term, a shortage of trained dental therapists and hygienists may limit expansion of PCDs. The dental workforce report ***recommended an increase in dually trained, (hygienist and therapist), PCD training places to 20 from the present 7 hygienists and 6 therapists.*** We encourage the developing concept of a modular course, with the theoretical component being delivered in Cardiff and practical training in outreach centres.

**The feasibility study into the expansion in the number of dental undergraduates trained in Wales will also consider the need to increase the PCD training places.**

The training of dental nurses has gradually become more formalised but with the advent of increased professionalism, see 3.11, we recognise the need consider the implications for pre and post qualification training for all PCDs. The dental workforce development/advisory group indicated that new dental nurses in Wales should be qualified through NVQ schemes and existing nurses should be registered in accordance with General Dental Council policy.

### **3.11 PCDs Professionalisation and Registration**

In the autumn the GDC will be consulting on curricula for all the PCD groups and the Council is reviewing its registration procedures in advance of registering new classes of PCDs. The indications from the GDC are that to maintain registration the requirements for PCDs will be very similar to those applying to dentists. We welcome this move. We have already entered into preliminary discussions with the postgraduate dental department and others on the CPD requirements of Professionals Complementary to Dentistry.

## CHAPTER FOUR - TOWARDS CHANGE

### 4.1 The Potential for Local Flexibility

The current national GDS contract does not allow the NHS to secure services in the mid- or long-term, nor can services be targeted on oral health inequalities. These issues could be more easily addressed if NHS dental services were commissioned locally. The introduction of Local Health Boards provides an opportunity to develop dental services sensitive to local requirements and in particular to evolve services in areas of high dental need or poor access to care.

However, the mechanism to achieve this aim will require gradual development of models of care that will be more focused towards those areas of greatest need rather than simply demand. Local Health Boards should be able to commission such services as are necessary to secure access to a high quality NHS dental service and to improve oral health and address inequalities. If this is to be achieved funding will need to be devolved to a local level, perhaps with some accompanying safeguards to protect provision for independent contractors and the salaried services. Such local commissioning could, however, take place within a national framework so it would not always be necessary to completely 're-invent the wheel' locally.

We have a vision of a future where there will be a greater variety of ways of providing the service and certainly options other than the single national contract for dentistry, over which the NHS locally has negligible leverage at present. Proposals for the reform, overtime, of dentistry will require changes in the framework for contracting GDS services. In addition, some changes are necessary to the arrangements for Personal Dental Services.

Under existing arrangements there is a single national list of treatments available under the GDS, with each item being paid for through a fee, charged to a national budget. LHBs would have no control over this. This has two direct consequences, that would have to be addressed by proposals for reform:

- LHBs will be hampered in targeting resources, for example on health inequalities. Dentists may choose to practice where they wish and NHS General Dental Services do not link to a wider NHS health improvement agenda.
- When dentists reduce their commitment to the NHS, funds they have drawn on are lost to the NHS locally. Although there are more dentists than ever before in Wales, their commitment is spread more thinly and is often of little relevance to local health action plans.

In the longer term changes to legislation will be required;

- to permit delegation of the national budget to LHBs, with arrangements to control both overall spend within the vote and to provide a floor at local level to guarantee funding.
- to address the current methods that exist in calculating patient charges by reference to remuneration.
- to enable a move away from item of service remuneration to forms of longer term contracting.

**Local Health Boards will be required to develop Oral Health Action Plans, reflecting local needs and guided by the national strategy.**

In the decade since the Bloomfield Report was published there have been a number of innovations in the delivery of care e.g. the Welsh Dental Initiative, the CDS/GDS model and the various PDS schemes and Access Centres in England. There are lessons to be learned from all of these. We intend to encourage the development of varied models of NHS dental provision so that, in time, local commissioners will be able to choose from a range of services with which to achieve the objectives of their Local Oral Health Plans.

**As Bloomfield envisaged, local commissioners should be able to choose from a range of service models.**

## 4.2 The General Dental Services

In Chapter One we explained why we see a need to consider change to the present system of NHS GDS delivery, that we are aware of the lessons of the early 1990's, and that any change must be introduced gradually and with the support of the profession. In this section we set out some choices for change in order to stimulate debate on the best way forward for Wales.

The aim of any system for the payment of GDPs should be to encourage the further improvement of overall levels of oral health. Bloomfield pointed out that the existing system is vulnerable to criticism in that it fails to reward quality as distinct from quantity. That the system is complex, not always fully understood even by those most affected by it and, does not always afford equal opportunities of access to the NHS to members of the public. **The same is true today.**

The current system has served the public, the dental profession, and government well but a system where over 300 items of service can be claimed is unnecessarily complicated and inflexible for modern day demands. A simple to understand fee scale would do much to make life easier for both the dental team and patients. This would be to the benefit of patients, practitioners and managers alike.

The GDS fee scale as originally designed accounted for the expenses incurred in running a practice. We recognise that the increasing demands on GDP's from Quality /Clinical Governance agendas and out of hours pressures have placed an increased load upon general dental practice. These and other pressures are a real component of the day to day practice working environment and not merely "add-ons".

The Department of Health in England has recently published a major piece of work, "Options for Change" that is a collection of proposals and suggestions for further work and implementation. Also, an English dental workforce review has been proceeding in tandem with the Options for Change project and is now in its final stages. As we have stated it would be imprudent and unfeasible to move straight to a radically different system of remuneration in the Wales GDS. The first priority must be attaining short-term improvement of the existing system. Throughout this strategy we clearly set out our short-term plans but we are not presumptuous enough to lay out a definitive long-term pathway forward for the GDS. We appreciate the need for a flexible, incremental approach with full involvement of the profession and due regard of the dynamics of reform processes in other countries of the UK.

**Nevertheless we consider it reasonable for us to set out possible alternative approaches to form the basis of a starting point for discussion with the profession in Wales.**

A logical way to forward in the delivery of care is to separate dentists' income from individual treatments delivered. Dental services need to be strategically planned around outcomes rather than

measured by technical volume, as at present. This could be achieved by adopting various options e.g. a salaried service commissioned by LHBs or through a capitation system (a capitation approach is being piloted in England through PDS).

As we have stated earlier, the Bloomfield Report 1992, see 1.2, outlined several suggestions that are still relevant to the restructuring of NHS dental services today. Bloomfield recognised that on a national scale, change must be incremental and some of his ideas form the basis of the models outlined below.

## Bulk Payment

One of Bloomfield's short-term models envisaged an increase in "Bulk payment" for care having a more prominent place, and fees for items of service a less prominent place, in the remuneration system. He gave, and we share his view, a high priority to bringing as many as possible of the nation's children within a pattern of regular dental care. Bulk fees could provide the core of a remuneration system, both for children and adults. Such an approach provides a guaranteed basic income for the GDP.

Many patients do not understand the concept of the current 15-month registration period. At present a very high percentage of "gross fees" are derived from examinations and non-interventive treatments and there is a growing consensus that for many patients examination intervals should be longer. Although it is not evidence-based, the six-month recall interval is sufficiently long-established that change can be most credibly introduced if advocated by an authoritative body. Therefore a referral to NICE for an appraisal of the evidence has been made and the following remit agreed:

*"To prepare guidance for the NHS in England and Wales, on the clinical and cost effectiveness of a dental recall examination for all patients at an interval based on the risk from oral disease."*

Bearing these factors in mind a system that "packages" together ***all examinations and non-interventive treatments that the clinician considers clinically necessary within that period, combined with a simplified fee per item retained for other treatments, for a set number of patients, over a set period of time*** is an option worthy of consideration. There is past experience of "Cost and volume" contracts in NHS Primary Care with commissioning authorities committing to spend an annual amount for specific activities to a defined level. Such contracts could be placed with individual GDPs or even with groups of GDPs working together within a local area.

We see advantages for patients and dentists in reducing the number of items of treatment. This revision could start with changes to the fillings and extractions part of the adult feescale. Simplifying the feescale would improve ease of communication between dentists and patients, reduce bureaucracy for dentists and begin to revise the feescale to reflect current clinical practice. Any reduction in the number of items of treatment should have amongst its prime objects the relief of the pressure on GDPs to work at excessive pace, care that is evidence-based, an increased emphasis on prevention and, *the facilitation of core care and treatment necessary for achieving and maintaining health*. We wish to discuss this proposal with the profession at an early opportunity.

## Salary plus bonus system

The most common criticism of the Welsh Dental Initiative was its perceived failure to reward existing, committed NHS practitioners. A model that would potentially have the additional benefit of acting as a positive incentive to recruitment and retention in "under dentisted" areas of Wales and for targeting specific initiatives is *a salary plus bonus system* :-

- **a guaranteed basic income** that would embrace a stipulated commitment to provide NHS care from a set list of treatments, for a set number of patients, over a set period of time. This basic income would include an element to cover the running costs of a modern quality based dental practice.
- **a bonus** – e.g. as a financial incentive to attract practitioners to commit more time to the NHS, or deliver specific additional programmes of care in designated areas of high need and/or demand.

The optional approaches briefly outlined above will do much to encourage the GDS to provide care to patients, both children and adults, with **special health needs** who may have a physical, learning or sensory disability or a medical condition which complicates the provision of dental care.

## Future Models

Maximising the oral health improvement from dental service provision requires removal of incentives that favour treatment at the expense of prevention and concentrated efforts to address the dental care needs of those with poorest oral health. Overtime, therefore, we must envisage the re-defining the ambit of GDS provision and moving to a more locally-sensitive system of administration. There would be potential for all the GDS models outlined above to evolve, long-term, towards a system where dentists practised from publicly provided premises, integrate and, possibly, converge with the existing salaried services. Such long-term developments would help to ensure the provision of NHS dental services for future generations over whole areas where patients have generally had difficulty in securing NHS treatment because of shortage of dentists or selective acceptance.

The Dental Practice Board (DPB) is currently the sole vehicle for paying General Dental Practitioners and its constitution and functions are set out in primary legislation. Aspects of the DPB arrangements will need to be reviewed within the overall process of reform, to accommodate local flexibility. This will allow for the DPB to match capacity to work load, deliver the management support needed for local commissioning and allow for clarification of information flows from the DPB to the NHS.

Our aim for any future system is for it to be widely available for all groups of the population. To achieve this it must: -

- persuade the maximum number of GDPs to care for their patients in the NHS
- incorporate positive incentives to encourage high quality dental care
- provide a financial incentive for patients to maintain regular attendance and dental fitness
- be readily understood by the public

- be locally sensitive
- have simplicity in administration
- reduce the present inequalities in dental manpower distribution
- be easy to monitor
- provide a predictable pattern of earnings for dentists and of expenditure for health departments
- provide dentists with an adequate return on the capital they invest in their practices.

**We look forward to discussing the way forward with the profession in Wales and other UK Health Departments.**

### Short and Medium term initiatives

As we have acknowledged, the majority of NHS Primary Dental Care is delivered from privately owned premises. The GDS fee scale as originally designed accounted for the various expenses incurred in running a practice. Separately, GDPs receive other benefits related to relief from business rates. However, we recognise that GDPs in Wales perceive a lack of support from the NHS for improving GDS practice facilities and working environments.

**Following consultation with the Welsh GDSC we have been able to offer general dental practitioners who have demonstrated a commitment to the NHS, a limited scheme to assist meeting the part of the costs associated with operating a general dental practice.**

The allocation of the fund to practices is based on the number of patients registered with each practitioner undertaking dental treatment for the general dental service in the practice as at 31 December 2001. Primarily, the fund is to be used for the benefit of patients and is to be paid to GDS practices towards the costs of improving premises or modernising equipment. Examples of how the money should be spent are: -

- The supply of new dental equipment to encourage up to date treatment
- The purchase of information technology systems or software
- Enhancing facilities for disabled patients and for children
- The re-decoration or refurbishment of surgeries or waiting areas.

The response from the profession to this limited scheme has been positive. We will maintain a dialogue with the profession on development of the primary care infrastructure.

We have developed with the profession a commitment scheme that rewards the loyalty of GDPs to the NHS. The scheme was at first limited to those GDPs who had demonstrated 10 years of commitment to certain minimum levels and requirements.

**We have recently extended an improved version of this scheme to GDPs who have demonstrated a loyalty to the NHS of 5 years.**

## 4.3 The Community Dental Service (CDS)

The CDS with over 100 fixed and mobile surgeries is a service well suited to the geographic, demographic and socio-economic conditions prevalent in Wales. The CDS plays a vital role alongside the GDS and HDS. Data from KC64 returns show that during 2000-01 the CDS in Wales made 67,300 first contacts with patients and that the total number of contacts made was 202,200, (children aged 5-15 accounted for approximately two-thirds of these). The CDS also screened 103,000 children for the presence of dental disease.

The role and functions of the CDS are formally defined in WHC (89) 28. This guidance outlines four distinct areas:

- The provision of facilities for a full range of treatment to patients who have experienced difficulty in obtaining treatment from the general dental service, for whom there is evidence that they would not otherwise seek treatment from the general dental service
- The screening of the teeth of children in state funded schools at least three times in each child's school life
- The monitoring of the dental health of all age groups in the population
- The provision of dental health education and preventive programmes.

In the thirteen years since the guidance was issued the basic values enshrined in it still hold well today. Across Wales on a "regional" basis the CDS has, overtime placed different emphasis to the various components of its function. We recognise this and encourage the flexibility displayed by the service working within the guidance framework.

In the short term we do not consider that the guidance, (WHC (89) 28), requires radical revision other than a general update to reflect the structural changes that have occurred since its original circulation. However, we intend to acknowledge more cogently the valued role of the CDS in epidemiological programmes, monitoring levels of oral health and planning the delivery of care and addressing inequalities in oral health. Indeed, to recognise the true extent of the public health function of the CDS. We will also recognise the important role that the CDS plays in rural areas providing support for outreach secondary care services. We will also include guidance on the commissioning of the CDS, see 4.6.

We also need to work with the profession to identify clearly defined objectives for screening and produce a clearly defined protocol. This will include guidance on which schools to screen and the frequency of screening based on defined need. We must explore the possibilities of utilising staff other than dentists to carry out the screening and ensure the process is better linked to relevant oral health promotion initiatives. The CDS must further investigate mechanisms to ensure greater uptake of care, by those children identified as being in need of treatment during screening.

However, as we envisage gradually re-defining the ambit of NHS GDS dentistry and moving to more locally-sensitive systems of commissioning all dental care. In the longer term, therefore, the co-ordination of service provision between GDS and CDS will increase.

### Main client groups of the CDS

The main client groups receiving treatment services from the CDS since 1989 are:

- **children in areas of social disadvantage** who frequently have high levels of dental disease and who do not or cannot access care in the General Dental Service and,
- patients, both children and adults, with **special health needs** who may have a physical, learning or sensory disability or a medical condition which complicates the provision of dental care.

*The CDS will continue to play an essential role in Wales caring for children.* We encourage the CDS to develop further its partnership with other healthcare professionals and patient carers, so that the services provided to these groups are enhanced.

We consider that we have recognised the good work of the dental staff within the CDS through pay awards, well above the rate of inflation, made over the past few years. We have also included a wide and comprehensive range of extra performance related payments. However, as the CDS develops and the process of reorganisation of NHS Wales proceeds there will be a need for flexibility by staff within the service and for strong local management if the CDS to reach its maximum potential.

We wish to see continued development of peer review within the CDS for all grades of staff both clinical and managerial. The peer review processes, especially for senior and managerial grades, should not be limited to in-house procedures but shared across Trusts to better ensure that good practice is disseminated. We also wish to see the continued development of personal development plans for all grades of dentists and PCD's within the CDS and GDS. We look forward to discussing these issues with the profession.

**We have agreed with the profession to set up a Welsh Joint Negotiating Forum to discuss specifically Wales issues. The UK Joint Negotiating Committee will continue to form the focus for UK wide negotiations on pay and terms and conditions of the salaried primary care dental services.**

## Oral health Promotion

A fissure sealant programme was announced in December 2001 giving health authorities an additional £450k Health Inequality funding this year targeted at 6 - 8 year olds in the 100 priority deprived areas identified under *Communities First* (12) using the *Welsh Index of Multiple Deprivation* (13). Similar levels of funding will be made for the next two years. Initially, this programme will be delivered through the CDS and represents a considerable investment in the service. The fissure sealants will be delivered as one component of an oral health promotional "package".

## 4.4 CDS/GDS Interface

This scheme was introduced in 1995, see 1.2. The CDS/GDS trial was a radical and innovative initiative in the provision of primary dental care in the UK. A recent evaluation report commissioned by the Welsh Assembly Government concluded that the CDS/GDS Interface had made a positive and worthwhile impact without destabilising other services.

The primary aim of the CDS/GDS trial was to improve access to routine and emergency NHS dental care. If the outcome measure is treating patients who would otherwise find it difficult to obtain dental treatment, this goal is being tackled. Approximately 10,000 patients were registered with the CDS/GDS during 2000 and a further 1,800 were treated as emergency/occasional patients.

It should be borne in mind that the trial arrangements were also envisaged as a way of supporting the CDS safety-net function, allowing the CDS to continue to provide treatments under its traditional role.

It is comparatively simple to set up a CDS/GDS post and it is a highly responsive form of delivery especially where there are sudden problems of access to GDS. Making the CDS/GDS a permanent scheme sitting alongside PDS offers Wales great flexibility in responding to access problems. Where CDS/GDS has a proven track record the option exists for developing it into a PDS, with all of the extra scope for service development that PDS offers. This presents Wales with the opportunity to pilot new models of care that already have a proven service base. This mechanism will provide a further means to evolve the delivery of dental care as discussed above, see 4.2

**We have made the CDS/GDS Interface a permanent scheme.**

## 4.5 Future commissioning of the CDS

As outlined above, the CDS performs *a vital function for some of the most vulnerable patient groups and this function must be maintained*. In the short to medium term fragmentation of the service between Local Health Boards must be avoided at all costs. We recognise that the division of 82.6 WTE staff across 22 LHBs doesn't make sense.

Future commissioning of the CDS must be sensitive to the fact that the CDS is composed of teams of small numbers of Specialist or specialised staff and PCDs. It can only perform its essential complementary role if the skills and experience of such staff are not limited by the boundaries of single LHBs.

With regard to arrangements with LHBs, we endorse the concept of a lead LHB commissioning CDS services on behalf of adjacent Boards as a pragmatic way forward. Initially this must be structured on the geographical deployment of the current 8 CDS services strengthened by clinical networks.

The larger and urban based CDS's in Wales have maintained a viable critical mass. In some of the smaller, rurally located services, however, there has been a notable lack of investment and in some areas dis-investment in CDS. In the medium to long term we see benefit in further merger of the existing services; we note the work already done in Dyfed Powys in developing a managed clinical network across several rurally based services.

The option of an all-Wales CDS has been proffered in the past, this option would be very strong if it embraced close links with dental teaching; especially if increased outreach training and more team based training becomes a reality, see 3.4, 3.5 3.10. Other options are for 3 CDS's coterminous with the 3 Regional Offices of the Welsh Assembly Government or 2 CDS's, one covering the more rural North and Mid and West of Wales with the second taking in the urban conurbation's along the M4 corridor. In the longer term such developments would enable the CDS in Wales to retain a critical mass with the flexibility to deploy staff, develop special interests and allow for personal development of staff to a greater degree than at present.

**Fragmentation of the CDS must be avoided. Future Commissioning of the CDS must be sensitive to the fact that the service is composed of small numbers of Specialist or specialised staff and, that it can only perform its essential and complementary roles if the skills and experience of staff are not limited by the boundaries of single LHBs.**

## 4.6 Personal Dental Services

Under the NHS (Primary Care) Act 1997 Health Authorities, Trusts and dentists may set up Personal Dental Service (PDS) pilots. PDS provides a vehicle for piloting innovative models of service delivery. There are no PDS pilots running in Wales at present, although, several proposals are being considered.

PDS has been slow to take off in Wales because health authorities have not recognised development of PDS as of sufficient priority. As a result the lack of development funds have held up several promising proposals. If the process of change is to come about we must, through "pilot projects" test alternative models of delivery and care. Trial projects could involve close working with volunteer LHBs (singly or in groups) to explore and demonstrate alternative approaches to providing primary care dental services through develop of commissioning options and new forms of contracting. Initially this could be delivered through the existing vehicle of PDS. Priority would be given to pilots that set out to explore models that addressed local conditions but held the added potential to be rolled out as a more generalised approach to provision in Wales. The aim will be to make investment in dentistry deliver better outcomes for patients, dentists and their staff (including those in the salaried services) and the NHS overall.

**It is essential that we pilot/test innovative models of providing dental care in Wales. We envisage PDS as one tool available to explore new approaches.**

## 4.7 Dental Bodies Corporate

The attractions of working in an employed service, particularly to younger graduates, (see 3.5), apply equally to corporate bodies. Dental Bodies Corporate are already making a contribution to the provision of dental care in Wales and the corporate sector has the potential to play an important role in the future provision of NHS dentistry in Wales. We recognise that there is a need to reform the current regulation of dental bodies corporate and will work with other UK Governments and the GDC to realise this goal.

## 4.8 The Primary/Secondary Care Interface

The feedback we have received from general practitioners suggests that arrangements for access to specialist care and advice are generally satisfactory. It has to be recognised, however that it is more of a problem in localities distant from the major conurbation's due to limitation on the outreach capacity in the HDS.

Outreach dental services by Consultants, to provide a diagnosis and advice Services are essential in rural areas, but they are "wasteful" in terms of travelling time. The potentials of new technology such as Teledentistry and E-consultations to assist these services need to be considered, see Chapter 8. Throughout Wales, especially in the rural areas, Secondary and Specialist care is supported and facilitated by the CDS. The North Wales CDS has taken the facilitation of specialist care directly via Senior Dental Officers further than other CDS's.

Consultant/Specialist outreach in Primary Care Dental Education Units such as those proposed by the dental workforce review, see 5.3, or in Primary Care Resource Centres, see 4.11, would assist the **development of a seamless interface between primary and secondary care and** maximise the use of emerging technologies.

The profession has developed a number of specialities and appropriately qualified dentists can register with the GDC as specialist practitioners. The 'specialists' can offer treatment within the context of primary care and may well reduce waiting lists for consultations in the secondary care service.

## 4.9 Professional advice

Effective commissioning and management of dental services requires professional dental advice.

### Dental Public Health Advice within an All-Wales Public Health Service

The NHS reorganisation brings in a new pluralism in management, with an emphasis on local sensitivity, decision-making and partnership working. To deliver this challenging local agenda, LHB's will need the support of strengthened and appropriately resourced local public health teams that are factored into the all-Wales network. Our detailed plans for Public Health advice are not yet completed but the basic principles are set. We are, therefore, only in a position to give a general overview.

We will be setting up a National Public Health Service (NPHS) hosted by an NHS Trust. The Welsh Assembly Government will relate to the host Trust through a Service Level Agreement (SLA) that will include Dental Public Health. The NPHS will not carry any statutory responsibilities in respect of public health, these will largely be the responsibility of individual LHBs. The NPHS will however provide the public health advice and expertise to enable the LHB to fulfil its role in this respect. A Specialist in Public Health from the NPHS will be an Executive Board Member of each LHB and be the normal route through which the NPHS and LHB engage.

We endorse a holistic generic approach to Public Health advice but we believe that within the NPHS arrangements the present Directors and Consultants in Dental Public Health must focus on addressing the oral health challenges facing Wales. This will be crucial if dental service and oral health strategy at national and local level is to be delivered effectively.

### Dental Practice Advisers

The continuation of the role played by Dental Practice Advisers who currently provide independent advice to health authorities is vital. There are two viable "homes" for the Dental Practice Advisers:

- In the future LHB's are set to take on many of the statutory functions of health authorities therefore there is reason to locate them in LHB settings.
- Overtime the Dental Practice Advisers have developed a wider public health function and as such a place within the National Public Health Service has advantages.

We are interested to learn from the profession where they consider the Dental Practice Adviser role is best placed.

It is not necessary or practical to have 22 such advisers in Wales. Perhaps ten advisors each "covering" the area of the local commissioning arrangements supported by a strong clinical network is a realistic way forward. We are keen to see consolidation, within the new arrangements, of their current functions particularly practice inspections and their the pastoral / mentorship role and to protect the resources necessary for them to carry out their work effectively.

## Dental Members of Local Health Groups

The role of dental members of Local Health Groups merits comment. Local Health Groups as originally constituted had by right a dental member on the Board. These members have local knowledge but in the future LHBs must recognise that the "expertise" of their Dental Member is limited in some instances to a particular service or branch of dentistry.

It is essential that LHBs recognise that while dental practitioners may well be elected/appointed to LHBs, their role should be viewed as generic, as a local practitioner and not viewed as the Board's only source of expert dental advice, nor by the profession as their only advocate. It will be vital in developing dental services, particularly if alternative models of care delivery are to be developed or existing schemes such as CDS/GDS expanded to meet local need, that LHBs utilise the dental public health resources of the NPHS.

## Local Dental Committees

We recognise and value the contribution of the Local Dental Committees, we will, in the near future consult on their future organisation.

## The Welsh Dental Committee

This committee will continue to provide advice to the Welsh Assembly Government.

## 4.10 Primary Care Resource Centres.

The Future of Primary Care consultation document introduced the concept of Primary Care Resource Centres. Potentially there are a number of ways in which dentistry could be involved, especially if they are to be "bricks and mortar" developments.

### Out of hours dental services

Provision of out of hours dental services present a range of problems – access to premises, availability of staff, safety of staff, the effects of workload impinging upon family commitments particularly of women, and the need for effective triage to minimise inappropriate recalled attendance. Primary Care Resource Centres could provide a secure and central location for out-of-hours dental services, patients being referred after appropriate triage via NHS Direct, see 5.5.

### Integration of primary care services

The potential is not only for integration of dentistry with other services but for better integration of the different dental services themselves.

### Dental service provision from Primary Care Resource Centres

It is assumed that if there is a development of purpose built Centres that they will be located in areas of high health need. They would then provide the ideal location for piloting new models of dental service provision. We recognise that the development of a dental surgery/surgeries requires considerable planning and infrastructure. Past experience has shown this to be most effectively considered from the initial design stage of premises. The decision to have a dental surgery as an "add-on" is almost always a compromise, and less efficient than when included from the outset

## CHAPTER FIVE – ACCESS AND AVAILABILITY

### 5.1 The Problem

We value the loyalty that GPs and those dentists working in the CDS have demonstrated to the NHS in Wales. In recognition of this we have developed with the profession a commitment scheme that rewards the loyalty of GPs to the NHS, see 4.2. Problems of access to NHS treatment in Wales are not nearly as acute as those experienced in some areas of England. To an extent the present social and economic make-up of Wales limits the potential for independent practice. However, many GPs in Wales whilst dedicating the majority of their time to delivering NHS dentistry also provide varying degrees of private provision within their practices. The Welsh Assembly Government is committed to ensuring that NHS dentistry is available to all whom wish to use it, no matter where in Wales they live.

In chapter 3 we discussed general workforce issues facing dentistry in Wales. Access problems tend to be limited to defined areas, particularly but not solely to North West and West Wales. It is recognised that the picture is dynamic. These factors predispose to restricted NHS access.

### 5.2 Welsh Dental Initiative – Stage Three

In the short term we intend to tackle this issue by building on existing schemes. Since 1995, the Welsh Dental Initiative has provided a means of improving access. The primary aim is to increase the amount of NHS dental service provision in those parts of Wales where it is most needed and thereby in Wales as a whole. The scheme offers financial incentives to dentists who are willing to make a sustained commitment to the NHS and who are prepared to establish new practices, or expand existing practices, in areas where patients may be experiencing problems in obtaining NHS care and treatment. Since 1995, over £3.4m has been committed through the Welsh Dental Initiative, mainly for 41 new practices, 41 expanded practices, 13 new posts in the Community Dental Service and 5 Mobile units for the Community Dental Service, one for each Health Authority.

In the past the most common criticism of the scheme, from some elements of the profession, was its perceived failure to reward existing committed NHS practitioners. We also recognise that from now on there will be a steady stream of beneficiaries who, having fulfilled the term of commitment required under the scheme, will be free to choose whether they continue to provide NHS treatment. This factor is already causing access problems in some areas.

Recently we announced Stage three of the Welsh Dental Initiative that combined with our decision to continue with CDS/GDS arrangements; forms a main plank of the short term initiatives of this strategy. *Stage 3 begins to target resources towards existing practices and link with other training and workforce initiatives.*

The main features of Stage 3 are :-

- An increase in the basic grant available in designated areas to £40,000
- New grants available to establish new vocational training practices and incentives to attract vocational trainees

- A grant payable to dentists "returning to work" in the GDS in Wales, which is also payable to the employing Practice

**We have recently announced Stage 3 of the Welsh Dental Initiative to help ensure that the people of Wales have access to NHS dental treatment**

### 5.3 Access to emergency dental care

Dental practitioners have a professional obligation, defined by clear ethical guidance from the General Dental Council, to make arrangements for their patients whom need advice or access to dental care in an emergency, both within and outside normal surgery hours. Under the NHS GDS dental contract, dentists are required to provide emergency cover, (telephone advice and, if necessary, treatment outside normal surgery hours), for their registered patients. Dentists, if they choose to do so, may also provide occasional treatment under NHS arrangements for people who are not registered with them.

GDS practitioners have no contractual obligation to patients who are not registered with them. Frequently, it is those who have not been accessing dental care on a regular basis who are most likely to present in an emergency. Furthermore, the arrangements for patients of salaried services are less than optimal. Many patients do not understand the concept of "registration" and see themselves as "belonging" to a particular dental practice, irrespective of the time since their last dental visit.

Arrangements for the delivery of out-of-hours dental services vary widely. In the short term, to assist Health Authorities meet the demand, particularly for emergency dental treatment, additional funding has been made available to facilitate greater access to NHS services in co-operation with NHS Direct see 5.5.

**From April 2002 new funding was made available to the Health Authorities for the purchase of additional access sessions from dental practitioners.**

We consider that in Wales we already have an extensive network of access centres, i.e. the hundreds of GDS surgeries already existing across the country. Health authorities will be able to purchase additional sessions from practitioners to help improve access to NHS treatment. The strength of this scheme is its investment in existing practices.

These sessions may be purchased during normal working hours or "out of hours". Treatment undertaken by the practitioner under the terms of this scheme will be claimed as occasional treatment in accordance with the terms of the Statement for Dental Remuneration. We are already monitoring the scheme and early indications are that in some areas the uptake by general dental practitioners has been slow. In view of this, and in the spirit of flexibility of the Dental Initiative, we have worked successfully with the North Wales health authority on developing an alternative approach so we utilise the funding to best support and develop existing emergency services to the benefit of patients.

As the scheme develops practitioners/services will be expected to prioritise referrals from NHS Direct Wales, see 5.5.

## 5.4 Occasional treatment

We have agreed with the profession to extend the availability of treatment on an occasional basis. Given the extent to which patients opt in and out of care and, the not insignificant proportion of the population who are at any given time not registered with a dental practitioner we and the profession consider that the change will help address access problems.

**We have agreed with the profession to extend the availability of treatment on an occasional basis and introduce a fee for assessment of occasional patients.**

## 5.5 The role of NHS Direct in Patient information and access to dental care

Until recently ad hoc arrangements existed throughout Wales for the provision of information to patients either seeking advice on dental and oral health issues or seeking access to dental care. We recognise the progress NHS Direct has made in offering oral health advice through its information helpline and the potential for increasing its effectiveness through the NHS Direct Website.

NHS Direct currently provides a dental helpline for Dyfed Powys Health Authority, in addition to more informal arrangements with other Health Authorities in Wales. We consider that there is immense potential for NHS Direct Wales to expand its activities in this area. We envisage its role as being central to the future co-ordination of access to emergency dental treatment in Wales, including to the purchased sessions referred to above. Indeed, in the medium to long term NHS Direct will have a major role to play in co-ordinating the access of patients to all types of NHS dental treatment and care. In establishing an emergency dental service there is always the potential that the system may be abused by a minority of patients, who for reasons of personal convenience, seek care out-of normal surgery hours. This will always be difficult to control but as NHS Direct Wales takes on the health authority helplines on an all-Wales basis its robust triage system should help to keep misuse in check.

**NHS Direct will, with a graduated approach take on the provision of all the health authority helplines. A uniform all-Wales system for access to emergency dental services will be developed through collaboration between LHBs, the profession and NHS Direct. This should be available to all patients irrespective of registration status. We recognise NHS Direct is well placed to lead this development.**

# CHAPTER SIX - ACTIONS TO ADDRESS ORAL HEALTH INEQUALITIES

## 6.1 Health Promotion – a common risk factor approach.

This strategy will not bear close scrutiny if we do not highlight the fact that while the major emphasis is on the future delivery of dental care, a key objective must be preventing oral disease in the first instance. *Promoting Health and Well-Being - Implementing the National Health Promotional Strategy* (14) outlined the National Assembly's integrated approach to improving health and reducing health inequalities through a programme of action cutting across all policy areas. Oral disease is largely preventable if individuals can be persuaded to adopt appropriate lifestyle changes. At a macro level, actions taken to tackle poverty and deprivation will in time impact on oral health.

A number of health promotion initiatives are underway in Wales e.g. National Nutrition Policy, Sure Start and Healthy Living Centres. In the past, the potential to incorporate oral health initiatives has not always been exploited to the full. Many risk factors for systemic disease also impact on oral health and vice versa. Inappropriate sugar consumption in childhood not only results in tooth decay but contributes to the increasing problem of obesity. The adverse effects of tobacco on general health are well recognised, but also impact significantly on oral health. Smokers increase their risk of periodontal (gum) disease threefold, while those who smoke and drink heavily are more likely to develop oral cancer. There is a need for a common risk factor approach to preventing oral disease. Too frequently in the past health promotion initiatives have not maximised their potential by neglecting to include oral health. We recognise the need to promote the inclusion of oral health within general health promotion initiatives using a common risk factor approach as laid down in the Ottawa Charter (15), that is through creating a supportive environment, developing personal skills and strengthening community action.

**Actions to promote oral health must be incorporated within the overall framework for promoting health in Wales.**

## 6.2 Water fluoridation

There are currently no water fluoridation schemes in Wales. The Acheson Inquiry into Inequalities in Health (16) supported water fluoridation to address inequalities in dental health. The Westminster Government commissioned an up to date review of the evidence on the relationship between fluoride and health from the NHS Centre for Reviews and Dissemination at the University of York. The report of the review was published in October 2000. The review found that the evidence showed that fluoridating water helps to reduce tooth decay. The review found no clear evidence of other adverse effects on general health associated with water fluoridation, other than the increased risk of dental fluorosis - mottling of the teeth, which, in its more extreme forms, will leave some people concerned about the appearance of their teeth. Severe fluorosis is extremely uncommon in the UK.

The report did however, identify the need for more good quality research and the Department of Health has asked the Medical Research Council (MRC) to suggest where it might be possible to strengthen the evidence currently available. We welcome the MRC report that was published recently and await the UK Governments further considerations of the implications for government policy.

### 6.3 Fluoride toothpaste

Fluoride toothpaste is an important public health measure that benefits not only children but adults as well. Its widespread availability since the early 1970s is held largely to account for the improvements in oral health seen since that time. Access to a toothbrush and toothpaste may be a problem in some disadvantaged families. The Fissure Sealant programme we introduced last year has the flexibility to include the distribution of toothbrushes and toothpaste's within the overall programme package.

### 6.4 Promoting oral health in infants

Good health in later years has as its basis, a sure start in infancy and childhood. Dental caries is not inevitable and can be prevented by adoption of appropriate behavioural and lifestyle factors. A fundamental plank of any oral health policy has to be actions to secure oral health in children and in particular those at greatest risk.

This is recognised by the Sure Start programme in Wales. Oral health has been successfully incorporated in some areas from the beginning whereby, oral health education is provided and, toothbrushes and toothpaste distributed to the parents of children in the programme localities via the health visitor network. However, in other Sure Start programmes oral health was added as an afterthought. The Gwent model of having an oral health member on the Sure Start team would ensure that programmes are best served.

**Oral health promotion must feature in Sure Start programmes and other similar initiatives such as Healthy Living Centres. Local Health Boards and Trusts must give consideration to the oral health needs of localities they serve within their Oral Health Plans.**

### 6.5 Diet and Oral Health

The Food Standards Agency has been drawing up a National Nutrition Policy for Wales. The need for a multiagency approach is exemplified in the area of school food policy. The proliferation of vending machines in schools selling carbonated beverages will impact significantly on oral health – both in terms of dental decay and erosion of the teeth. Programmes such as the Healthy Schools Initiative should address this issue.

**We recognise the impact of readily available sugar-rich foods and drinks in schools and their potential to contribute to poor oral health/general health. Local Health Boards working in partnership with Local Authorities should develop policies that encourage healthy options for drinks and food in schools.**

### 6.6 A more preventively orientated dental service

The need to place more emphasis on health promotion and preventive approaches in the delivery of dental care rather than simply treating the outcome of dental disease needs to be addressed see 4.2, 4.3. The Early Years Initiative was launched in 1999 to improve the dental health of children from deprived areas. It gives higher payments to dentists to encourage them to register more children from deprived areas. As a further incentive to increase registrations the Welsh Assembly Government has led the way in the UK by making dental examinations free to all patients under 25 or over 60 years of age.

## 6.7 Maximising the potential of workers outside the immediate dental team

### Health and Social Care Staff

It is vital that policies aimed at improving standards of care provided by staff in general incorporate oral health care. A current example of this is the 'Fundamentals of Care Project' that is developing standards for basic aspects of health and social care provided by the statutory and independent sectors. There are 12 standards being developed including 'care and comfort of the mouth and teeth'. Assuming that these standards are effectively taken on board by providers of health and social care, this policy development should have a positive impact on oral health and wellbeing.

### Health visitors

The current contribution and the potential for greater involvement in oral health promotion by Health Visitors and of other workers out-with the immediate dental team is recognised. In Wales, the first experience of dental care for many children is when they attend in pain with, in too many instances, a resultant general anaesthetic for tooth extractions. Considerable numbers patients who develop a phobia about dental treatment ascribe this to an adverse dental experience in childhood. The early birth visits and other contacts made by health visitors with new mothers and their families provide an ideal opportunity for imparting oral health messages within the overall advice they impart. Commissioners and providers should ensure that oral health advice is an integral part of the service provided by health visitors.

**Health visitors are ideally placed to support the dental team in promoting healthy dietary and life style options and encouraging early dental attendance.**

### Pharmacists

The role of community pharmacists in relation to contributing to oral health comes in three areas. Firstly, they dispense medications prescribed for dental and oral conditions and need to have an understanding of oral pathology. We encourage pharmacists to promote the prescription and sale of sugar free medicinal products whenever appropriate. Secondly, they frequently sell oral hygiene aids and products and need to be knowledgeable about the merits and efficacy of these. Finally, patients may well present to pharmacists seeking advice or a cure for an oral problem e.g. toothache or a mouth ulcer. Provision of appropriate advice and onward referral as necessary is crucial.

**We recognise and encourage the contribution of pharmacists to the promotion of good oral health.**

## 6.8 The role of an Oral Health Educator

Oral Health Educators are a small and often neglected part of the dental team, usually with a background in dental nursing they hold a Certificate in Oral Health Education and may have a teaching qualification. They are mainly employed within the CDS. Their duties include provision of oral health education in schools and in "training the trainers" e.g. to the training of general nurses.

There is potential for developing role of oral health educators in training the trainers and integrating oral health within health promotion initiatives at an operational level within other services and organisations. There is a potential in developing a formal training programme for Oral Health Educators, possibly via NVQs.

**We will discuss with the profession the potential and feasibility of developing a formal training programme for Oral Health Educators moving from basic certification to more advanced levels.**

## 6.9 Community involvement

Community involvement should be seen as an important element of oral health promotion. There is a need to account for cultural and ethnic diversity in oral health promotion programmes and the provision of dental care. Certain population groups such as immigrants and refugees may have particular dental needs and special provision may need to be made for their care as part of an overall health and social care package.

## 6.10 NHS Direct Wales

Through its dissemination of information on oral health issues, in the widest sense, NHS Direct has a major contribution to make towards the promotion of oral health. We strongly encourage the development of the productive links NHS Direct has already forged with the dental profession, see 5.5.

# CHAPTER SEVEN - QUALITY

## 7.1 The drive for quality

*Quality Care and Excellence* (17), detailed our ten-year plan for improving the quality of health services in Wales. This was followed by clinical governance guidance that was contained in WHC (99) 54. The consultation document *Improving Health in Wales Clinical Governance Developing a Strategic Approach* (18) was our next step in that it considered further the strategic approach that organisations may wish to take.

In developing a strategy for Primary Dental Care the development of a quality service is a key issue. Two major factors impact on this area in Primary Dental Care - the clinical governance agenda and the introduction on mandatory continuing professional development and re-certification by the General Dental Council.

Wherever and however it is provided NHS dentistry must provide a high quality service defined by:

- safe, appropriate, clinically effective and cost effective services
- a system of professional self- regulation which commands the confidence of both the profession and the public
- patients who know, or can easily find out, their rights in relation to NHS treatment and what they can expect of their dentist
- the best use of the skills available in dentistry and opportunities for individuals to improve those skills.

Many of the components of that sort of service are already in place, giving us a firm underpinning for improvements. Dentists who qualify in this country have rigorous training and can be proud of their skills and professional standards. In the NHS those standards, backed by the General Dental Council that regulates dentists, dental therapists and dental hygienists, are supplemented by:

- clear guidance on the appropriateness of different treatments and the standards those treatments should meet
- a system of prior approval by the Dental Practice Board for more complex, expensive work.
- the Dental Reference Service, which regularly reviews the work of every NHS dentist in the GDS
- a national clinical audit and peer review scheme for the GDS in Wales
- a formal system for making and investigating complaints
- Welsh Assembly Government support for continuing training and education

Despite all this there are still some areas where the quality of the service, and the ways of guaranteeing that quality, need strengthening e.g. in a very few cases treatments can still be unsafe, ineffective or do not represent good value for money. Also, patients may not know, and may have

difficulty finding out, their rights and what they can expect from the NHS. These and similar issues are being tackled jointly by the UK Governments, the NHS, the GDC, the British Dental Association. Some positive action has already been taken, the NHS Tribunal will be abolished and the power to suspend and remove and impose conditions on dentists on health authority lists will be devolved to health authorities themselves. We will also be introducing supplementary lists, which will introduce similar controls over locums, deputies and assistants. The Government will reinforce that and do more, guaranteeing the quality of NHS dental care and protecting and empowering dental patients.

## 7.2 Empowering Patients

Too many people are uncertain about exactly what they can expect from NHS dentistry. In the worst cases this can lead to patients suffering pain and disease by going without dental care altogether or paying for private work without realising that the NHS could have met their needs. It is also possible for patients to be left unsure about whether they are getting NHS or private treatment. We will continue to work with the dental profession, patient organisations and the NHS to make sure that patients are better informed about the full range and quality of treatment that they are entitled to expect from the NHS.

In Chapter 4 we explain how NHS Direct Wales will in the future play a big part in providing information about NHS dental care. Patients also need to be better informed when they are in the surgery. We will ensure that patients can get clear, comprehensive and up to date information about:

- the range of treatments available from the NHS
- the charges payable for their treatment
- the arrangements their dentist has made for urgent, out of hours treatment and
- whether their dentist is suggesting any private treatment.

This information must be supplemented by personal estimates of what a treatment plan will involve and cost, and receipts showing patients exactly what they have paid. There must also be a clear distinction between NHS work and private work. If a patient would prefer private dental work for all or part of a course of treatment, he or she must sign to show agreement to having the treatment carried out privately. If it is necessary to change the treatment plan or the charges the dentist must tell the patient and discuss the changes before going ahead.

Patients need to know exactly what treatment they are getting and whether all of it or some of it is being provided by the NHS or privately. Other aspects of the relationship between NHS dental care and the private sector have also prompted complaints from patients. For example, some dentists will provide NHS treatment to children only if the parents agree to be treated privately. We understand the issues around this, including patients' concerns, and will consider whether it represents a significant barrier to NHS treatment for all.

Like NHS patients, people having private treatment expect high quality treatment, good information and an overall package of care that meets their needs. They lack access to an effective complaints system and the UK Governments and profession will continue to discuss how to address this issue. The GDC is currently consulting on a complaints scheme for non-NHS dental care.

The main ways in which the NHS can safeguard NHS patients and their rights are:

- through the NHS complaints procedure
- through the DPB's role in protecting the interests of patients, dentists and taxpayers by financial and quality audit
- through the Dental Reference Service, which approves/reviews treatments provided by every dentist. This helps to make sure that dentists are acting properly, that their decisions about what treatment to provide are correct and that the quality of that treatment is high.
- through indemnity cover; all NHS dentists are now required to hold adequate cover, so that their patients are guaranteed proper compensation on the rare occasions when it is needed, this is also an ethical obligation.

### 7.3 Clinical Governance

Clinical governance is a programme aimed at changing the culture of the whole NHS to improve the quality of its services. It means:

- clear lines of responsibility for the quality of clinical care
- a comprehensive programme of activity which improves quality
- clear policies for managing risk
- procedures for all health care professionals to identify and remedy poor performance.

Clinical governance is not just a matter for the NHS. It is a professional issue that must be led by the profession whether practising in or outside the NHS. It embraces the whole dental team and all services providing dental treatment whether they are GDS, CDS, Independent Services, Corporate Bodies or PDS and it includes all aspects of care and treatment.

In 2001 the setting up and operating of a practice based Quality Assurance System (QAS) and participation in peer review or clinical audit became a term of service within the Wales GDS. We recognise that the pursuit of quality introduces new "pressures" into the working practice environment. Clinical Governance is a concept that will continue to evolve over the next 5 to 10 years and we look forward to working with the profession during its development.

**We have provided funding for a national Clinical Audit and Peer Review Scheme for the Wales GDS and funding to practices for setting up the QAS systems.**

### 7.4 Continuing professional development

In 2001 we funded a revised scheme for dentists working in the GDS, that reimburses them for time spent on Continued Professional Development contributing towards their re-certification requirements. Trusts must ensure adequate access to CPD opportunities for staff within the salaried dental services and commissioners should take care to include its requirement within service specifications.

**We will continue to work with the profession to refine the current GDS scheme.**

## 7.5 Strengthened self regulation

Just as for other professions in the NHS, the legal framework for the regulation of the dental profession is undergoing reform. The General Dental Council has consulted on a package of measures designed to modernise regulation and has asked for amendments to the Dentists Act 1984 allowing them amongst a range of reforms to:

- create a smaller more strategic body with greater lay representation
- make continued registration as a dentist dependent on the dentist taking part in continuing education requiring re-certification
- increase the efficiency of investigation into possible poor performance

**We are firmly committed to eliminating poor performance across the NHS, including NHS dentistry. We support the UK Government in bringing about the necessary legislation to strengthen self-regulation.**

## 7.6 Safe and Clinically Effective Treatments

Patients have the right to expect treatment that is safe, clinically effective and appropriate to their needs. The National Institute for Clinical Excellence (NICE) was set up to give advice on best clinical practice to NHS clinicians, to those commissioning NHS services (Health Authorities and LHBs), and to patients and their carers. It is a key aspect of the Welsh Assembly Government's agenda for quality in the new NHS.

NICE is part of a new partnership between the Health Departments of Wales and England, clinical professionals and patients. In establishing NICE Government has acted to clarify, for patients and professionals alike, which treatments work best for which patients.

The National Institute for Clinical Excellence will develop clear guidelines improving both the clinical effectiveness and cost effectiveness of dental treatment. One of the first treatments NICE looked at was the extraction of wisdom teeth, and its guidance for the profession should mean better treatment for patients.

## 7.7 Orthodontic Reforms in the GDS

There is a need to ensure that orthodontic care provision within the NHS is based on need and the potential for clinically beneficial outcomes. Work with the profession on reforming the NHS GDS orthodontics in Wales and England is continuing.

## 7.8 Incoming dentists

Dentists qualifying from outside the UK are coming to practice in Wales. Some of these dentists may not be familiar with the NHS GDS regulations, referral procedures, and natural history of oral disease in Wales. Legislation prohibits mandatory vocational training for many of these dentists but we consider that a short voluntary induction course would be of benefit to such practitioners, see 3.7.

## 7.9 Single-handed practitioners

Single-handed practitioners are particularly prone to professional isolation. In some rural areas of Wales over 50% of dental practices are single-handed. The profession and we recognise the dangers of professional isolation but in the rural areas of Wales, under the current GDS system, the patient bases do not exist to support larger practices. We have funded initiatives placing CPD Tutors and Audit Facilitators into the field to support local practitioners in developing Personal Development Plans and taking part in clinical audit and peer review. We believe this will begin to break down isolation. In the future LHBs will be ideally placed to combat professional isolation amongst their community of GDPs.

## 7.10 Research and development

Improving Health in Wales and the Primary Care Strategy set out an enhanced and challenging vision for primary care that will need vibrant R&D support. This challenge, particularly as the pace of change in our primary dental care in the UK increases, provides an opportunity for R&D to become a factor in the provision of treatment. There is a need to strengthen the evidence base, particularly from a primary care perspective. The movement towards evidenced-based dentistry recognises the need for the effective and efficient delivery of dental care. Work by bodies such as NICE, the Cochrane Collaboration, and Scottish Intercollegiate Guidelines Network is beginning to produce evidence and guidelines that will help identify and summarise current knowledge and provide a mechanism to encourage more evidence-based practice.

There is a need for effective research and the development and implementation of research outcomes in the Primary Care setting. Whilst many advances have been made in dental treatment and technology in recent years, dental research is carried out within a secondary, academic or specialist care settings. The vast majority of dental care is delivered in primary care settings and as a result the findings of research are often of limited relevance to the context in which the bulk of NHS dentistry is delivered. A sound base of research expertise and experience of relevance to dental practitioners is available principally within UWCM Dental School but it is also developing within the University of Mid Glamorgan.

Lack of funding, lack of expertise in research methodology, and the need for assistance in compiling grant applications and protocol development were viewed as barriers to dental practitioners becoming active in research. Involvement in research is a potential "carrot" for keen young practitioners or a way of developing and maintaining an interest for those in the middle of their careers. The implications for service delivery should also be borne in mind should practitioners become involved in research. In Scotland, funding has been made available in the form of scholarships to encourage interested primary care practitioners to participate in research. Consideration will be given to a similar scheme in Wales.

**We acknowledge the need for the encouragement of research, applicable to the primary dental care setting**

# CHAPTER EIGHT - INFORMATION AND MANAGEMENT TECHNOLOGY

## 8.1 The current situation

### General Dental Services

The extent to which practices utilise information technology varies widely. At one end of the spectrum some practices are fully computerised and utilise complex patient management systems, which are capable of maintaining clinical records (including digital radiographs); organising appointment scheduling and patient recall systems. They can also transmit claims directly by electronic transfer to the Dental Practice Board. On the other hand, some practices barely make use of information technology, if at all. Precise figures of the balance between these extremes are not available, but data from the Dental Practice Board show that the percentage of practitioners submitting data electronically varies from 53 % to 62 % across health authorities.

The needs assessment identified that general dental practitioners consider they have fared badly in IT developments when compared with their colleagues in the General Medical Services and perceive this as further evidence that they are not embraced fully within the NHS Family. Although grants are available to aid transmission of data to the Dental Practice Board these were not seen as an incentive to develop a more IT orientated practice.

### Community Dental Services

The development of an IT infrastructure within the CDS lags behind even that in the GDS. The benefits of an improved IT infrastructure identified above apply equally to the CDS. Work completed within the past two years, funded by the Welsh Assembly Government, has identified the information needs of the CDS.

The profession has told us that current information for management within the CDS was not as useful as it could be to the service. This is an important issue, because if some of the recommendations made elsewhere within this strategy are adopted then activity and management data will be crucial to efficient commissioning and management of such a service. We look forward to discussing this matter with the profession.

## 8.2 The Developing Picture

The potential benefits of developing and enhancing the information and technology infrastructure within primary care generally are well documented (19) and apply equally to primary care dentistry. The development of Local Health Boards provides an opportunity for dentists to be more closely integrated with primary care team working. The needs assessment informed us that dental practitioners felt strongly that to function in an integrated way with the wider "NHS family" their needs must be specifically addressed within national IM&T strategy.

As part of the implementation programme for 'Improving Health in Wales', an Information Task & Finish Group was established. This group is working up a National IM&T Development Plan (NIDP) for Wales. The NIDP will set out a programme of work, aligned to the long-term vision of 'Improving Health in Wales. This Plan will represent a radical response to the current shortcomings in information and IT uses in care settings in Wales. It will attempt not only to solve the problems

of today but also to provide the NHS and its partner organisations with the capacity and flexibility to handle the public and policy requirements of the future.

**We propose that, within the compass of the NIDP, provision should be made to extend access to the NHS Wales Wide Area Network to all primary care practitioners. Such connectivity would enable electronic communication to all other parts of the NHS, appropriate sharing of relevant patient health information and access to the knowledge bases for health.**

# CHAPTER NINE - PROGRESSING THE CHANGE

## 9.1 The Steps Forward

In the short term we all have a balancing trick to perform. We have to consolidate the present services to see them through this immediate period of major structural change in NHS Wales. As we do this we must ensure delivery of NHS dentistry to all those whom wish to access it. We must also begin the first steps towards reform and change for the medium and long-term future.

In the immediate and short term:

- It is essential that we pilot/test innovative models of providing dental care in Wales. We envisage PDS as one tool available to pilot new approaches.
- Local Health Boards, will be required to develop Local Oral Health Action Plans, reflecting local needs and guided by the National Dental Strategy.
- We acknowledge that the GDS requires reform, and that at the heart of this is the need to reform the system of remuneration. We look forward to discussing the way forward with the profession in Wales as a matter of urgency.
- We have recently announced Stage 3 of the Welsh Dental Initiative to help ensure that the people of Wales continue to have access to NHS dental treatment. This includes an increase in the basic grant and innovative schemes to support vocational training and "return to work" in Wales.
- From April 2002 we offered general dental practitioners who have demonstrated a commitment to the NHS, a limited scheme to assist meeting the part of the costs associated with operating a general dental practice.
- We have extended an improved version of commitment scheme to GDPs who have demonstrated a loyalty to the NHS after just 5 years
- We have recently made the CDS/GDS Interface Trial a permanent scheme.
- We have agreed with the profession to extend the availability of treatment on an occasional basis and introduce a fee for assessment of these patients.
- From April 2002 we made available new funding to the Health Authorities for the purchase of additional access sessions from dental practitioners.
- NHS Direct will, in a graduated approach, over the next 12 months work toward taking on the provision of all the health authority dental helplines. One of our aims will be a uniform all-Wales system for the management of access to emergency dental services available to all patients irrespective of registration status. NHS Direct is well placed to lead this development.
- We will commission a feasibility study into expanding the number of dental undergraduates and of PCDs in training in Wales and this study will also consider further development of educational initiatives within the primary care setting.

- We will review the advisory structure for Dental Vocational Training in Wales.
- Fragmentation of the CDS must be avoided. We will issue revised guidance on the role of the CDS.
- We have recently set up a Welsh Joint Negotiating Committee to discuss issues affecting the salaried services in Wales.
- We will discuss with the profession the potential in developing a formal training programme for Oral Health Educators.
- We acknowledge the need to promote an enhanced IT infrastructure in primary dental care within the National IM&T Development Plan for Wales.

In the Medium term we wish to see development and evaluation of innovative models of care, and of gradual reform in the GDS. In Chapter 4 we opened the debate. We will seek to rationalise the management structure of the CDS and utilise PDS as a vehicle to pilot innovation in service provision that has the potential for development into general models. Conditions under which dental care has to be delivered in the Principality are far from homogeneous, and a variety of service delivery mechanisms will be needed to ensure that quality NHS dental care is genuinely available in different communities and for different age groups.

It is imperative that any change is introduced on an incremental basis, followed by appropriate evaluation, before wider rollout and ***that this is done with the full support of the profession.***

In the longer term the process of change described throughout this strategy would require a major change of culture which would mean:

- devolving funding to a local level and using it in a more targeted way to achieve locally-determined objectives, with safeguards, as necessary, to ensure it remains focused on dentistry
- addressing the issue of equity of distribution of funding and, for the future, control of entry to NHS contracting arrangements
- ensuring that all services contribute to the objective of an NHS dental service which serves a population fully
- reviewing the concept of registration with a General Dental Practitioner in the light of the new locally-based framework
- ensuring that no dentist working within or contracting with the NHS loses out from any change.

We envisage over time the re-defining of NHS GDS dentistry and moving to a more locally-sensitive system of commissioning and administration. Through this evolutionary process better integration of GDS, CDS and PDS will follow. In the long term NHS primary care dental services could potentially develop into a Public Dental Service for Wales. This would sit in an environment that encouraged strategic planning between service providers and was delivered through locally sensitive action plans guided by national strategy. We believe that services managed on a larger

scale have greater flexibility, increased economies of scale and provide better opportunities for patients and those who work within them. It is in such an environment that the facilitation of the care and treatment necessary for securing and maintaining health for all can be best be achieved.

## 9.2 Delivering and Monitoring

We must have a robust mechanism in place to deliver the action plan, in order that opportunities afforded to primary dental care by this strategy achieve their maximum potential.

**To help make this happen we will set up within the NHS Wales Department of the National Assembly a cross-divisional group that will pool experience on dental issues and lead to better co-ordination.**

Under the new structures for the delivery of primary care, the requirement for each LHB to develop an Oral Health Action Plan, (guided by national strategy), will provide a means whereby commissioners will be held accountable for assessing oral health needs, proposing actions to address oral health and commissioning services in their locality. The Welsh Assembly Government will be able to performance-manage LHBs against planned outcomes within their Oral Health Action Plans. Similarly, providers will be held accountable for delivery by the commissioning organisations.

## 9.3 Conclusion

Health policy on dental services has lagged behind other health sectors. A key aim of the Welsh Assembly Government is the achievement of health improvement and the reduction of health inequalities. The Welsh Assembly Government needs primary dental care to be a central performer in the development of a healthier Wales and a major contributor to ensuring equality of health service provision.

There is an over-complex NHS regime, and a mixture of private and NHS care in many practices. The experience of grappling with the current systems often leaves patients feeling disempowered and dentists disengaged. We have a vision of gradual change where innovation is first tested and evaluated at pilot sites by dentists and LHBs in selected areas, using PDS flexibilities. This will allow change to be introduced carefully and with the consent of all concerned. Over time, a new NHS dental service should be available to everyone, a universal system, one that is capable of meeting the needs of particular groups in the population, with referral to specialist NHS dental services as necessary. Furthermore, the new service should allow the dental team to increasingly focus on preventive measures to combat dental disease, and to tackle the oral health inequalities that exist, particularly in the child population.

Wales has a very broad approach to primary care and it is vital that dentistry takes its place at the heart of it. Dentistry in Wales faces considerable challenges as it tackles the rising demands for dental treatment, changing public expectations and technological developments. We need to build on the successes of NHS Dentistry in Wales and make working in Wales a continuing career choice for members of the whole dental team.

This strategy sets out to take hold of the opportunities these challenges offer so that we can strengthen delivery of primary dental care and oral health improvement in our communities. It begins to outline a co-ordinated approach, not only through the short to medium term but also the longer term, it begins to map out a vision of how dental services and the oral health of the people in Wales can be improved. It requires full discussion with the professions, the service and patients to ensure that it is implemented effectively.



# DENTAL WORKFORCE DEVELOPMENT/ADVISORY GROUP

## EXECUTIVE SUMMARY

### Recommendations

- 1) *The number of dentists and Professionals Complementary to Dentistry in Wales needs to be increased by the following measures:*
  - a) The number of dental undergraduate students in training in Wales should increase from 55 to 76 students per year.
  - b) The development of multi-centre training is strongly recommended with the provision of a multi-chair facility (18-20 chairs) in Bangor to encourage dentists and Professionals Complementary to Dentistry to work in North Wales. Local general dental practitioners should be encouraged to teach in these units.
  - c) Two additional vocational training schemes (approximately 20 places) should also be created together with an increase in the number of GPT places.
  - d) There should be an increase in operating Professionals Complementary to Dentistry training places to twenty and those existing places should convert to the double qualification in dental therapy and dental hygiene. The whole dental team should be trained in integrated training programmes.
  - e) These developments will need to be funded adequately and before the first new students start in order to provide high quality educational facilities.
  - f) All new dental nurses in Wales should be qualified through NVQ schemes and existing nurses should be registered in accordance with the General Dental Council policy.
- 2) *Action is required to encourage dental personnel to remain in Wales and to provide high quality training locally based*
  - a) Incentives for General Dental Practitioners to practise in under dentisted areas should continue.
  - b) There should be incentives to encourage dentists to undertake VT in Wales and to continue in NHS commitment or employment, under contract or in NHS honorary employment for 5 years. These incentives might be bursaries to aid students to train or postgraduate incentives paid either to practices or to trainees to stay in Wales or grants to provide facilities to provide additional surgeries for VTs in addition to the existing grants for additional surgeries.
  - c) Continuing professional development needs to be provided for the whole dental team in order to maintain quality.

- d) Consideration needs to be given to the development of modular access courses that are 'family friendly' but would also enable access to be widened. These courses should be both for basic and post-basic training of Professionals Complementary to Dentistry.
- e) Building on the existing successful 'Return to Work' schemes for dentists, easy access schemes need to be readily available to enable all staff to return to work after a career break.
- f) Consideration should be given to the development of dental nurses and receptionists to be practice managers
- g) Dental therapists should be allowed to work in the general dental services.
- h) Post-basic training for all groups should be integrated and developed. It should be provided locally, build on existing good practice but co-ordinated on an all-Wales basis.
- i) Regulations should be altered to allow practices and trainers to be registered for VT for three years.

3) ***Further work is required in the following areas:***

- a) The skill-mix across Wales, the viability of small practices in rural areas and the need to keep practitioners up to date.
- b) Take account of Life Long learning, recertification and clinical governance, all of which will reduce patient contact hours.
- c) A review of primary, secondary and tertiary care in Wales in the light of the introduction of the General Dental Council specialist lists. The future recruitment and retention of academic staff.
- d) The payments system, in order to encourage dentistry to adopt a preventive rather than a reparative approach.
- e) The effects of changing practice in dentistry e.g. corporate bodies, change in gender mix.
- f) An overall review of dental services in Wales.
- g) The role of clinical dental technicians in the light of the General Dental Council recommendations.
- h) Other initiatives e.g. general anaesthesia and sedation and the possibility of new Professionals Complementary to Dentistry groups.

## TERMS OF REFERENCE

The group had the following terms of reference:

1. To review the existing workforce in Wales in relation to the projected needs and demands.
2. To review the current dental workforce planning system in NHS Wales and draw up proposals for a new system.
3. To examine the Scottish Strategic Review of Workforce Planning and agree which elements are also appropriate to Wales.
4. To consider specific issues for Wales in relation to Dental Workforce Development.
5. To draw up a report for consultation and agree an appropriate approach to the consultation process throughout Wales taking on board views as necessary.
6. The group will report through the All Wales Workforce Development Group

## MEMBERSHIP OF GROUP

Elizabeth Treasure (Chair): Professor of Dental Public Health, University of Wales College of Medicine

José Prior, Director, Dental Auxiliary School, University of Wales College of Medicine

David Edmunds, Vice Dean of the Dental School, University of Wales College of Medicine

Stuart Johnson, General Dental Practitioner

Richard Herbert, General Dental Practitioner, Director of Vocational Training, Wales

Eric Nash, Postgraduate Dental Director, Dental School, Cardiff

Sandra Sandham, Clinical Manager, North Wales

Russell Bennett, General Dental Practitioner, North Wales

Sue Greening, Chairman of the Central Committee for Community and Public Health Dentistry

Alex Michael, Cardiff Dental Students Society, President

John Galloway, Eastman Dental School

Tom Nesbitt, Consultant in Restorative Dentistry, North Wales

Naomi Maderson, Vocational Trainee

Gail Marsh, Chair, British Dental Therapists Association (B.A.D.T.)

Mr Paul Langmaid Chief Dental Officer, National Assembly for Wales

Mr Hugh Bennett Senior Dental Officer, National Assembly for Wales

Mrs Sue Cromack Head Workforce Planning, National Assembly for Wales

Ms Janet Wilkinson Head Recruitment Retention, National Assembly for Wales

Mr Cedric Moon Primary Care Health, National Assembly for Wales

Mr Carl Eley Medical & Dental Education, Human Resources Division, National Assembly for Wales

Mrs Helen Freese Workforce Planning, Human Resources Division, National Assembly for Wales

Mrs Cheryl Broad Workforce Planning, Human Resources Division, National Assembly for Wales

## 1. Purpose

1.1 The Workforce Development Group recognised that there were certain staff groups that had particular problems that needed to be tackled in the short term as well as having a long-term strategy. This included dentists and it was agreed that a sub group should be established to carry out some research and identify exactly what the problems were. The purpose of this report is to present the recommendations and findings of the Dental Workforce Sub Group.

## 2. Background

### Description of Service

2.1 Dental services are very different when compared with medical services. Most dental care is provided by general dental practitioners. There are some 1015 General Dental Practitioners in Wales although the whole time equivalent is not known, 102 in community dental practice and a further 174 whole time equivalent in hospital dental practice. These are supported by a range of staff in the professions complementary to dentistry (PCDs) including dental hygienists, dental therapists, dental nurses, dental technicians, receptionists and practice managers. It is estimated that there are some 1166 PCDs in Wales at the present time.

2.2 General dental practitioners are independent contractors paid on a fee-for-item of service basis. An element of their payment is for continuing care. The Community Dental Service (CDS) provides a safety net service for those who are unable to receive care from general dental practitioners. The CDS sees mainly children, adults with special needs and some other adults. The hospital dental service receives secondary and tertiary referrals. In Cardiff, there is a university teaching hospital where student dentists, dental therapists, dental hygienists and dental nurses are trained. These students go on placement to many locations throughout Wales.

## 3. Description of Health Needs in Wales

3.1 The oral health of the people of Wales is poorer than that generally for England. More adults in Wales have no teeth of their own (they are edentate). There are more decayed teeth per person and there is more periodontal (gum) disease. This is documented in epidemiological surveys 1-3. There is evidence that the incidence of oral cancer is rising currently. The incidence of oral cancer is similar to that of cervical cancer. Survival rates have not improved in the last 30 years.

3.2 Oral disease is also strongly related to social deprivation. People living in more deprived areas are more likely to have poorer oral health than those in less deprived areas. The differences are considerable. These health inequities can lead to marked differences in how treatment is provided and of particular note is the difference in the number of general anaesthetic procedures inflicted on Welsh deprived children by the age of 5 years. Encouragingly, there is evidence that demand for dental services, in these deprived areas, are increasing as a result of local and national oral health awareness initiatives. It will be a major challenge to the National Assembly for Wales to meet the increasing demand for care.

## Decay Experience in 5-year-old Children in Wales, 1999/2000

	<b>% of population with no decay experience</b>	<b>mean number of teeth with experience of tooth decay (dmft)</b>
Best area (Rhiwbina)	75	0.61
Worst area (Tredegar)	27	4.20
Wales	48	2.18

**3.3** Oral health has improved dramatically over the last 30 years. However, this does not necessarily lead to a reduction in demand for health care. For example, many more people in Wales have teeth now than in 1978. The percentage with some natural teeth has increased from 27% in 1978 to 39% in 1998<sup>3</sup>. There is an intermediate generation, those currently aged approximately 40 to 60 who have considerable amounts of treated disease and therefore a large number of filled teeth who will require a lot of maintenance work until they die. Those aged under 40 years, in general, have lower restorative dentistry needs except for those in disadvantaged areas where treatment needs are higher.

## 4. Description of the Welsh Issues

**4.1** Many areas of Wales, particularly North Wales and other rural areas, have been historically 'short' of NHS dental provision because the population of Wales is too sparse to support a viable GDS practice. In these areas the departure of a long established dentist through retirement or other reason can be catastrophic for service provision.

**4.2** Age profiles of dentists in many areas of Wales show a worrying picture. There are major concerns in parts of Wales both in the number of dentists predicted to retire in the next ten years and also in the inability to recruit any dentists to parts of north and west Wales. Some communities have to travel for nearly two hours to reach a dentist. The retirement profile suggests that there will be a need to recruit more dentists into these areas and that the demand may outstrip the supply.

**4.3** Data recently made available by the Nuffield Trust shows Wales lagging some way behind in dentist to population when compared with England, Scotland and Northern Ireland. Wales currently has a ratio of one dentist per 3005 population heads compared with 2846 in England, 2619 in Scotland and 2417 in Northern Ireland. There is a strong case to bring Wales more in line with other UK Nations and establishing a benchmark with the mean (Scotland at one dentist per 2619 heads of population) would seem a realistic target. That would mean Wales needing to recruit an additional forty-four dentists to its workforce.

**4.4** In the last few years, a high proportion of dentists registering with the General Dental Council have qualified outside the United Kingdom. In 1995 for instance the proportion was 36%. By 1998 this had risen to 45% and last year to 52%. The numbers have been split approximately half and half between dentists from inside and outside the European Economic Area. The majority - well over a half - of those from within the EEA have been Swedish, with a third of the rest from the Republic of Ireland. The majority of dentists registering from outside the EEA have been South African.

## Numbers of dentists registering each year in the UK according to original qualification

Date	UK	EEA/EU	S Africa	Other overseas	Total
1995	670	231	65	75	1041
1996	731	337	148	113	1329
1997	717	360	117	109	1303
1998	781	329	183	115	1408

4.5 These figures suggest that the UK dental services rely significantly on dentists who are not "home-grown". This may present something of a problem, since there is clear evidence that the numbers of dentists moving from both Sweden and the Irish Republic have started to fall. Furthermore this year has seen the introduction of the International Qualifying Examination (IQE) for dentists from outside the EEA who wish to practice inside it. The effect of this is likely to reduce the rate of increase in dentist numbers.

## 5 Environment Scanning

5.1 Accurate workforce planning has a chequered history partly because the process can be influenced by many factors, some apparent and others less so. The Scottish report 4 (<http://www.scotland.gov.uk/library3/health/sacd-00.asp>) highlighted many issues but the group reviewed further factors that may be relevant. Possible effects are discussed below but these can be only speculative at this stage.

## 6. Corporate Bodies

6.1 In the last five years the few corporate bodies that have always existed in dentistry have expanded. It is very difficult to know in what ways these will affect the practice of dentistry. Some are NHS practices while others are entirely private. Specialist services are also included in some. The range of hours worked may increase. Lessons learnt from pharmacy suggest that there may be a considerable salary differential particularly for newly qualified dentists. This may cause recruitment problems particularly for junior hospital staff. The initial phase of recruitment to corporate bodies has seen dental nurses and dental hygienists leaving established practices.

## 7. Clinical Governance and Quality Assurance

7.1 The introduction of clinical governance in the health service will bring about a considerable number of changes. The General Dental Council has introduced 'life-long learning', which will enable all dentists to re-register every five years. Although many dentists have already been participating in continuing education programmes it is likely that the introduction of clinical governance will lead to a reduction in supply as the amount of time spent in continuing education increases.

7.2 All professional groups will need to be involved in improving quality. Taken together this will mean a considerable increase in the number of hours spent in education, audit and other activities. Resources will need to be developed to enable quality assurance to be implemented.

7.3 A view has been expressed that some older dentists may retire because of clinical governance and although it is not possible to validate or quantify this view, if correct it will lead to a further reduction in supply.

## 8. Single Handed Practitioners

8.1 These isolated practitioners are often seen as failing to maintain their postgraduate education and are at most risk of developing abnormal prescribing patterns, suffering stress and developing the subsequent problems. Rural areas/small towns might only support a single-handed practice.

## 9. Generation X

9.1 Dentists qualifying today are part of what is known as Generation X. Their attitudes to work are very different to their predecessors. It is suspected that they will work fewer hours and accept less financial reward in an effort to have a better lifestyle than their predecessors. This may reduce supply. Younger dentists report wanting to work fewer hours and, importantly, are prepared to accept a lower income to do so. They wish to remain flexible in their working patterns and do not want to buy practices. The effect of these changes is starting to become apparent.

## 10. Gender Mix

10.1 The proportion of women entering the profession has increased greatly and is now around 50%. In some years of entry it is higher. It is known that women tend to work fewer hours and earn less money and this would be anticipated to reduce supply. What is not known is whether their work pattern and geographical distribution is more appropriate than that of men. Employment legislation will also affect the supply of dental services. Family friendly policies will alter the working pattern of both men and women.

## 11. Dentists Act

11.1 The practice of dentistry is limited by the legislative framework, in which it sits and limits the recommendations that this group can make. However, where relevant, recommendations to change the legislation have been made. The processes by which legislation can be altered are changing so that Orders in Council may be processed. These changes are being managed on for the UK as a whole.

## 12. House of Commons Select Committee on Access to NHS Dentistry

This committee is of relevance to Wales and concluded that:

45. During this inquiry various concerns have been voiced to us about the Government's strategy. The British Dental Association considered that Modernising NHS Dentistry had helped put dentistry on the agenda and that this, after years of neglect, was in itself welcome. But they felt that, although the strategy offered opportunities for both dentists and their patients, it concentrated too much on short-term solutions for the unregistered patient who does not attend regularly. The British Dental Association felt that the opportunity to address the root causes of the problem of access—the General Dental Service remuneration system, and the size, composition and distribution of the dental workforce—had not been grasped. [109] John Renshaw told us: "it is not

really a strategy, it is more of an action plan to sort out the access problem."<sup>[110]</sup> A recent survey of BDA members suggests that the drift out of NHS dentistry would continue and that the incentives designed to keep General Dental Practitioners in the service would have little impact. <sup>[111]</sup> The General Dental Practice Association similarly commented that Modernising NHS Dentistry merely "tinkers at the edges." They argued that more complex problems, such as access for exempt patients or access to advanced conservative treatment within the NHS, were ignored. In addition the perverse incentives created by the remuneration system were not addressed. There were also concerns about the lack of consultation on the strategy. <sup>[112]</sup>

**46.** The Government maintains that commitment payments, the dental care development fund, and health authority grants for practice improvement will have a positive effect on the motivation and retention of dentists in the General Dental Service. But we were also told that these incentive schemes would not benefit all dentists working in the NHS and were not always perceived as equitable. <sup>[113]</sup> The British Dental Association, while welcoming these measures, noted that selective incentives could have a negative impact on the morale of those dentists who did not benefit. The overall effect might be to drive more dentists into the private sector. <sup>[114]</sup>

**47.** We also heard concerns that emphasis on Dental Access Centres might create a two-tier service: a health authority-led relief-of-pain NHS service and a private GDS, and that they would prove expensive to run and would face recruitment problems because the work they provided would not be sufficiently varied to attract high-quality staff.

**48.** As we have said this was a very brief inquiry based on a single oral evidence session, but we have received extensive written evidence and we are quite clear that urgent action is required. We consider that dentistry has never been fully integrated into the NHS and as a result major health inequalities exist. We believe that the present arrangements for accessing NHS dentistry are inequitable, uncertain and getting worse; patients do not know where they stand. Unregistered patients find it hard to get any form of care. Registered patients can lose that status without redress and often without knowing they have done so. Patients do not always get the advanced conservative treatment they need (crowns, bridges, implants etc) through the NHS even when they are registered. Certain very vulnerable groups of patients, such as elderly people and those with dementia, face particular problems. We agree with the Eastman Hospital, that "there should be greater clarity and honesty regarding availability of NHS treatment."<sup>[115]</sup> Modernising NHS Dentistry aims to address immediate problems of access. But these are, as the BDA told us, multi-faceted long-standing problems to which solutions will not be found overnight. There are widespread concerns that the proposals in the document merely provide a quick fix and do not go to the root of the problems. There are also concerns about current workforce levels and distribution, about which at present we have little detailed information. We believe these are serious concerns and that Modernising NHS Dentistry lacks the weight to alter fundamentally what is a deteriorating situation. We would suggest that a long-term strategy for dentistry within the NHS is still badly needed.'

## **13. Research on Recall Frequency**

**13.1** NICE have commissioned a review to look at the required frequency of dental check-up. The results of this review are likely to affect the demand for dental care possibly by reducing it.

## 14. Prevention

14.1 Although it might be desirable to change the emphasis in general dental, setting up a practice to provide a preventive service is not rewarded under current regulations. There is a need to recognise and reward the provision of preventive services. The increasing emphasis on quality is not easy to deliver through the present structure. A review of workforce deals with only half the issue in parallel there is also a need to look at what should be provided and to whom.

## 15. Associate Vacancies

15.1 Many practitioners experience considerable difficulty in filling vacancies especially in the more rural or deprived areas. Mixed practices (private / NHS) are more attractive to associates than 100% NHS. Research is needed to find out if associates are moving to salaried jobs in dental bodies corporate outside Wales. Vocational Training is seen as a way of attracting practitioners to compensate for the shortage of associates.

15.2 Some of the Dental Bodies Corporate (DBC) compensate by recruiting overseas and employing assistants. If they cannot find an associate practice owners try and hold on to the list size. However long-term pressure often results in practitioners moving their paying adults into private care with an accepted loss of patient numbers and a corresponding reduction in the availability of NHS care. Retiring General Dental Practitioners are now encountering problems finding buyers for their practice. In the past the sale of their practice was seen as an important part of their retirement fund, now it frequently just closes.

## 16. Secondary Care

16.1 The hospital based dental specialities are small, and relatively small changes in referral patterns can have a major impact on secondary services. An increase in workforce in the primary sector rapidly feeds through to the secondary sector in the form of increased referrals and leads to increases in waiting lists. Addressing these factors would require an investment in higher training.

16.2 Most secondary services are provided by a small number of consultants (often single-handed) who work across a number of Trusts (both Acute and Community). This is done to improve access but gives rise to logistic and training problems. Except for maxillofacial surgery, there is critical mass to develop clinical networks, unless on an all-Wales basis, which would be impractical for geographical reasons.

16.3 Speciality training, along with a reduction in Junior Doctors' hours, and the increased demand for more didactic teaching, all impact on service provision. This is felt to a disproportionate extent in smaller specialities with relatively few consultants. In addition, it is becoming difficult in parts of Wales, to provide out of hours 'on call' cover, since the workforce, that may be appropriate for day time working, may not be sufficient to allow for legal on call rotas and may lead to concentration of the out of hours cover to an unacceptable degree in rural parts of Wales. This will also impact on the primary care service.

16.4 There are concerns that, along with other small specialities, the dental-based specialities have difficulty accessing the commissioning process. This may get worse with the increasing role of Local Health Groups and the abolition of Health Authorities. Since most consultants cover large areas, they have to interact with a number of LHGs which may lead to them having to spend a disproportionate amount of time informing these bodies as well as, perhaps, in negotiation with

them. These groups would be strongly advised to take advice from local consultants in the smaller specialities. This doubly necessary given the 3 year turnover in these bodies.

## 17. Factors Influencing Supply and Demand

17.1 A workforce review in Scotland (Workforce Planning for Dentistry in Scotland: A Strategic Review: Interim Report and Recommendations) 4 has recently published an interim report and recommendations. This report investigated in some detail the factors that may affect supply and demand together with their estimate of what that effect may be. The tables are reproduced below together with a subjective view as to whether the factor applies in the same way in Wales.

17.2 In general, these factors may be summarised as leading to an increase in demand and a reduction in supply.

### Factors Influencing the Supply and Demand for Dental Services

<b>Demand Factors</b>	<b>Estimated Effect on Demand</b>	<b>Welsh View</b>
Trend of increased demand for all health services	Increased demand	Agree
Increasing proportion of the elderly in the population	Increased demand	Agree
Increasing number of individuals who have natural teeth	Increased demand	Agree
Increased average number of retained natural teeth	Increased demand	Agree
Increasing number of more complex treatments available	Increased demand	Agree
Increasing public expectations of dental treatments/services	Increased demand	Agree
Reduction in oral disease	Reduced demand	Disagree, when taken with above may lead to an increase in demand in some age groups
Technological changes	Increase/Reduction	Agree
<b>Supply Factors</b>	<b>Estimated Effect on Supply</b>	<b>Welsh View</b>
Predicted decline in numbers of registered dentists	Reduction in supply	Agree
Increased early retirements	Reduction in supply	Agree
Increased part-time working	Reduction in supply	Agree
Increased proportion of women in dental workforce	Reduction in supply	Agree, but may not be inappropriate, more information required
Reduction of UK dental graduates	Reduction in supply	Agree
Loss of dental workforce to other countries	Reduction in supply	Agree as Wales is a net exporter
Increase in non-NHS working	Reduction in supply	Agree

<b>Demand Factors</b>	<b>Estimated Effect on Demand</b>	<b>Welsh View</b>
Working time directives, conditions of service, e.g. maternity leave	Reduction in supply	Agree
Dissatisfaction with working conditions	Reduction in supply	Agree
Lack of PCD's	Reduction in supply	Agree
Reduction in number of hygienists being trained	Reduction in supply	Currently not applicable
Lack of funding for PCD training	Reduction in supply	May have some relevance

**17.3** In the Welsh situation there are three other factors that we consider to be important in affecting the supply of workforce.

<b>Supply Factors</b>	<b>Estimated Effect on Supply</b>
Requirements of clinical governance and life long learning	Reduction in supply
Overseas graduates: reduction in those from commonwealth countries; Increase in those from EU	Reduction/Increase in supply
Unknown developments	May reduce or increase supply

## 18. Training of Dental Personnel

**18.1** Dentists qualify after undertaking a 5-year university based course. In Wales, training begins at the University of Wales College of Medicine Dental School based in Cardiff. There are about 55 places available each year. The places at the school are funded partly through the Higher Education Funding Council for Wales (HEFCW) and partly through the NHS Service Increment for Teaching (SIFT) programme. Once qualified, graduates are confirmed as fit to practise and have to register with the General Dental Council and have to remain registered with the General Dental Council if they wish to practise dentistry in the UK.

**18.2** Dentists generally enter general dental practice after completing one year of vocational training. Hospital dental staff undertake similar training pathways to medicine and these usually extend to over 7 years for those wishing to become specialists. The age profile of hospital consultants and academics is such that there is likely to be a shortage of both.

**18.3** The recruitment of dental academics is a significant issue and is a worldwide problem, not limited only to the UK.

The Dental Auxiliary School currently provides UWCM courses leading to: -

- The Diploma in Dental Hygiene (2 years)
- The Diploma in Dental Therapy plus the Diploma in Dental Hygiene (27 months) for Professional Complementary to Dentistry (PCDs)

**18.4** An annual output of 7 Dental Hygienists and 6 dually qualified Dental Therapist/Hygienists is achieved. More favourable remuneration and conditions attract the majority of qualified dental hygienists to employment in the General Dental Services rather than the Community Dental

Services. The potential, added attraction of the Corporate Bodies seems likely to maintain this trend. All the dental hygienists qualifying in September 2000 obtained employment in the General Dental Service but only 1 found employment in Wales. Thus an increase in the number of dental hygienists in training will provide an increased workforce for the GDS/Corporate Bodies but not necessarily for the Clinical Dental Service/salaried services. As qualified dental therapists are restricted to the salaried services and PDS schemes they have more limited employment opportunities. Those with dual qualification opt by necessity, for a mix of dental therapy/hygiene or for whole time dental hygiene employment. Of the 6 dental therapists qualifying in March 2000 only one obtained full-time dental therapy employment and 5 are employed as dental hygienists in Wales. Of the previous qualifying group only three obtained therapy employment in Wales.

**18.5** Dental Nurse trainees are accepted annually onto the 2-year hospital training course. Dental nurses are also trained within dental practices. NVQs in oral health care levels 2 and 3 are in the process of being introduced for all dental nurse training. Transfer to NVQ Courses is already underway and commences at the Dental Hospital in September 2001 where only the NVQ level 3 will be offered.

**18.6** In order to enhance the concept of team working in dentistry it is essential that all members of the dental team be trained together.

## **19. Dental Undergraduate Expansion**

**19.1** Nuffield Trust data shows that at least 45% of dentists who train at the University of Wales College Medicine, Dental School remain with Wales. So increasing the throughput of dental students in Wales would seem to provide a very secure means of increasing the number of dentists into the Wales dental service. There are currently plans in Scotland to increase their throughput of dental students by 120 per annum for the next 5 years. Proportionately that would mean Wales increasing its current throughput of 55 to around 75 per annum. Expansion on that sort of scale in Wales would require significant financial investment to upgrade existing dental training and research facilities in Wales probably including the development of a second major satellite clinical school.

**19.2** Experience would suggest that it is essential that new builds are adequately resourced and that the resources come on stream before the students start, to provide a rapid increase in graduates of proven quality.

**19.3** UWCM, including the dental school, has a background of experience in the management of students on outreach placements. There is an existing network of student support throughout Wales by virtue of the placement of undergraduate medical students in District General Hospitals and the secondment of dental students to Dental Departments in DGHs. Dental students are already involved in primary care placements in community clinics in North and South Wales. All of these would be of value in developing additional dental facilities. It is also in conformity with the All-Wales role of UWCM. A possible model for what is required is to be found in the joint UWCM/Trust facility of St David's Hospital, which is due to come "on-stream" in March 2002.

**19.4** If the annual intake to the undergraduate dental course were to be increased by 15-20 a robust business case and a memorandum of understanding would have to be developed with partners. The following factors would have to be considered:

- The earlier introduction to clinical dentistry envisaged in the new integrated curriculum to be introduced in October 2001, would mean an extra 100 students requiring some access at least, to clinical facilities when the scheme was fully mature after 5 years.

- Negotiations with Cardiff University, or another provider, for the provision of foundation teaching for the increased student numbers will be essential.
- Investment within the Cardiff Dental School would be required to increase pre-clinical laboratory provision for both undergraduate dental student and PCD training.
- It is estimated that 4 additional dental academic facilities of the St David's type but preferably slightly larger (16-18 operatories) would be required to accommodate the additional 100 undergraduate dental students. Each unit would require 3-4 wte dental staff to supervise the clinical work undertaken by the dental students and appropriate staff for PCD training if PCD training is to be undertaken also. These units will provide clinical service to the communities in which they are placed and can be used to alleviate access problems.
- St David's primary care dental education unit comes on stream in March 2001. It is recommended that a second unit be planned for North Wales based in Bangor. The effect of these units should then be evaluated after two years at which time a third may be required probably in Merthyr Tydfil.
- While there are anticipated recruitment problems in South Wales the major problems are in North Wales. There is evidence that dental students tend to practise either where they were brought up or where they trained. In order to encourage dentists to live in North Wales it would seem sensible to train them in North Wales. Thus the recommendation is made to create a teaching facility in North Wales at Bangor to train students in their penultimate and final years.
- It would be highly desirable to facilitate PCD education in all of the satellite clinics that are established and this is one reason why 16-18 operatories in each has been suggested. In addition there would be a need to accommodate more PCDs within the Cardiff Dental School and Hospital for core aspects of their courses. The generally accepted concept of team working makes it highly desirable that undergraduate dental students and PCDs should be trained alongside each other.
- All sites remote from Cardiff would require full learning infrastructure support and connectivity to the host institution preferably with Teledentistry facilities.
- If students were to be sent to these units "on attachment" from the main base in Cardiff, subsidised accommodation would have to be provided.
- These units would inevitably generate an increased need for secondary care in their localities and, although the nuclei for such care exist in most of the above centres, additional resources would be required for Paediatric and Restorative Dentistry.

## 20. PCD Expansion

**20.1** Dental therapists can provide for a high volume of "low technology" restorative dentistry/prevention if required. However under current regulations dental therapists can only be employed within the salaried services or a PDS. Creation of PDS schemes across Wales would be necessary to enable dental therapists to work in this way. Therefore an increase in the numbers of dental therapists in training is not justified until the employment opportunities improve or until the restriction on GDS employment is removed.

**20.2** If the future demand is for periodontal care and for dental hygienists in the GDS then numbers in training will need to increase appropriately. If the need is for more dental hygienists working in the CDS/salaried services then the employment prospects and infrastructure will need to compete with that in GDS. It is important to note that any proposal to allow dental therapists to work in the GDS, which this group strongly supports, would need to ensure that the CDS salary structure can compete with that in the GDS.

**20.3** Existing Dental Auxiliary School facilities could support only a minimal increase in PCD numbers the main limitation being availability of clinical space and for therapy training the shortage of suitable clinical material.

**20.4** Any significant increase in the number of PCD's in training would require the provision of clinical experience in multi-centre locations similar to the St David's Primary Dental Care Education Unit. Within the each of these locations it is desirable that the entire dental team is trained together and therefore each unit is staffed accordingly. Core training would continue to be provided by the Dental Auxiliary School/Dental School for:

- the pre-clinical (phantom head) courses (PCD/Undergraduate integrated as at present)
- clinical skills to a basic competency level
- all theory modules

## **21. Practice Managers/Receptionists**

**21.1** The increasing management requirements of practice, aspects of clinical governance, health and safety, IT issues and team management are all areas where the skills of practice managers and receptionists are necessary. As many practices are too small to support a full time practice manager it may be necessary to look at an enhanced role for dental receptionists. More recognition and better training opportunities delivered locally are required for practice managers and receptionists. At present the training courses are in Birmingham.

## **22. Vocational Training, General Professional Training and Life Long Learning**

**22.1** An increase in undergraduate numbers needs to be accompanied by a corresponding increase in the number of VT places to encourage dentists to stay in Wales. All dentists must complete a VT year before working in the NHS GDS and it would be sensible to tie these increased places to areas with a greater need of a dentist. The development of Dental Vocational Training (VT) has been essential to sustain dental workforce in Wales. Improvements in the current numbers of VT places and the quality of training undertaken could be aided by:

- Practice incentive grants applied to prospective trainers wishing to extend their practices to attract a Vocational Training Practitioner. This is particularly important in the rural areas of Wales.
- Payments for Travel and Subsistence for Vocational Dental Practitioners (VDPs) and Trainers paid directly through the Postgraduate Department to avoid constant delays and complaints about non-payment by the Health Authorities (HA).

- Expansion of Vocational Training Schemes in North Wales with the possibility of establishing a scheme based in Wrexham.
- Subsidised accommodation in rural areas of Wales.
- Differential payments for T&S on education trips.
- Reimbursement of grants via HAs or LHGs to commit new graduates to complete Vocational Training in their areas.
- There is a need to increase the resources and facilities available for life long learning for the whole dental team in the light of quality assurance requirements. Practice-based training is desirable.

## 23. Post Basic Training for PCDs

**23.1** There are no funded resources to support these activities and the uptake of self-funded courses is inconsistent throughout Wales. There is a very serious lack of education opportunities in Wales for this group although there are examples of good practice both led by the Dental Auxiliary School, the Dental Postgraduate Department and those training schemes that have been developed in North Wales. The Dental Postgraduate Department would recommend:

- A central funding stream established through the Department to support all post basic continuing education of the Dental Team in Wales.
- The Department provide a vehicle between all interested parties in providing continuing education for this group
- A standard CPD protocol be developed for use throughout Wales in the light of the needs of clinical governance and the quality issues in primary care
- An adequate appraisal system should be implemented
- Active support in the form of postgraduate auxiliary tutors appointed to further develop post basic education in Wales.
- Programmes of education directed towards the whole dental team and funding made available to allow this concept to be developed at local level.

**23.2** The Scottish model of provision of postgraduate dental education that allows the integrated approach to continuing and postgraduate dental education of the whole dental team through a common funding mechanism should be followed. The good aspects of continuing education of these groups should be maintained and initiatives should be introduced to bring other aspects of CPD up to the standards of other areas of the UK.

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## Description of the types of workforce available in Wales

**Dentists:** work mainly in practice but also in hospitals and community clinics. They prescribe and provide dental care.

**Dental therapists:** may only work in hospitals, community clinics or PDS schemes. They are permitted to undertake a range of restorative, preventive and periodontal treatment.

**Dental hygienists:** may work in all settings. They are limited to providing preventive and periodontal treatment to patients.

**Dental technicians:** provide support to dentists by making appliances and other items e.g. crowns or bridges

**Dental nurses:** provide support to operating staff, dentists, hygienists and therapists, in assisting within the surgery

**Others:** dental health educators provide one-to-one and group health education. Practice managers and receptionists.

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