Written evidence submitted by the Oral Health Foundation (DTY0065)

The Oral Health Foundation is a charity established in 1971 which aims to achieve better oral health for all through support, education, information, campaigns and by influencing public health policy.

We are responding to this call for evidence because we believe the NHS dentistry is at crisis point. Urgent reform is needed, otherwise we fear millions will face unnecessary dental disease and be plunged into a poorer Oral Health Related Quality of Life.

It is extremely disappointing to note that of the 41 conclusions and recommendations from the last Health Select Committee Report in July 2008, very few have been implemented and the situation is if anything worse today.

After more than 10 years of pilot and prototype new contract models, based on a preventive approach as recommended by the Committee, these proposals were summarily dropped.

The 'short term' measure recommended in 2008 of adding additional bands to the UDAs was only partially implemented last autumn some 14 years after it was proposed. This was to be a temporary short-term measure and not a permanent solution to the problems faced by the service.

If NHS Dentistry is to survive, it is essential that on this occasion more notice is taken of the conclusions and recommendations of the Committee.

1. **What steps should the Government and NHS England take to improve access to NHS dental services?**

    1.1 Firstly, access to dental services is not the main parameter for improving the oral health of the population, indeed needing to access restorative services represents a failure to deliver preventive messages in the community.

    1.2 Access to NHS Dentistry cannot be improved unless the dental workforce is expanded.

    1.3 Oral health problems such as toothache are costing the UK economy more than £105 million each year in sick days.

    1.4 Childhood tooth extractions (as a result of dental decay) under general anaesthetic costs £55 million per year. It is appalling that this remains the single biggest cause

for child admission to hospital for general anaesthesia. Children's educational attainment is severely affected by the impact of dental pain and disease.

1.5 A totally new view to commissioning is needed if access to NHS Dentistry is to be improved.

1.6 A model where payment is based solely on treatment of disease is totally outdated with current patterns of disease and incentivises intervention rather than prevention. No other area of NHS healthcare operates on this basis and Treasury needs to recognise that like GPs, dentists can operate effectively with a capitation and preventive approach.

1.7 The original goal of the 2006 Dental Contract was to improve dental access. The 2008 Health Select Committee Report on Dental Services highlighted access has not improved and in 2022 this still remains true.

1.8 The 2008 Health Select Committee Report on Dental Services also highlighted workforce concerns, particularly across rural areas. Now, 15 years later, these access problems have grown into dental deserts across many rural communities where accessing NHS dentistry for non-registered patients is almost impossible.

1.9 There has been a massive reduction in commissioning manpower. Without adequate and informed specialist management the system will not work.

1.10 The 2006 contract with some additional contracting in 2006-9 effectively capped the volume of dental services and there has been little or flexibility to address the needs of the increasing population with most of the provision being locked in existing contracts.

1.11 We do not accept the revisions made to the contract in October 2022 as making any discernible difference in improving access to NHS dentistry. Improvements in NHS dental access will not be made by moving the margins of a system which is not fit for purpose.

1.12 Some regions became very reliant on dentists from the EU and Brexit continues to present a real threat to the dental provision in these areas as existing EU dentists return home and are lost to the system.

1.13 The larger corporate bodies are disproportionately affected by an inability to recruit associates.

1.14 There should be organised and systematic primary care outreach to reach the disadvantaged and disenfranchised.

1.15 Dentists are meeting the needs of the system, not patient needs. In some cases, this may lead to an overprovision of treatment for patients who actually are just seeking basic treatment and pain relief.

1.16 A one size fits all dental contract does not take account of regional variations in cost base and patient needs. As a result, there are regional variations in the ability to deliver.

1.17 Patient charges are a significant barrier to attendance for many and this leads to inappropriate attendance for dental problems in primary medical care and in already overburdened secondary care emergency departments. The latter at a cost of an estimated £5 million per year.

1.18 We have good geographic data on where disease levels are greatest and, prevention and access efforts should be concentrated on these.

1.19 Historic practice location does not match the areas of greatest need and there may need to be a recognition that resource needs to be reallocated.

1.20 The extended dental workforce does offer opportunities to improve access and provide high quality services, but this needs to be correctly funded and for many use of dental therapists remains unviable economically.

1.21 The dental workforce is disenchanted after many years of broken promises and failure to reform. Dental practice income has been eroded and for may the only option for viability is to move to Private Dentistry. This move further exacerbates the access crisis.

1.22 COVID 19 uniquely affected the provision of dental services with complete closure for 3 months and less than 50% provision possible for some 18 months after that. The backlog of treatment has again made the access crisis worse. Only additional provision will address this problem.

1.23 Many countries saw increased adoption of teledentistry during COVID, but advantage of its possibilities was not grasped in the UK. Teledentistry models seem particularly relevant in resource poor areas and with the rise of dental deserts in the UK many areas could benefit from its implementation. In some schemes, using

remote triage and examination by members of the dental team or other healthcare workers, the need for face-to-face surgery time was reduced by up to 80%.

1.24 This approach needs innovative and flexible solutions and different funding models, not a single system driven by patient attendance in a practice.

1.25 Currently private practices are unable to take on foundation trainees, although many would be willing to do this. Changing this could help provide NHS access in dental deserts.

1.26 The current system constrains expansion of provision by dental practices through planned growth. Many Foundation trainees finish their training and are unable to stay in the practice of their trainer and in many cases have no option but to go into private practice as NHS contracts are not available to them

2. What role should ICSs play in improving dental services in their local area?

2.1 Historically, NHS Dentistry has sat at the side of other NHS services and there is currently little integration with ICSs.

2.2 ICSs may have a role to play if they truly adopt an integrated approach to the provision of healthcare in their area but there is a danger that they will not understand the unique nature of dental services.

2.3 Dentists are uniquely placed to help ICS's provide diagnosis and prevention programmes for other health conditions since they see a cohort of patients who are not presenting as 'ill' This could be facilitated by greater integration of medical and dental commissioning.

2.4 The landscape of organisations involved in supporting the provision of NHS dentistry is complex and constantly changing. Consistency would seem to be preferable to constant change.

2.5 Primary care networks are the latest 'new idea'. Conceptualised as grouping medical GP practices together it is now suggested that dental practices and pharmacy services are also integrated into them. Integration across the piece is to be welcomed but it remains to be seen how effective these new structures are in improving service for patients.

2.6 Primary care homes would benefit hugely from the integration of dental services, but the different contracting systems makes this problematic. Any ICS should directly address their role against a national NHS payment system and allow ICS to be innovative and allow them the flexibility to address specific regional issues.

3. How should inequalities in accessing NHS dental services be addressed?

3.1 A peer reviewed study into the impact of COVID on dental care in the UK found that people living in more deprived areas have fared worse than people living in less deprived areas, in terms of uptake of NHS primary dental care following the resumption of services in June 2020.

3.2 The same research found that the cessation of oral health improvement programmes in the community and the dramatic decline of hospital dental services due to the COVID-19 pandemic have also primarily impacted the more socially disadvantaged groups, further widening inequalities.

3.3 Addressing the widened oral health inequalities requires long-term investment in oral health, prioritising public health programmes and supporting access to services.

3.4 The evidence around the efficacy and safety of water fluoridation is unequivocal. Water fluoridation is one of the most widely researched public health interventions and successive studies in the US, UK and other countries have constantly supported its use as a public health intervention most recently Cochrane and previously analysis by York University and the Medical Research Council. This evidence is well summarised in the American Dental Association's publication Fluoridation Facts. Fluoridation should become fully funded and supported public health policy rather than the lukewarm support it currently receives. In terms of cost effectiveness fluoridation would yield immediate cost savings against the burden of restorative care. Reduction in disease levels can be seen withing the lifetime of a government.

3.5 The prevalence of childhood tooth decay in the UK is unacceptable. Successful interventions include targeted supervised-tooth brushing in childhood settings, targeted community-based fluoride varnish schemes, integration of oral health into targeted home visits by health and social care workers, targeted provision of toothbrushes and toothpaste by health visitors, healthy food and drink policies,

targeted peer support groups, oral health training for the wider professional workforce.

3.6 Fiscal policy such as the sugar tax is proven to reduce dental disease levels. Backtracking on policies to reduce sugar consumption will have the effect of increasing levels of dental disease and treatment costs.

3.7 We need to access hard to reach patients with 'wrap around care' and for dental provision to be seen as part of the offering in conjunction with charities, general medical practitioners and social care. Access solutions need to specifically target ethnic groups, older people, those with disabilities, people in rural communities and individuals and households with low income.

3.8 The success of a preventive approach has been illustrated in the Scottish Childsmile project. Through delivery of supervised toothbrushing in schools it has hugely reduced the levels of poor oral health of Scottish children. This initiative has been extensively researched and published and has recently been awarded Best Practice status by the EU Commission. Remarkably the cost of the programme yielded cost savings to the budget for child dental treatment within the first five years of operation. It is quite unique for an upstream public health intervention to yield such an effect within the lifetime of a government.

3.9 Since responsibility for oral health improvement lies with Local Authority public health budgets, rather than at a national level, this has prevented a similar approach in England. There is a hugely variable adoption of oral health as a priority by LAs.

4. Does the NHS dental contract need further reform?

4.1 The NHS dental contract does not need further reform – it needs to be scrapped entirely. It was considered unfit for purpose by the Health Select Committee in 2008 and remains so today. A new contract presents a huge opportunity to modernise NHS dentistry and introduce a fully preventive system.

4.2 The 2008 Health Select Committee Report on Dental Services found that payment system lacked sufficient incentives for the provision of preventive care and advice. In addition, the Department argued that there were too many incentives to provide complex treatment. Since then, the payment system has not changed and continues

to focus on pain relief and treatment, not prevention – an admission that the 2008 Committee believed needed to change.

4.3 UDAs should be removed completely from the contract. Drill, fill and bill is an obsolete concept reflecting disease levels of the 1950s.

4.4 Insistence of output as well as outcome measures needs to be removed.

4.5 Moving towards a capitation system with reward-based health improvement is desirable.

4.6 Focus should be on prevention and capitation with capitation fairly based on patient need determined by DEPCAT.

4.7 Adjustments to capitation were promised last time around and has never been delivered. The Treasury has to trust dentists to care for (not treat) their patient base in the same way they do with doctors and much of secondary care.

4.8 If the NHS dental budget is to remain cash limited, then it cannot afford provision of cutting-edge dentistry and this should only be provided on the basis of patient need and suitability, not patient demand and should be free of perverse output based payment drivers.

4.9 Where complex dentistry is considered necessary, this should only be provided for those patients who are able to demonstrate motivation and capability to maintain their oral health status. The pyramid approach from the Steele review should be implemented.

4.10 Patients need to have ownership of their oral health.

4.11 Dental Care Teams, seeing their patients less frequently, must have responsibility for maintaining messaging around good oral care in between visits to fully motivate their patient base towards better oral health.

4.12 There should be up front oral health interventions by the wider dental team before the patient sees the dentist perhaps by direct access to extended duty dental nurses. Dentists and hygiene therapists should only be working on clean mouths in patients who have demonstrated motivation.

4.13 DQOF should be central as a performance measure not the number of fillings done.

4.14 Behaviour change is key to improving oral health, but a total mindset change is necessary to implement this approach. Different skills are required and will require educational support.

4.15 The dental emergency service needs to be integrated not isolated and to have structured follow up.

5. What incentives should be offered by the NHS to recruit and retain dental professionals, and what is the role of training in this context?

5.1 Dentistry has a history of flawed and tardy manpower reviews dating back to the 1986 Schanschieff report.

5.2 Declining workforce was cited as a significant area of concern in the 2008 Health Select Committee Report on Dental Services, particularly retaining dentists within the NHS. Since then, little has been done to address, or support the growth of, an NHS dental workforce.

5.3 There now needs to be a fully independent structured manpower review as a matter of urgency.

5.4 Expansion of student numbers and the establishment of new dental schools in the mid-2000s reversed a significant manpower shortage but had failed to recognise the impact of the expansion of the EU and the number of EU trained dentists who would enter the market. The increase in student number in existing schools was then scaled back as a result.

5.5 Expanding the number of dental places at universities while subsidising tuition fees in the form of grants could encourage more take up. In return graduates would be expected to provide 'x' years NHS service.

5.6 Dentists' real income has been eroded over many years and if the NHS wishes to retain its dental workforce it must ensure that they are adequately rewarded.

5.7 Despite knowing about Brexit since 2017 (and since leaving in 2020), there appears to have been no contingency planning to increase dental training to replace the EU NHS dentists who being.

5.8 Many EU dentists come for a period before returning to their own country and this 'revolving door' has now become one way. The fall of sterling has also made the UK far less attractive as a destination for dentists from abroad.

5.9 Revisions to the process for overseas dentists will take time to implement and will not provide sufficient new dentists to combat the shortage.

5.10 Some geographical areas and the dental corporates have been disproportionately affected by the effects of Brexit. As EU dentists continue to leave, more areas notably the rural east, could become dental deserts.

5.11 The larger dental corporates are being seen to underperform based on an ability to recruit dentists and this situation is likely to get worse.

5.12 Without an immediate new manpower review we risk an access crisis such as that which existed in the early 2000s. Even then, with the extended interval to train new dentists and have them active in the workforce, it is likely that this growing access crisis is inevitable.

5.13 To implement a preventive approach greater use of an expanded dental workforce, in particular extended duty dental nurses will be essential.

5.14 There seems to be a naïve assumption, without proper modelling, that implementation of an extended recall interval will solve any potential manpower crisis by allowing the existing workforce to see more patients. 19 years on from the NICE recall recommendations this is patently not true and policy makers need to stop hiding behind this as an excuse for inaction.

5.15 A move towards a more preventive approach whilst yielding long term oral health improvements can in fact be more labour intensive to deliver in the short term as was found in the pilot phase of the new dental contract. This needs to be taken into account when the manpower review is undertaken.

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