Evidence submitted by the Newcastle University School of Dental Sciences (DTY0066)

The following report draws together research from across Newcastle University's School of Dental Sciences. The school has academic staff whose research interests include access to dental services across general dental practice and hospital services, for a wide range of patient groups. These groups include the general public, regular and irregular dental attenders and under-represented groups such as those from the most deprived areas and requiring special care dentistry. Furthermore, we have researchers specifically interested in dental contract reform and the impact of the contract on oral health inequalities. Finally, many of our academic staff have clinical backgrounds, meaning they have in-depth knowledge of the demands of clinical practice.

Before discussing the questions posed to us, it is important to acknowledge that research in this area is difficult for a multitude of reasons and can make the problems outlined challenging to address. The government can change this and provide the urgently needed contemporaneous data about the nation's oral health. Currently, data is provided decennially through the Adult Oral Health Survey (AOHS) and the Child Dental Health Survey (CDHS). *The CDHS is due this year but has yet to be commissioned.* These surveys are both vital resources and need to be continued. Accessibility to annual data obtained by the Business Services Authority (BSA) also needs to be improved to give a clearer picture of who is being treated in dental practices to identify the extent of oral health inequalities, and issues affecting access and utilisation of dental services. Furthermore, hospital data relating to dentistry (including dental hospitals) is known to have numerous deficiencies and inaccuracies which, unless addressed, will continue to limit our understanding of the care provided to patients in this setting.[1]

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

There is a shortage of NHS dental services, causing widespread problems with access. This problem can be addressed in at least two ways:

1) Increase the number of NHS dental staff
2) Reduce the need for dental care

1) Increasing the number of NHS dental staff

There are three ways the government and NHS England could increase the number of people willing and able to work in NHS dentistry without needing to train more people – and therefore improve availability of appointments and access quickly. These are to:

- **Reform the NHS dental contract.** There is a large workforce available to provide NHS dentistry, but many dental professionals choose to deliver care privately as they feel the current contract is unworkable. [2] Existing dentists will resume providing NHS dental services if the contract is changed. **If the contract is not significantly overhauled soon, many practices will likely stop providing NHS dental care when the current contracting period ends.** We have ongoing research with members of the dental team exploring the problems with the current NHS dental contract. The key issues from our research are discussed in relation to the question, 'Does the NHS dental contract need further reform?'
- **Make providing NHS dental care easier for practices employing migrant workers.** The other source of dental professionals is migrant workers. Immigration to the UK is now more complicated for EU workers. If a dental practice tries to recruit a dentist from another country, the process to get their NHS performer number is complicated and the burden to navigate this falls upon the dental practice. As such, when a dentist from overseas immigrates to the UK, they are able to provide private dental care which does not require a performer number before they can provide NHS work.
- **Ensure practices have the correct information to use the skills mix efficiently.** Recent guidance from the Deputy Chief Dental Officer has clarified the role of the wider dental team in general dental practices.[3] This information must be widely disseminated and understood by the profession to enable direct access to dental care professionals, such as therapists, hygienists and nurses. Previously our research has shown those who do employ a large skills mix in their practices have been shown to underutilise the dental team.[4] Furthermore the information needs to be disseminated to the public; in order to be successful, people using NHS dental services need to understand that they will see an appropriate oral health professional who is competent and qualified.

2) Reducing need for dental care

There are two potential ways in which the need for dental appointments can be reduced:

- **Increase prevention and therefore decrease disease burden.** Dental disease is largely preventable therefore increasing prevention means less treatment need and therefore reducing appointment demand. We are currently researching what members of the population would be willing to pay to receive the benefits of water fluoridation. There is already a strong economic case for water fluoridation, which will be enhanced by any public support within our data given its low cost and propensity to reduce treatment need/demand. Other preventive schemes have also been shown to be cost-effective but the societal benefits of these schemes do not accrue to those who are responsible for commissioning them.
- **Ensuring patients use the most appropriate services at the right time.** Prior to the COVID-19 pandemic approximately one-third of the UK's population were problem-orientated dental attenders, meaning they only seek care when suffering with toothache rather than attending for routine dental care. [5] This patient group is important to consider as they: (1) do not engage with preventive dental services; (2) attend a wide range of (inappropriate) health professionals; and (3) delay seeking urgent dental care, putting them at risk of serious adverse events. This patient group face a complex network of barriers to seeking regular dental care, including: lack of knowledge, negative experiences with dentists, dental anxiety, cost of care, attending around work in addition to difficulty gaining dental access.[6]
    - To improve appropriate use of dental services, we suggest **lengthening the allocated time for urgent dental care appointments to ensure the dentist has time to provide information and a positive dental experience**.

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

ICSs have a huge potential in impacting the oral health of their populations. They are uniquely placed to know what the needs of their local populations are. However, in order for them to be effective in dentistry, we need to learn from the difficulties experienced by NHS regional commissioning teams.

In research to explore how priority setting for dentistry happened NHS regional teams, we identified that there was no capacity to plan resources strategically. The following key issues were:[7]

- Knowledge: Commissioners did not have adequate knowledge of dental services to make decisions about what should be a priority. Often the people in these roles had responsibility across 'primary care', meaning their role would have to cover GP services, optometry, pharmacy and dentistry. **ICPs need to have dental-specific representation for their areas and input from clinicians.**
- Time: The areas for NHS regional teams changed and often grew, teams merged and commissioning was often burdensome. Contracts and their management became increasingly complex. **Commissioners and advisory clinicians need time to strategically priority set.**
- Direction: Decisions need to be made independently, with information about national and regional priorities for the NHS, especially in terms of oral health. Political pressure and influence from professional bodies can interfere with the priority setting process. Furthermore, there needs to be clarity about the role of ICSs in achieving goals. **ICSs need to know the national direction, what is their responsibility whilst remaining independent of political and professional bodies to make decisions.**

How should inequalities in accessing NHS dental services be addressed?

We need to ensure correct incentives are in place for dental teams to provide care for patients with complex oral health needs, and for individuals to use the services before their oral health starts to decline.

For dental practices and the primary care network, there are several changes which will improve their ability to supply care to high-needs individuals:

- Flexible commissioning & integrating care
    - Recently we have conducted research with adults with learning disabilities, their carers, and dental professionals working within community dental services. This work is currently unpublished, but indicates that oral healthcare needs of this population are high and have increased due to the pandemic. One of the suggestions made to address this issue was **flexible commissioning and increased integration of care between primary care physicians to help address treatment needs in adults with learning disabilities**.
    - Our research has identified that fear of the dentist and stigmatisation is a key barrier to seeking dental care in people with alcohol dependence. To address this **dental care could be integrated into alcohol recovery services or other services associated with chronic illnesses to help alleviate anxiety and start re-engaging people with oral hygiene behaviours and regular dental care.**
    - Problem-orientated dental attenders are likely to seek care from non-dental professionals, including general medical practitioners and medical emergency departments.[8,9] Such attendances are inappropriate as medical professionals cannot provide dental treatment and are limited to prescriptions for analgesics and (often inappropriate) antibiotics. Patients from rural areas and/or deprived areas where dental access is even more challenging are more likely to present to non-dental services, more likely to be given antibiotics, and less likely to be referred to a dentist.[8, 10] To help address this, **increase the availability of dental services in rural and deprived areas and knowledge among other primary healthcare physicians about when to refer to dental services**.
    - Well designed capitation would renumerate practices according to patient needs. Some of the worst oral health is in deprived areas. Capitation offers a potential partial solution to ensuring practices in high-needs areas are still viable for those providing dental care in them. Capitation can weight payments made to practices depending on the profile of the practice and the people likely to attend that practice. Data relating to the deprivation, age and other key indicators of need can give an idea of if, and how much, payments to practices need to be adjusted.[11] **Using a robust capitation formula means that practices can serve high-needs populations and take on new patients without fearing they will provide treatment at a loss. We are currently working on capitation formulae at Newcastle University**.

At the individual level, (i.e. changes would directly impact the people who use dental care and improve their use of services), we have the following suggestions:

- Lack of clarity around dental charges often stops individuals from seeking both regular preventive dental care and urgent dental care. This is particularly an issue for those most in need of dental care.[6] The cost of care is both a barrier in terms of patient's financial means and the public's misunderstanding around the current NHS dental charging system, including who is exempt. Having **transparent dental charges would partly address this along with public education**.
- Work commitments are a barrier to accessing care, particularly for those on zero hours contracts. At present there is no legal right for any employees to have time off work for medical appointments.[12] If **dental appointments were classified as mandatory then patients would be able to access necessary dental care during working hours and using more service capacity at non-peak times**.
- Adolescents are often regular dental attenders as children, but as they transition into independence and young adulthood they become problem-orientated attenders.[5,6,13] Part of the reasoning for this is related to the introduction of dental charges at 18 years of age; an age when these individuals go through significant changes in society, e.g. moving to university, starting employment and becoming independent adults, hence paying for dental care cannot be prioritised. This is again particularly important for those from the more deprived areas, who are less likely to attend higher education and therefore not be included in the current exemption to 19 years old. **Raising the age at which dental charges are introduced would partly break down this barrier and support this patient group in continuing to seek regular dental care**.

Does the NHS dental contract need further reform?

The reforms announced in July 2022 show a measure of goodwill from the Department of Health and Social Care.[14] However, the reforms do not offer a significant change to a lot of practices. There are still several reforms which need to happen. The following section will discuss the key issues with the contract specifically relating to the payment mechanism (Units of Dental Activity – UDAs) which have been raised by members of the dental team in ongoing research.

- **UDAs are not proportional to the amount of treatment provided, nor the time it takes to deliver these treatments.** Practices are not taking on new patients as there is uncertainty about whether the new patient will have no treatments needs, or if they will be a patient who requires extensive dental work. If the latter, the time and materials are likely to exceed the UDA payments. The increase in UDA values of 5 for 3+ treated teeth and 7 for molar endodontic work are not sufficient to combat this issue. Some dental professionals are buying their own materials out of pocket so they are able to provide their patients with quality dental care.
- **There is no incentive to provide preventative advice**. One-to-one time with an oral health professional is an important factor in improving oral hygiene, but the current contract does not acknowledge the value of preventative advice.
- **The threat of clawback** (where the unfulfilled contract value is reclaimed by NHS England) also contributes to dental professionals feeling under continual pressure to meet targets, which can lead to appointments focusing on immediate treatment needs and feeling rushed for patients. This also contributes to a lack of preventative advice being issued in dental appointments.
- **UDAs are not adjusting proportionately with inflation**. Practices can now go up for sale with contracts but if the UDA rate is too low there is no incentive for someone to buy the practice and continue a contract which will ultimately loose them money. A minimum UDA value of £23 is not sufficient.

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

Recruitment

There needs to be increased efforts to ensure there is diversity within the student dental population. Ensuring diversity across ethnicity, class, disability and other protected characteristics means that the workforce will reflect the population. Recruitment of dental students from rural areas also has the potential to increase workforce in these areas.

Retention

Reforming the dental contract will be key to retaining more dental graduates within NHS dentistry. Concerns about irregular pay, stress, and lack of professional development in the NHS all make providing private care more appealing to young dental graduates.

Training

Any professional development which happens for dental professionals working in general dental practices is self-funded. Granting professional bursaries where people can both pay for training and have an income while they are undertaking their training for extended courses will help prevent those providing care within the NHS from de-skilling.

Concluding remarks

To address all the issues raised by this Inquiry further reforms to the NHS dental contract are required. We need reforms which will:

1. Fairly renumerate dental practices
2. Focus on prevention
3. Make NHS dental services more accessible for vulnerable populations and those with the worst oral health
4. Value the workforce

From a research perspective, it is difficult to examine the current status and change, therefore, to help with this researchers/reformers need:

a) Continued funding of the Adult Oral Health Survey and Child Dental Health Survey
b) More detailed routine data collection by the Business Services Authority to incorporate information regarding each course of treatment provided
c) Information about the utilisation of dental services according to the Index of Multiple Deprivation to be readily available from the Business Services Authority
d) Improved data quality from hospital dental services

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