Written evidence submitted by The LDC Confederation (DTY0073)

The LDC Confederation is a membership body for Local Dental Committees (LDCs) which in turn represent all performers and providers of primary care dental services operating under a General Dental Services contract. The LDC Confederation's LDC members represent almost 3,000 NHS primary care dentists across 22 Local Authorities across the Greater London area.

The LDC Confederation welcomes the Health and Social Care Committee's inquiry into NHS Dentistry. Our response to the Health and Social Care Committee's inquiry into Integrated Care Systems is available on the House of Commons' website. As we mention in the submission, our member LDCs have enjoyed early engagement with their Integrated Care Boards and many of the Local Care Partnerships. We are pleased to see this engagement and are encouraged by the ambition and interest shown by colleagues in the Integrated Care Systems. South East London Integrated Care Board in particular has been very engaged with the LDC and we are excited by the opportunity to work with them and look forward to taking that learning to the other Integrated Care Boards in our areas.

We have endeavoured to keep our response as concise as possible and so have not addressed all issues or opportunities we feel are available for NHS primary care dentistry. We would be happy to expand on any of the points we have raised either in an additional written submission or in oral evidence.

We address the Inquiry's specific questions below but a summary of our key points is available here:
In the short term:

- Integrated Care Boards and Local Care Partnerships must ensure that Local Dental Committees are engaged in all local care plans.
- Discussions on access to be premised on need, not on meeting recall guidelines or other criteria which do not reflect an individual patient's health status.
- Improved use of language so that everyone is clear that primary care includes all four primary care professions and not only general medical practice.

In the medium term:

- All dental care professionals involved in the delivery of NHS primary dental care to have access to NHS benefits.
- If water fluoridation is pursued, for it to be accompanied by an appropriate public awareness campaign and investment in dental services to meet the anticipated increase in demand created by increased awareness.

In the long term:

- Full contract reform developed in partnership with the British Dental Association.
- An ambitious restructure of NHS dentistry, which takes into account the new strategic priorities of the NHS and allows NHS dental services to play its part in reducing health inequalities and improving health outcomes.

Summary of additional key points:

- The NHS is a universal service available to all, based on need and not the ability to pay so NHS dentistry should operate on the same principle.
- Until NHS dentistry is treated in the same way as the rest of the NHS more careful wording and messaging from the NHS and government is needed when saying that "the NHS is free at the point of care", as well as more clarity when the term "primary care" is used as often it is used to refer solely to general medical practice.
- If water fluoridation is pursued this must be in addition to continued investment in primary care NHS dental services and must not be seen as "vaccine for your teeth".
- If water fluoridation is pursued it must be accompanied by a clear public awareness campaign about the importance of oral health and regular attendance at the dentist, this will require additional funding for access.
- Integrated Care Systems must work with Local Dental Committees and bring them into all Local Care Partnership meetings to ensure that clear and robust pathways can be developed to ensure every contact counts.
- Regular dental needs assessments, based on access and treatment data, must inform local strategies.
- The Government and NHS must commit to meaningful dental contract reform developed with the British Dental Association based on an ambition to eradicate unwarranted variations in access to NHS dental care.
- Dentists are being trained in sufficient numbers but do not want to work within the NHS because the contract prevents them from being able to provide care in the way they have been trained to do.
- In order to encourage the recruitment and retention of dental nurses and other members of the dental team they should have access to NHS benefits such as the NHS pension, parental leave and sick pay.

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

1.1 Firstly there needs to be an honest statement of intent and ambition from all parties with an interest in the provision of NHS dental care. How far is the Government and NHS England intending to increase access? What funding are they prepared to allocate to that? How ambitious and forward thinking are they in their view of the role primary care dentistry can play in reducing health inequalities and improving health outcomes? A clear plan for NHS dental services is needed.

1.2 Instead of episodic tweaking of the dental contract pursued in complete isolation from the ambitions of the rest of the NHS a comprehensive and ambitious plan for NHS dentistry is required: A plan which takes into account how the rest of the NHS operates and how Integrated Care Systems are looking to reduce health inequalities and improve health outcomes in their local areas. If NHS dentistry continues to be assessed only in light of dentistry and oral health it will never play its full part in reducing health inequalities and improving health outcomes[1].

1.3 To date, statements from NHS England have not been encouraging. It has stated that any reform to the dental contract must increase access but be delivered within existing funding and without jeopardising access for those who already attend a dentist[2]. This is not driving efficiency, but is a statement which supports the existing system and fails to address fundamental issues. The LDC Confederation is ambitious for dentistry and believes that dentistry can play a vital and exciting role in reducing health inequalities, improving health outcomes and helping people lead healthy and happy lives. But this requires honesty, investment and ambition from all partners.

1.4 The primary way that the NHS has been looking to increase access to date has been to focus on recall intervals and in ensuring that as many patients as possible are on the longest possible recalls in order to create appointments[3]. We consider this to be dangerous, especially in light of the reduction in access to preventive care caused by the pandemic. Dentists are clinical professionals trained to use their judgement to assess risk. By focussing on targets to increase recall intervals with no regard to the individual patient is irresponsible and this focus should be dropped in favour of trusting dentists to act in the best interests of their patients[4].

1.5 As mentioned above what is really required in order to increase access is a clear understanding of what each stakeholder means by access. We support the British Dental Association's call for funding based on capitation as the only practical solution to increasing access. We support their calls and urge Government and NHS England to engage with the BDA seriously on developing such a model and allocating the appropriate funding.

1.6 Dentistry can play a significant and life changing role in reducing health inequalities and improving health outcomes[5]. The WHO definition of oral health "encompasses psychosocial dimensions such as self-confidence, well-being and the ability to socialize and work without

---

[1] C.f. https://integratedcarejournal.com/local-voice-key-dental-success/

[2] https://www.england.nhs.uk/coronavirus/documents/nhs-dental-contract-reform-and-arrangements-letter/ last accessed 21.12.2022

[3] Ibid. C.f *Delivering Better Oral Health* which has been advocating risk rated recalls since its inception, https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-13-evidence-base-for-recommendations-in-the-summary-guidance-tables

[4] The NICE guidelines on dental recalls is clear about what criteria a patient must fulfil for each recall and unless there is greater investment in prevention and access to NHS dentistry in the short term what should and could be a long term goal of moving as many people as possible to the maximum recall will not be met. It is not appropriate to work backwards and assert that the longest recall simply is what most people should be on without actually understanding each patient and only a chairside dentist can make that judgement. Given that that is what they are trained and regulated to do, they should be trusted to do just that.

[5] C.f. "Dental decay among young children remains an important public health issue as it leads to pain and distress, sleepless nights for children and parents, and time off school and work. Decay levels among five-year-olds can give early indication of the success, or otherwise, of interventions aimed at improving the oral and general health of very young children including those designed to improve parenting, children's weight or overall health or diet." *Oral health survey of five-year-old children 2017. A report on the inequalities found in prevalence and severity of dental decay.* Public Health England 2018.

pain, discomfort and embarrassment[6]". These abilities are vital to employment in any public facing work and to breaking isolation and improving mental health[7].

1.7 The most significant barrier facing patients accessing care is patient charges[8]. Patient charges for dental care must be removed at the earliest opportunity and the dental contract must be funded directly from the Treasury. The removal of patient charges would increase access for the most vulnerable by removing fear and confusion over who is eligible for free dental care[9]. It would prevent difficulties for care homes as their residents are often not eligible for free NHS dental care but lack capacity to pay and the care home may not have power over their finances[10]. There is no exemption of patient charges for those who are rough sleepers which causes barriers to entry[11]. The requirement to pay causes confusion and creates a transactional relationship in a healthcare arrangement which is counterproductive, turning people from patients into consumers. Confusion can also arise between NHS and private fees due to a misunderstanding that the NHS is free at the point of service. All messages that the NHS is free at the point of service must stop until it is actually true as this can result in unnecessary complaints caused by an avoidable misunderstanding.

1.8 Currently the NHS recoups about 30 per cent of its dental budget from patient charges[12]. We are concerned that this creates a disincentive in the NHS to prioritise and drive up access among the most vulnerable, perversely meaning that dentistry drives up health inequalities and reduces health outcomes by preventing groups from accessing care at the right time and in the right place. In order for care to be planned effectively based on the needs of the population and not the needs of finance teams. This needs to change and the emphasis needs to be back on the population that the NHS was set up to serve and not on what benefits the NHS financial directors or Treasury.

1.9 The recent Health Act gives power over fluoridating the water supply to central government. Fluoridating the water supply, however, is only effective if it is part of a coordinated campaign for oral health. In order to fluoridate water there will have to be public engagement, and that public engagement must make it clear that although the fluoride in the water will help reduce caries it will only do so as part of a good oral health regime. The danger is that without

---

[6] https://www.who.int/health-topics/oral-health#tab=tab_1 last accessed 19.12.2022

[7] C.f. "Does dental appearance impact on employability in adults? A scoping review of quantitative and qualitative evidence" *British Dental Journal* 2020 available from: https://www.nature.com/articles/s41415-020-2025-5 last accessed 19.12.2022

[8] That is aside from simply trying to find a practice with capacity. https://www.healthwatch.co.uk/news/2021-05-24/twin-crisis-access-and-affordability-calls-radical-rethink-nhs-dentistry, c.f. https://bda.org/news-centre/press-releases/Pages/Dentists-back-free-check-ups-and-call-for-action-on-access-crisis.aspx

[9] ibid.

[10] Page 27 *Smiling Matters* Care Quality Commission 2019 available from https://www.cqc.org.uk/sites/default/files/20190624_smiling_matters_full_report.pdf last accessed 20.12.2022

[11] Page 30 *Healthy Mouths: A peer-led health audit on the oral health of people experiencing homelessness* Groundswell 2018 available from https://groundswell.org.uk/wp-content/uploads/2018/10/Groundswell-Healthy-Mouths-Report-Full-Report-Web.pdf last accessed 20.12.2022

[12] https://committees.parliament.uk/writtenevidence/7651/pdf/

effective messaging people may assume it is an oral health panacea. If this is assumed by those most at risk then their oral health will deteriorate. Any water fluoridation must, as a result, be supported by a drive to increase dental attendance and this in turn will require investment for dental services.

1.10 In the long term we consider that greater ambition is required for the NHS and for primary care in particular. We note that Healthwatch England also supports a much more ambitious role for NHS dentistry in general health[13]. A proposal for a joined up system based solidly on prevention for vulnerable groups may sound ambitious but ambition is what is required if the NHS is to be fit for purpose in the future.

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

2.1 As mentioned in our introduction we are very pleased to see that all the Integrated Care Boards and many Local Care Partnerships in the areas we represent are beginning to engage with primary care dentistry in ambitious ways. We would like to see this ambition continue and are looking forward to engaging with our local partners to drive forward exciting integration projects to improve patient outcomes.

2.2 The primary role of an ICS in regards to NHS dentistry is to integrate oral health into the rest of health: to ensure that dentists can play their part in reducing health inequalities and improving health outcomes as part of coordinated local efforts. Integrated Care Boards need to ensure that Local Care Partnerships at the local authority level involve key stakeholders, which includes the Local Representative Committees of the four primary care contractor professions, in local planning. The locally led health and social care needs assessments need to address individuals' requirements holistically and assess how each of the local stakeholders' particular skill set can contribute to people's ability to live happy and healthy lives[14]. The recent report from Public Policy Projects on their ICS Roadshow made several recommendations[15]. In particular we would like to draw attention to their recommendation that "Government should consider broadening the statutory framework of ICPs to ensure a minimum level of representation to tackle the wider social determinants of health". This recommendation appears to have been made to address the issue: "If population health is to be effectively addressed, the default primacy of one sector over the others must be eschewed in favour of creating a 'partnership of equals'.". This analysis supports our call for LDCs to be involved in ICS discussions as key representative stakeholders of a vital primary care service.

---

[13] https://www.healthwatch.co.uk/report/2021-05-24/dentistry-during-covid-19-insight-briefing

[14] See paragraph 1.6 above.

[15] Public Policy Projects: Insights, *ICS Roadshow Part 1: Getting a seat at the table: Links with social care, primary care, and wider community services.* 2023 available from https://publicpolicyprojects.com/wp-content/uploads/sites/6/2023/01/ICS-Roadshow-Report-Chapter-1-1.pdf (last accessed 20.01.23) C.F. The statement in the report: "Given the degree to which population health is influenced by wider social determinants, it is arguable that achieving the population health objectives set out in Core20PLUS5 will be near impossible for ICSs without a broad spectrum of perspectives represented at the top levels of the system." Dentistry is one of those broad spectrum of perspectives that can influence the wider determinants of health as discussed in paragraph 1.6.

2.3 There needs to be support to develop clear integrated pathways for specific conditions relevant to the local area. Such pathways and integration could focus on specific health conditions such as dementia, diabetes, eating disorders, Parkinson's, stroke rehabilitation, hypertension etc[16]. Local voluntary service providers need to be supported to help those who rely on their services to access comprehensive holistic care and support from whichever entry point they have.

2.4 As well as condition specific pathways the ICSs may wish to support programmes for specific communities.

2.5 The oral health of older adults, especially those in care homes, is often overlooked[17]. Many of those relying on carers because of conditions such as Alzheimer's and other dementias, Parkinson's and old age more generally, are at potential risk of greater health inequalities exacerbated by poor oral health management. Many medicines that people in care will take can lead to a reduction in the amount of saliva produced in the mouth[18]. This in turn can lead to oral health problems including an increased risk of decay. According to the National Institute of Health and Care Excellence (NICE), more than half of older adults who live in care homes have tooth decay, compared to 40 per cent of over 75s who do not live in care homes. In addition sugary medicines in liquid form will contribute to increase risk of tooth decay. Other problems will be caused by those who have no teeth, but who have lost dentures or who have ill-fitting dentures. Ill-fitting dentures or other oral pain can lead to dehydration and malnutrition, which if not identified early on can lead to avoidable hospital admissions. A regular oral health assessment by a dentist can help identify these issues early on, thereby reducing the chance of an unnecessary hospital admission[19]. A coordinated effort to address holistic health needs of those in care homes should be a priority for ICSs, involving local Training Hubs to share information and training for the whole health and social care workforce.

2.6 All those who the Local Authority or GPs have registered as house bound should have a comprehensive care plan with oral health domiciliary visits factored in. Simply joining up information about vulnerable groups and ensuring that that information is shared and used by all stakeholders with a holistic view of the outcome expected would reduce health inequalities and improve health outcomes.

2.7 In order to boost access for children ICSs could support all schools to capture data on which dental practice children attend, as they capture GP details. Any child who does not have a regular dentist could be signposted to a local practice which has a relationship with the school. This would go some way to delivering comprehensive access for children. Any such programme would have to be delivered in association with the LDC. Importantly an impact

---

[16] C.f. paragraph 1.10 above and footnote 12.

[17] *The State of Health Care and Adult Social Care in England 2016/17* Care Quality Commission pg. 92 available from https://www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf

[18] https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/improving-oral-health-for-adults-in-care-homes last accessed 06.06.18

[19] Walls, A. G., Steele, J. G., Sheiham, A., Marcenes, W., & Moynihan, P. (2000). "Oral health and nutrition in older people". *Journal of Public Health Dentistry*, 60(4), 304-7

assessment on access for other parts of the community would be required. Under the current contract if access is increased for one cohort it is reduced for another. The second impact that needs to be assessed is on patient charge revenue as children are exempt from charges. Any practice which was operating in this way would also have to be exempt from penalisation for missing targets if they are working with local stakeholders to help meet their priorities. If, however, the ICS is to deliver even basic initiatives like this effectively then comprehensive dental contract reform is required which adequately funds the dental service to meet local priorities.

2.8 However the ICS chooses to work with and integrate NHS primary care dental services it will have to ensure that there is appropriate funding available to support initiatives and that dental contractors are not placed in impossible situations. In the short term this means giving local areas more flexibility (with the agreement and cooperation of the contractor) to ensure that funding can be used to its best effect before a properly reformed dental contract is delivered. Jeopardy for missing functionally useless UDA targets must be eliminated, particularly for any practice which is engaged with local work to deliver other objectives. If dentistry is to play its part in reducing health inequalities and improving health outcomes then it cannot be considered and measured against UDA figures which even in 2008 the Health Select Committee identified as not fit for purpose[20].

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

3.1 Ultimately inequalities in accessing NHS dental care should be eliminated through a comprehensive funding model which encourages and supports access for the whole population, i.e. contract reform. Until then, however, the Integrated Care Boards must work with the local profession to understand and map service requirements based on a comprehensive and multi-aspect needs assessment, not just an oral health needs assessment. This may result in the short term in access programmes to target improved access for specific cohorts based on age, health status, deprivation or other locally determined indicator. Such interventions, however, have to be carefully managed in the current severely limited circumstances to ensure that those who do currently access care do not lose that access.

4. Does the NHS dental contract need further reform?

4.1 The dental contract requires comprehensive reform in line with the rest of the approach taken by the NHS, with an ambition for dentistry to play its part in reducing health inequalities and improving health outcomes. We refer to the response from the British Dental Association for more detail on what is required and urge the Government and NHS England to engage with the BDA in a meaningful discussion about the future of NHS dental care. The LDC Confederation supports the position of the BDA in calling for a service based on capitation.

4.2 Until recently communications to dentists about using dental therapists have been unclear and do not represent any coherent approach to reforming NHS dentistry. It was concerning

[20] https://publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/289i.pdf

that a policy was announced before the practicalities of implementation had been considered. There are 4,378 therapists on the GDC register[21]. We can assume that all of these will be working, and to date many will have been working privately. The increase in the workforce to the NHS will, therefore, be minimal. There is little incentive for therapists to move from private work to NHS work, and little incentive for practice owners to encourage this either. As far as we understand therapists will not be able to access NHS benefits for providing NHS care. Given that the intention of the promotion of use of therapists on the NHS was to address the lack of dentist workforce it is outrageous that these professionals would be expected to do the work formally done by a dentist but without access to the NHS benefits which a dentist would have. It remains unclear what the effect of this proposal would be on the National Performers' List or indeed on future workforce planning.

4.3 If discussions are to be meaningful and to result in a dental contract fit for purpose for the future then the arbitrary limits placed on discussions need to be removed. For instance if there is no discussion about funding then there can be no meaningful reform which will enable dentistry and dentists to work with Integrated Care Boards to help achieve their objectives of reducing health inequalities and improving health outcomes. Furthermore there has been no public engagement to understand the public's attitudes to and expectations of an NHS dental service. Reform to the dental contract cannot be meaningful if it does not include those who use and wish to use the service. During the pandemic Healthwatch England reported that access to NHS dental care was one of their main issues showing the public appetite and value of NHS dentistry[22].

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 Building on our point in paragraph 4.2 all members of the dental team involved in the provision of NHS dental care should have access to NHS benefits. Ultimately the financial reward in the NHS dental sector needs to be improved and this needs to be grounded in effective dental contract reform as the independent Review Body on Doctors' and Dentists' Remuneration states: "reformed contracts have the potential to improve care, whilst delivering a boost to recruitment, retention and motivation, including by reaffirming the attractiveness of providing NHS/HSC care to dentists who may otherwise be considering increasing the amount of private work they do, or leaving dentistry entirely.[23]"

5.2 A thorough analysis of the workforce in dentistry is required. There is no comprehensive understanding or data capture on how many whole time equivalents there are in the dental workforce, or a satisfactory register of skills. The "tier 2" services offered by the NHS are

---

[21] https://www.gdc-uk.org/docs/default-source/annual-reports/4787---gdc_annual-report-21-22-v7-accessible.pdf?sfvrsn=7dfa926c_3

[22] https://www.healthwatch.co.uk/news/2022-10-12/our-position-nhs-dentistry

[23] Para. 10.64 *Review Body on Doctors' and Dentists' Remuneration Fiftieth Report 2022* Office of Manpower Economics 2022 available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1092259/DDRB_2022_report.pdf last accessed 20.12.2022

locally registered and do not relate to the national register held by the GDC so there is no standardisation or understanding of existing capacity or skill set within the profession.

5.3 As well as understanding the workforce it is also necessary to understand the estates available to dentistry. The CQC has a register of dental practices but there is no accurate data on what the capacity in practices is, i.e. how many surgeries are active or could be active. This is what will ultimately determine access rates, and requires practice owners to have financial security and flexibility if they are to invest in developing their practices.

5.4 In order to address retention issues for dentists in the NHS we recommend the Department of Health and Social Care, and NHS England work closely with the BDA to analyse the responses to the BDA's annual morale, motivation, recruitment and retention surveys. The LDC Confederation would be happy to be involved in specific discussions on this topic.

Jan 2023