Written evidence submitted by Professor Paul Batchelor (DTY0074)

I enclose my submission to the inquiry that I would wish the Committee to consider. I am making the submission as having acted as the advisor to the Health Committee when they last considered the dental contractual arrangements, am disappointed by the lack of progress since the report's publication.

I would be willing to give oral evidence should the Committee feel it of value.

SUMMARY

This submission argues that the current arrangements for the delivery of National Health Service (NHS) dental care have continued to fail the public. Access to care has declined and inequalities in levels of oral health risen.

NHS England has ignored available evidence to develop high performing care arrangements and has paid little or no notice to the obvious shortcomings. Not least developments have paid little or no heed to the failings identified in the previous dental report by the Health Committee in 2008. Improvements in access and a reduction in the inequities of disease levels have not occurred and will not do so under the current contractual arrangements.

More specifically, the component of dental care provided through the NHS GDS contract has continued to decline. Furthermore, the structural changes of the NHS care system in England have failed to engage with the dental system in a sustainable manner. There is a lack of a coherent vision of how dental care or how the NHS funded component can be provided to the population through cost-effective, efficient and sustainable arrangements.

The existing contract through which NHS GDS dental care is provided continues to remain unfit for purpose. The allocated dental NHS GDS budget in previous financial years has not been spent despite the difficulties that patients have in accessing care. The contractual agreement has had a major impact on workforce moral which has suffered and in consequence, workforce retention has declined. This is also likely to have impacted on the qualities of care.

To address the above three fundamental changes need to be implemented. First, a more coherent collaborative approach which sees all care sectors working together to tackle the determinants of poor oral health at a local level must be developed. The logical structural arrangements, the Integrated Care Systems (ICSs), would see a far greater dental involvement in primary care networks with the necessary NHS GDS contractual changes to support this.

Further contractual changes must recognise the need to support the dental professions to provide care of the right qualities and be focussed on reducing disease levels not simply providing increased number of interventions. In addition the barriers to care for those interventions which are provided in dental premises must be tackled. The ideal solution is to remove patient co-payment charges.

INTRODUCTION

1. The present submission is based on my areas of activity as an academic, policy adviser and former Consultant in Dental Public Health. I have had considerable experience of working and analysing both dental and health care arrangements in the United Kingdom (UK) and abroad. This work has included: examining the health status, both general and dental, of the population and its determinants; the usage of medical and dental services by the population and associated factors; workforce planning; funding of care, and; quality assurance arrangements.

2. The work has included acting as an advisor to a number of agencies that have been involved in examining care policy including the Health Committee when it last examined dental care in 2008. In addition, I have acted for numerous agencies abroad including the Health Service Executive and the Competition Authority in Ireland, the World Health Organisation and as an advisor to a number of other foreign national health bodies.

3. Since the Health Committee's last dental Inquiry, there has been considerable changes in the structural and operational elements of the NHS with the four territories, England, Northern Ireland, Scotland and Wales, exhibiting internal variation in the manner in which dental care provision occurs. Most notably, NHS England initially adopted a model in which the Primary Care Network was seen as the delivery structure for care and commissioning based upon the Integrated Care Boards. Currently dental links to such arrangements are at best weak.

4. Numerous reports have reiterated a common theme surrounding dental delivery arrangements, in particular, perceived difficulties in accessing dental care. Although there have been attempts to develop a new General Dental Services contract through pilots, their published outcomes have failed to identify any sustainable and/or effective models that can be scaled across England. Most importantly, the work failed to explore let alone address the key barrier to care, patient co-payments. As such, a system that aims to address inequalities in disease levels and requires service contact are unlikely to be successful.

5. The success or otherwise of the present care arrangements need to be based within a framework to help identify the extent to which any reforms could provide benefits for patients and the public at large. The framework should set dental care as a whole within the NHS architecture with common goals. The current system need to improve three elements: access to NHS dentistry, levels and distribution of oral health and the qualities of NHS dental services.

6. The main proposals of any reform programme should include benefits for those working within the system including allowing more time being spent with patients, not least to help improve quality, less bureaucracy and work pressure, and the ability of the profession to plan and invest in their businesses. The abilities of the present arrangements to address the shortcomings and, not least to improve oral health and reduce inequalities, are at best limited.

7. The issues above cut cross a number of the points in the Term of Reference that the Committee are using as a framework. The goal of the dental care system is to meet, indeed reduce, the oral health needs of the population. The conditions are in the majority chronic in nature and common to many other health conditions, including obesity and diabetes and a number of cancers. To achieve this goal, namely improve the population's health in an efficient and effective manner, collaborative working across all care crafts and that support the professions is required.

8. Finally, while NHS England, indeed, all of the NHS systems have attempted to improve attendance. It is bizarre that the main deterrent in determining attendance, the co-payment arrangements, have increased above inflation rates when the stated goal is to increase attendance. Indeed, even for children, who are exempt from charges, it is parents or guardians that are responsible for ensuring attendance. Unless the system is designed to reduce the barriers for adults, programmes focussed on children will be at best of limited success and fail to address inequalities.

FACTUAL INFORMATION

What steps should the Government and NHS England take to improve access to NHS dental services? What role should ICSs play in improving dental services in their local area?

1. The term dentistry covers that care which the population receive from individuals on the General Dental Council's Register. NHS dental services are simply one element through dental care can be provided and that in itself consists of three components: the Hospital Dental Services, the Community Dental Services and the General Dental Services. Since the inception of the NHS in 1948, some dental care has always been provided through non-NHS arrangements. However, the ratio of NHS to non-NHS care has changed considerably following the introduction of the new NHS GDS contract in 2006. For the year 2017-18, NHS dental spend through General Dental Services (GDS) or Personal Dental Services (PDS) contracts in nominal terms was £3.46 billion while for non-NHS, the figure was £4.36 billion, i.e. the NHS spend was 44%. In 2005-06 the percentage of NHS spend to total spend was 48%. In real terms NHS spend has decreased from £2.6 billion to £2.4 billion while non-NHS has increased from £2.8billion to £3.1 billion.

2. In summary, in monetary terms the NHS is now playing a smaller role in dental care provision than previously and overall now makes the smallest contribution to dental care since the inception of the NHS.

3. When launched, the *NHS Long Term Plan* focussed heavily on the creation of PCNs as the key delivery vehicle for integrated neighbourhood working, bringing together primary and community care. While the roots of health inequalities lie outside of the care system, such an approach can help address them providing certain criteria are meet. These include: collaborative working; data linkages, and; consistency in approaches and messages.

4. Dentistry did not feature in the proposals for PCNs. Structural reforms of the NHS have seen the creation of Local Professional Networks (LPNs) for the three independent contractor groups, namely pharmacy, ophthalmology and dentistry. One of the stated roles of LPNs is to reduce health inequalities for their local

communities. While for pharmacy and ophthalmology LPN engagement with PCNs is occurring, dental linkages are weak to non-existent.

5. Moreover, to date the performance of dental LPNs is very varied and limited. The size of each LPN population coverage (there are 25 listed of which a number have no identified Chair) is far greater than that of a PCN (of which there are approximately 1250). The web page for LPN contacts (https://www.england.nhs.uk/primary-care/primary-care-commissioning/lpn/lpn-contacts/ Accessed: 24th January 2023) highlights the failure of dental engagement. For example, while there are Pharmacy and Eye Steering Groups, dental care does not feature. Indeed, even where some contact details are provided, they are considerably out of date.

6. The PCN structure envisages registered populations. The current NHS dental delivery arrangement does not include registration as a feature, indeed has not done so since the introduction of the 2006 GDS dental contract. This creates an issue in which sizeable sections of the population will be accessing dental care in a different area to that covered by the PCN in which they are registered. This issue has consequences for collaborative working that in turn will impact on the ability to reduce health inequalities.

7. If the ICSs are to improve dental services, they need to address the lack of 'connectivity' between the dental sector and other aspects of the NHS primary care system. Better working relationships between the dental sector and other independent contractor groups which sees work to tackle the determinants of the chronic diseases should be central to developments.

How should inequalities in accessing NHS dental services be addressed?

8. There is considerable work that highlight that the major barrier to accessing NHS dental care is cost, both directly, i.e. patient co-payments and indirectly, transport, child care or working arrangements Patient Charge Revenue in England totalled £807 million in 2017-2018 (28.7% of GDS/PDS total expenditure), a substantial increase from the 18.6% in 2005-06. The inequalities in oral disease distribution means that those with the greatest disease burden and most likely to be found in the financial disadvantaged groups.

9. The recent publication of service usage over a 16 year period concluded that "If the goal of modern dental care arrangements lies with an emphasis on prevention rather than intervention the implications of trying to address inequalities in disease levels must recognise the economic barriers within primary dental care that co-payments make irrespective of the funding system.".

10. Given the increased pressures on primary medical services and Accident & Emergency Departments for dental problems, many patients are not seeking care outside of the NHS. This reinforces the importance of understanding the collaborative nature of helping patients navigate the system and the importance of the financial barriers that exist. The pressures on families in deprived areas, the very high areas with high levels of unmet dental needs will only increase given the current economic climate.

11. To address the issues described above four steps could be taken. First, dental care co-payments are scrapped. Second, a move to registration arrangements as found in primary medical care and in line with PCN geographical structural workings. Third, the development at all levels of care, education to include joint training in addressing health determinants and their management. Finally, a move to support the dental professions to create a more positive support environment in which practices that have been successful are rewarded and the rationale for the success promoted and spread. Currently, there is a very negative approach to quality assurance arrangements which is not helpful to building a trusting environment for service development.

Does the NHS dental contract need further reform?

12. The question implies that 'reform' has taken place and that, whatever changes were introduced, progress to address the major shortcomings identified in the report by the Health Committee in 2008 are occurring.

13. The modifications to the 2006 contract are at best marginal and have had little or no impact on the oral health of the population. The pilots developed have now ceased and the lessons learnt can be best summarised as 'not workable'. In the meantime, the contract's shortcomings continue to impact on care delivery with a continued exodus of care professionals from the NHS delivery system and growing shortcomings in access to dental care.

14. Moreover, the changes introduced following the implementation of the current arrangements have completely reduced the levels of quality and risk assurance arrangements for NHS dental care. The changes have seen the dismantling of the most cost-effective and efficient quality assurance mechanism that existed anywhere in the world. The current arrangements, largely the counting of Units of Dental Activity (UDAs) against a predetermined annual target and a record check on a small number of dentist selected patients, are more or less useless for ensuring the quality of care.

15. Unlike medicine the vast majority of interventions and patient interaction remains based in primary care. However, a key differences between medical and dental arrangements concerns when patients decide to access care. For dental care, the majority of people access services when they have no symptoms. It is the opposite for medical care – it is based on perceived need, when they have symptoms.

16. The impact of dental problems on medical practice is considerable. In 2015/16 more than 600,000 patient contacts in medical practice were for dental problems and 135,000 accident and emergency (A&E) attendances were related to dental issues. The resource implications are significant, A&E costs alone estimated to be at least £18 million.

17. The development of PCNs provided a number of excellent opportunities to improve both the general and dental health of the populations they are responsible for but have not been taken. The opportunities could be grouped into two categories: approaches to tackling the determinants of poor health and the management of ill-health. The majority of chronic diseases have common antecedents and a coherent

care system in which all those involved in helping individuals attain the best health work together is the most efficient and effective arrangement.

18. At minimum, care providers of all disciples working together at all levels would add value to health promotion programmes as well as support best practice and improve treatment outcomes.

19. Closer working relationships between the dental sector and partners working in PCNs provide opportunities to improve the patient health and experience. There are also potential efficiency gains with care provided in the right setting, a reduction in medication use through the benefits that dental care can bring to a person's self-esteem, the broader support of public health programmes and conditions identified at an early stage.

20. Such opportunities have not occurred and there are growing pressures on all aspects of the NHS due to the shortcomings described above. These shortcomings should be addressed through a far more constructive contract which is based on the goal of reducing the need for oral health care and tackling both current levels of disease and their causative factors, the determinants of oral health.

21. The contract should aim to achieve the goals of a high performing health care system, namely improving the experience of health care by the individual, improving the health of the population, managing the costs of health care and improving the experience of providing care.

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

22. All workers, irrespective of the craft or field of endeavour want to feel appreciated and recognised for their contribution to helping individuals achieve their goals, in this case a level of oral health. The current NHS GDS contract is a major source of discontent creating low morale and unhappiness within the profession. While career opportunities and financial rewards impact on workforce retention, factors such as social atmosphere, job content, work-life balance are of equal if not more importance. A recent review suggests that to enable individuals to move beyond satisfying their basic needs through the construction of their own sense of meaningful work. Practice principles, the owners of the dental practices, should be encouraged to build and maintain work environments characterized by three key issues: well-designed, good-fitting, and quality jobs that provide opportunities to ‘job craft’; facilitative leaders, cultures, policies and practices, and high-quality relationships, and; an access to decent work. The NHS needs to create a GDS contract that help promote this.

23. The limited data on the income of dentists working outside the NHS shows earnings to be remarkably similar but earned through treating fewer patients. This suggests that one determinant in retaining the NHS workforce lies not necessarily with financial incentives, but through improving their workload.

24. There is currently a mismatch between the expectations of recent qualified dental graduates and their experiences at undergraduate level. Training should be viewed

as the opportunities to imbed the concept of lifelong learning namely pursuing additional education and the development of further skills beyond an individual’s formal or compulsory education. This should be based on the needs of the population where the individual dental registrant is working and consist of both technical and managerial skills to help achieve the overall goals of the care system.

RECOMMENDATIONS FOR ACTION

25. An NHS GDS dental contract should centre on allowing the workforce to tackle the two main problems that need to be addressed: access to and inequalities in oral health. To date the contract introduced in 2006 and minor changes highlight the lack of insight by policy makers and continue to provide care arrangements that are failing the public. Access to NHS dental care should be improved and inequalities in health need to be reduced. A contract that provides the opportunities for the workforce to address these issues is central.

26. The problem of access is as of consequence of: an increase in the numbers trying to access the system, dentists moving away from the NHS and a co-payment system that is diametrically opposite to improving access. Simply increasing the numbers of care providers will fail to alter the trend towards non-NHS provision and will prove extremely costly. When combined with the co-payment structure that is different to the vast majority of the NHS system, collaborative and

27. Due to the fragmentation of the delivery system when combined with the totally inadequate monitoring arrangements, poorly constructed remuneration system and the shortage of dental public health expertise at a local level, accountability to Parliament is substantially weakened.

28. The solution must centre on ensuring that practice is evidence informed and that clinical governance is used to ensure that the care meets the appropriate quality standards.

29. The delivery system needs to change to objectives that meet the evolving needs of the population. The payment system should discourage inappropriate intervention and reorient efforts to address both the determinants as well as improving effectiveness and quality. The most appropriate arrangement for achieving this should centre on a capitation based payments with long-term registration arrangements.

30. The creation of integrated care systems provides an opportunity to ensure that patients and the public at large receive co-ordinated care that help build a collaborative and trusted environment. However, given the pressures on the ICSs, and the lack of dental engagement to date, ICSs need to be given a steer on how to develop a collaborative approach between the care crafts to ensure both the determinants of health are tackled and the professions can work together to help achieve both individual patient and population health goals.

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