Written evidence submitted by Agi Tarnowski (DTY0089)

Information for this inquiry was gained from GDP's in Kent, Surrey and Sussex pooled anonymised and submitted.

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

At a most basic level the funding needs to improve and incentivise access.

The Government needs to examine why we are where we are today and perhaps that will assist with answers to move forward. The reasons are complex but underfunding accelerated through the years of austerity, Brexit (Europeans were previously doing NHS dentistry) and devaluing of the workforce (systemic failures by successive governments to work with the profession- for example on new contracts + pensions for support staff) and Covid being the final nail in the coffin. The world has moved on but NHS dentistry hasn't.

The system remains unattractive and a dead-end job. No career progression, high stress, long hours for very little reward financially or professionally. Can't do the dentistry you are trained to do or want to do.

UDA system needs scrapping entirely.

The business models for NHS dentistry are poorly understood by government, dental practices whether independent or corporate are businesses which need to be profitable to be sustainable. Dentists won't strike but will walk away and unfortunately this is happening currently. Many believe the tipping point has already passed and that of after decades of decreasing funding at practice and performer level there is no hope for real change. Continued pressure to do more for less has led to this. Why are 9 out of 10 practices not taking on new patients? Have the government asked this question?

Survival of NHS practices is enabled by mixed economy. NHS Practices are not financially viable without private income. Consideration should be given to what practices can provide and not just what the state wants. For example, does caring for a set number of patients, child only contracts, over performance, flexible commissioning to meet different needs help or hinder provision?

The government has already capped NHS spending via the UDA contract.

It needs to establish a fee-per-item fee scale for treating new patients on the NHS to get them dentally fit before they are accepted on the existing UDA system to offer incentives for new patients. Once dentally fit they can be accepted in the UDA system.

Much has been made of the practice environment affecting care but the system in itself is not held accountable for failings.

The government could look at addressing these difficulties:

- *in a demand driven service funding only 50% of the population leads to access problems, a basic service should be accessible to all.*
- *keeping the dental budget within the same financial envelope.*
- *decreasing government spend and increasing patient charges.*
- *allowing clawback monies and contract hand backs to be lost from dental funding with no ringfencing.*
- *considering the UDA currency as the only means of funding primary dental care with little consideration to where this widens health access inequalities.*

- *if funds are too limited for comprehensive care, then honesty and discussion of what constitutes an NHS core service needs consideration*.
- *Some advocate for a simpler NHS dental offer that practices to take adopt; simple dentistry (exams, cleaning, extractions and dentures) in return for a sessional rate or a core service.*
- *Some advocate fee per item service to fund new patients better.*
- *Consider how, where and when more complex patient needs are funded.*
- *Decrease administrative compliance burdens*

Government must recognize and address recruitment and retention problems in NHS Dentistry. GDC data suggests increased numbers on the register but fewer performers of NHS Dentistry.

Retention:

Make it easier and more pleasant to work within the GDS.

Better funding, less administration.

Once dentists leave the NHS they do not return because in terms of financial and job satisfaction they are better off. Going private means seeing fewer patients for better remuneration and a chance to develop your interests and grow a career.

Funded mentoring, CPD, Audit work and career development could be built into the contract through flexible commissioning for this and the next generation of dentists.

A recognition of ongoing commitment to the NHS is now entirely missing.

Litigation has been making a fortune out of NHS dentistry over the past 20 years, creating a culture of fear within dental ranks and taking no blame for the collapse of dentists willing to work for the NHS for fear of being sued. The government can reform the litigiousness culture in this country and shut down agencies such as DLP.

NHS work could be supported by separating liability from compensation so that if work caried out in good faith fails the government protects the healthcare dental clinician and compensates at a fixed rate. This rate would be limited and different from those practitioners' providing specialist or private work which may be judged at a higher bar. A no-fault-compensation scheme operates well in New Zealand. Liability and referral to the GDC should be reserved for serious cases of professional misconduct. Standards of record-keeping are now so high that they can take up more and more clinical time leaving less time to provide the interventions needed, what can be done to address this ?

Recruitment:

New starters from home and away can start working privately immediately with few hurdles. The ORE happens only twice a year. Becoming an NHS performer through PCSE, NHSE and PVLE is problematic at many levels and takes far too long. It needs to be streamlined, accessible and transparent. Currently it needs a case worker to help a candidate navigate through the process.

UK graduates are burdened with debt from university fees of about £9000 per year and student loans. Consideration could be made to pay these 5 years of debt off by an annual grant in addition to a salary for the first 5 years of NHS work.

Fund training and link to pay increases.

Is a variable UDA not linked to DDRB fair to associates ?

Consider probation years in NHS dentistry prior to full GDC registration.

Access for routine and emergency care is often conflated. The public want both, different approaches and measures of effectiveness are needed. Incentives currently are not aligned with the outcome of improved access for new routine care patients or those in need.

A very simple way of improving access to those in need of treatment would be to fund 1.2 UDA as 3 UDA for emergency/urgent care. This would help deliver care for regular and irregular attenders from any willing provider.

The role of therapist has been put forward as part of the solution but has this been thought through? Can an NHS practice compete with a private practice offering £30-40 per hour? The DCP providing NHS work will have no NHS benefits such as occupational health / pensions. They may do potentially higher risk work and may need increased indemnity, they will not have an LDC PASS scheme to support them if they run into difficulties. If unused since qualifying skills may have been lost further training may be needed. The expectation of learning on NHS rules has not been made clear.

Are the economics right? If not, it will not be a sustainable solution. The practice UDA value needs to be high. If a cheaper work force is providing the easier less complex work, the dentist workforce may find a drop in income and increase stress when only providing higher time and higher complexity NHS work which is less well remunerated.

2. What role should ICS's play in improving dental services in their local area?

ICS's are in their infancy and evolving. They have been given a problem decade in the making with national contractual and regulatory confines that will be challenging to overcome. If dental budgets are not ringfenced funding will be lost at a time access is at an all-time low.

Can ICS's do anything with a broken system - no. They need central government to make real meaningful changes. Are they being set up to fail?

Quick wins with ICS could be achieved through regular and better communication, simply knowing who the contract managers for each practice & how to contact them with an issue would be a good first step.

ICS's need to accept that dentistry is resource poor now and should do all they can to keep the practices they have got. Practices are alienated when pressure is applied over small matters that could be resolved without enforcement of contractual levers. For instance, mandating Christmas opening rather than enabling remote triage and a rota. Another example is allowing NHSE to apply additional demands when a small contractual change like opening hours or change in premises location occurs. ICS need to build relationships and goodwill that have been eroded over time through the overzealous application of rules.

ICS's need more data. Why hasn't more comprehensive Adult Dental Health Survey been carried out to reveal the dental health of the nation and the level of need at this time? Why aren't practices asked why they are leaving?

ICS's need to understand the dental landscape from all sources, not just the commissioning team.

If true integration is to be achieved possible collaboration between services in their geography needs to be understood, but how can this be facilitated?

ICB's should understand that DDRB is not perceived as independent & changes little on the ground in terms of uplift for those working in their area, local incentives should be explored.

Enabling flexible commissioning, working with practices and LDC locally to provide healthcare out with the UDA is an aspiration.

Where flexible commissioning is taking place, the details of the various schemes must be shared nationally with ICB's.

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

The NHS must be a service for all, not just targeted groups - crucially the offer and financials are key. GDS can be the best most efficient and effective provider, but one size doesn't fit all, some populations need different strategies. Consider greater investment in salaried services as well as primary dental care.

The major inequality is that not everyone can access services in part because we commission for 50% of the population, so it is a self-fulfilling prophecy.

Some say there is no point in pumping more money into areas with greater needs until the UDA system is sorted out or changed. It has been argued around the time the UDA system was introduced that the old fee-per-item system encouraged over treatment but the UDA system encourages under-treatment and supervised neglect. What happened to spot checking from dental officers policing the system?

A dentist working in a deprived area, must perform more treatments before they close a course of treatment. This takes more clinical time compared to a dentist in lower need area. As a result, good performers on paper meet their targets and another group of dentists are under-performers on paper despite doing far more clinical treatment. Their reward for this hard work is clawback for under-performance. UDA's need to be higher value in deprived areas but this only works if the practice owner passes this on.

The underfunding leads to second rate care and many leaving the system so further reducing access. Solve the funding and system, make dentistry attractive to work in and commercially viable to run.

- *More salaried services for preventive care and Dental Emergencies.*
- *Create a proper Emergency Dental Service not just an Out of Hours service.*
- *Create a Core service that is free or low cost for patients but pays dentists properly.*
- *Realise that any service without private income such as salaried service will inevitably cost more to run but will service an identified need if planned well.*
- *Where non-attendance can be a problem for scheduled care drop in maybe needed for some*

Level 2 work remunerated at a higher level encourages carer progression, retention to the NHS and greater job satisfaction. Employ or contract more specialists for Sedation, Oral Surgery, RCT and Perio so that these services are easier to access in cases where they are genuinely needed.

The viability of practice needs to be considered. Currently practices can't survive without private work. In areas where this isn't possible or is limited, the practice becomes unsustainable.

Many dentists now consider they can't afford to stay in the NHS. Dental inflation and expenses are rising. Is there a recognition that a mixed- model private practice supports NHS work?

It is hard for practices to grow; all barriers should be removed.

Inequality due to affordability are perhaps nearly impossible to fix.

What innovative community-based approaches can deliver to the populations locally?

Consider poly clinics where patients can attend for GP, pharmacy and Dental services all under one 'roof'. This would improve communication between service providers, and I think improve patient safety overall.

School screening and outreach to early years settings linked to referral if disease found.

Remove barriers to screening and mandate all regions to submit data.

School and nursery toothbrushing programs that have the best evidence for effectiveness.

Consider water fluoridation.

What digital solutions can be evolved to help deliver care or to ascertain risk of dental disease?

Specifically fund dental prevention separate to capitation and activity.

4. Does the NHS dental contract need further reform?

YES

The Private offer is much more available and accepted now. The population and the profession campaign for a better NHS Dental service.

A new contract needs to entice dentists into the NHS. Current expectations are so different than in 2006 and before…. What is a realistic NHS offer?

If funds don't allow for comprehensive care what is a deliverable core service?

How could capitation/sessional rates work?

Why and how did the Pilots and prototypes fail? What can we learn from this?

Contract reform must be aligned to extra funding or at least retaining funding planned for dentistry. While the treasury demands the dental budget stay within the same financial envelope, ~~and~~ this funding is reduced by clawback and yet-to-be re-commissioned hand backs, progress will not occur.

The recent changes are not a reformed contract and have not motivated the profession who have waited over a decade and now see no future in the NHS.

Dentistry is a demand led service, a new contract or NHS Offer should be co-designed with patients and the profession.

Is a risk based targeted approach aligned to practice needs and viability?

Consideration should be given to the place for urgent and emergency, routine care, specialist and complex care, the offer to regular and irregular attenders, the needs of the population now and in the future.

One to one healthcare with a skilled professional can't be cheap and should not be.

What digital solution can be evolved to help deliver care, how could practices be funded to use these.

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?

Young students have no interest in the NHS. It gives them neither status nor good remuneration and no hope of promotion over time as experience is gained. The incentives must be in place to attract the next generation. At the least a financially sound contract and no fear of being sued with better funding and better conditions.

Remove disincentives to treat patient by protecting NHS dental clinicians from complaints and litigation. Crown Indemnity for NHS work or no-fault compensation for NHS care. Offer a sympathetic approach to managing complaints. GDP's especially younger ones working for the NHS should not be judged at same standard as specialists. Compensation must be separated from GDC regulatory jeopardy. No fault compensation scheme with fixed sums should be in place for NHS treatments.

The costs of services needs to be relative to time and expenses spent within the NHS this should not be borne by the worker and the practice with so little coming from the state.

Pay correctly in the first place, allow clinicians to do decent dentistry they trained to do. Provide a career pathway. The role of training would be to guide through a funded pathway to different performance levels which attracts a better financial reward. Currently no training in primary carer leads to a level 2 contract. No entry to another level of pay is possible because of procurement rules.

Current standards and patient expectations are different then in 2006 and before. Patients seem to consider the private offer more acceptable now, less believe that the NHS offers parity.

High speed activity based dentistry is less acceptable or possible now. There should be an acceptance that slow dentistry isn't bad. Activity measures and a treadmill approach for either capitation or activity would be unwelcome.

Dentists want a better work life balance so pay for CPD, mentoring, NHS commitment and fund a career progression to roles that society will need. Better professional support & mentoring like GP's. Staff also need to see incentives to stay. Occupational health and pension as a minimum for DCP's and support staff in NHS dental practice.

NHS pension maximum threshold prevents retention of the more mature workforce and senior committed clinicians who otherwise might still want to contribute to the NHS in a small or part time role are prevented from doing so.

Acknowledge that younger dentists now need more support to do more complex work they didn't have the opportunity to become confident with at university.

Career progression is needed with increased options. Train and provide contracts for more dentists with special interests in Sedation, Oral surgery, RCT and Perio. Consider other specialties like gerontology and paediatric dentistry - increase number and funding for these roles.

Less red tape and nonsense. Reduce administrative burdens or fund administration time.

Have a streamlined easy pathway to help overseas dentists in that doesn't put them off at the front door. PLVE positions need to be funded and equal to that of DFT.

Training would be helpful for dentists who are thinking of employing therapists and therapists who are starting to take on more responsibilities.

Consider whether tax break incentives for NHS work can be used as in incentive for practices.

Consider a grant to re-imburse university tuition fees.

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