Response to Health Select Committee Inquiry on Access to Dental Care

25th January 2023

1. **What steps should the Government and NHS England take to improve access to NHS dental services?**
   a. Access to NHS dental services is vitally important to promote health, prevent oral disease and manage existing diseases/conditions and their sequalae. The oral cavity plays a vitally important role in health and wellbeing enabling people to eat, speak, chew and socialise effectively (1, 2).
   b. Ensuring access to essential dental care is a challenge of global importance. The most common oral and dental diseases are non-communicable diseases and the World Health Organization has launched a global strategy for oral health (2, 3). The NHS in England has traditionally led the way in being an exemplar in the provision of dental care for the population in support of oral health. This is a time for innovation and providing leadership in change for oral health (4).
   c. Oral and dental services, however, have been particularly challenged because of COVID-19, and the impact of this respiratory virus on working practices. Dental providers carry a significant business risk (5). Dental teams are stretched and access to care remains a challenge for the population. This needs to be recognised in the investment Invest in oral and dental care for the public sector to ensure that public dental services are appropriately funded to meet the needs and demands of our growing and ageing population.
   d. Oral and dental disease affects the whole population; however, there is a clear social gradient, with more socially deprived populations having higher levels of need. Retaining existing dental services through flexible commissioning, where possible, is particularly important in the short term as longer-term stable solutions are planned. It is vital to do so in areas of higher social deprivation where local practices are needed, and providers cannot rely on additional private income.
   e. Existing resources should be used to develop innovative new services (range of models) across the life-course where care pathways are clear (6-8), and ensure that services are evaluated to contribute knowledge to the health systems. We need to move forward with innovation to strengthen the dental system, and test new models of care, in line with changing oral health needs, service delivery and workforce expectations.
   f. Access must be considered across primary, secondary, and tertiary systems to ensure care pathways function. This will require creative thinking and may involve health professionals working across types of traditional contracts (8).
   g. Professional health and wellbeing and patient outcomes in healthcare are linked (9). Enhancing professional careers by linking professional development to roles within the health and social care systems will be important in tackling health and wellbeing issues within the dental workforce which existed pre-Covid (10-13), but have been exacerbated since 2019.
   h. The creativity and commitment of our workforce should ideally be harnessed within dentistry for the benefit of population and patient health. Young people can no longer hope to set up their own services as past generations have done. Most services are now delivered by organisations and so we need to find innovative ways to 'liberate the workforce to better serve the population across the life course' (6-8).

2. **What role should ICSs play in improving dental services in their local area?**
    a. ICSs should take account of oral health as a priority, recognising when it is appropriate to consider care planning at regional level, not just local level, to achieve the best outcomes. Regional considerations will be very important in relation to care pathways and specialised services to ensure best use of expertise and equitable access to care.
    b. Integrate oral health into the care of wider health and care teams so that oral health is supported by the wider system(s). This will include practitioners and/or specialists across health and care systems knowing how to access to appropriate dental care services for their patients.
    c. Promote self-care (6, 7, 14), and deliver health promoting/preventive care in line with the contemporary evidence-base (15).
    d. Consider how health and care services can be co-located to ensure ease of access for vulnerable groups.

3. **How should inequalities in accessing NHS dental services be addressed?**
    a. Addressing oral health inequalities is urgently required (16).This will require co-ordinated health services and public health leadership to reshape dental care, together with primary and community services across health care and social care. Action will be required at all levels to effectively tackle inequalities in oral health.
    b. Integrating prevention and care with a range of other providers for early years is vitally important (6). Integration of care should be a priority across the life course for vulnerable groups and especially later life with new models of care emerging. Not all care needs to be delivered in dental surgery settings, but should harness the dental team skill mix in a range of settings (7).
    c. Preventive care should be embedded within contemporary dental care at all levels of delivery – not an optional extra. Led by Public Health England, experts have collaboratively updated the evidence on 'Delivering better oral health'; version 4 of the guidance document is now available online in digital format (15). This resource should be central to dental care provision across all aspects of the system (primary/secondary/tertiary), with dental care professionals playing a leading role in its delivery in dental settings and the wider community.
    d. Oral and dental care services should be actively developed to serve people in care homes. This required appropriate training for health professionals involved in delivering care, and supported by functional remuneration systems to ensure that inequalities are not widened further by people's inability to pay for care (17).
    e. People in later life require routine dental care in the community to better maintain their oral health at a satisfactory level to enable them to age well (7). This would reduce the risk of their entering care homes in poor oral health, whilst enabling them to benefit from a satisfactory quality of life in later years. This is particularly an issue for people living with dementia (18-22).

4. **Does the NHS dental contract need further reform?**
    a. Yes, we have changed dental care very little since the inception of the NHS, albeit that different fundings systems have been utilised. Systems reform is urgently required to get

dentistry on a better footing (6, 7), and ensure that contemporary high quality preventive patient-centred care can be provided as a matter of routine.

b. Patients and tax payers should not have to go to the private sector, unless they choose to do so, for oral health care.
c. The NHS primary dental care contract should facilitate and incentivise the delivery of high-quality care including prevention by the dental team, meeting public and patient needs in a timely manner.
d. Future care delivery should be considered in a range of modes such as tele-dentistry and delivered a range of community settings. Such provision should be facilitated by future contracts for care, with governance arrangements facilitating the health workforce moving across settings as required to better meet patient and population needs.
e. Furthermore, secondary care should also be accessible when it is not possible to deliver in primary care settings.
f. Ensure parental/maternity leaves do not disadvantage provider organisations (note over 50% of the profession will need to take time out of practice.

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?

a. It is rarely acknowledged that the UK has one of the most, if not the most, professionalised oral and dental workforce in the world (8), all of whom are registered with the General Dental Council (23), once they have completed education and training (24). Retention of our highly educated and trained oral and dental health professionals is key to the future, particularly dentistry in which it is expensive to educate and train.
b. Nationally we have relied on international dentists to provide care through active and/or passive recruitment strategies (25). It is important that we do not deprive lower- and middle-income countries of their dental workforce in seeking to build our workforce and further increase global inequalities. However, there are dentists in this country whose skills and expertise could be engaged but the process of accreditation and integration requires careful consideration, learning from past experiences (26).
c. For dental professionals in the latter stages of their career, amendments to the pension system to retain their expertise will be important. Solutions for younger oral and dental professionals may vary across the country.
d. When dental professionals are leaving the NHS, and/or the profession, as is happening currently, this represents a major and urgent systems issue. It suggests that significant reform is required to improve our dental system. Dental professional's want to work in an NHS system which enables them to achieve professional satisfaction and deliver of high quality, evidence-based patient-centred care that is adequately remunerated, without it impacting on their health and wellbeing (10, 11). Career progression with further acquisition of enhanced skills may contribute to professional satisfaction and meet population needs (27-30).
e. There is an imperative to monitor oral health and plan the oral health workforce to meet patient and population needs effectively, taking a longer term perspective (31, 32).

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