Written evidence submitted by the Nuffield Trust (DTY0098)

Nuffield Trust submission to the Health and Social Care Select Committee

The Nuffield Trust is an independent health think tank. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

We believe the Committee is entirely right to identify NHS dentistry as a priority. Access to publicly supported services is close to a state of crisis, with many dentists turning away NHS patients, and significant reform is overdue.

The Nuffield Trust has been conducting a review of dental and oral health services, drawing on data analysis of performance and activity, extensive interviews with experts, representatives and leaders, and a review of policy documents. This submission pulls out selected key findings for the Committee ahead of publication later this year. It focuses primarily on our conclusions as to a positive way forward, rather than demonstrating the problems that the sector faces.

Key points:

- The existing contract can disincentivise taking on patients with more severe difficulties. It drives quantity over quality, and is currently failing even to drive quantity. It is overdue for reform.
- Integrated Care Systems should be at the centre of bringing dentistry in to work with other services and improve population health. They need to be allowed to take decisions to make this happen.
- Many interventions to improve people's oral health have a very high return on investment, and should be prioritised.
- Tackling the serious workforce situation will require making better use of professionals other than dentists, including by changing university tariffs to reward their training.

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

Immediate actions, like international recruitment, can help deal with some areas of crisis. But the longer term issues which are making NHS dentistry fail will only be sustainably addressed with long-term action on the dental contract, and on workforce.

Contract reform, discussed below, is required to stem the move into private sector provision and the introduction of different models of direct provision where the dental market is failing NHS patients.

Access issues are deeper than the 'backlog' created by the pandemic. However, Covid did considerably exacerbate the situation and should be addressed in the same way as is occurring in relation to NHS Trusts, i.e., significant funding committed over a long-term period. If the NHS wants dentists to increase provision funding needs to be for a period sufficient to allow providers to invest in sustainable capacity. Short-term funding offered at short notice will not work. Providers must be incentivised to offer more – the realities of competing with private payment cannot be avoided.

'Flexible commissioning' is where contracted dental activity is set aside for specific "dental access" sessions. This is a sensible approach in varying the terms of existing contracts to support access for new patients – it should be deepened and broadened at scale.

Policymakers should also consider working with the profession about messaging and commissioning of routine check-up intervals. Being seen every six months is not universally necessary, and a firmer line could be taken on this to free up capacity for new patients. This should be accompanied by a public awareness campaign (jointly between Government and profession) explaining that this is neither an unacceptable clinical risk or a cut by the back door.

Fundamentally, Government needs to engage in a systematic and on-going way with dentistry and oral health rather than only responding with vigour when access issues make the headlines.

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

Locally connected commissioning based on local relationship and knowledge is highly desirable. ICSs should be at the centre of bringing dentistry and oral health into the mainstream of local health improvement activity – this should include much better integration, collaboration and mutual support between dentistry and general health services.

Addressing health inequality is a core focus for ICSs. Oral health inequality must be part of this. It should not be addressed in isolation - many of the issues and the people impacted are the same for broader inequalities and oral health.

However, to fulfil this role effectively a number of conditions need to be met:

- ICSs need the relevant skills and capacity to deliver on this responsibility. Delegation of responsibility from NHSE does not always come with the necessary resources to hire staff who can understand and shape dental services.
- ICSs need to be given real flexibility – if they are simply administering a national contract, they won't be able to make the difference needed. They must be able to explore options and opportunities beyond the national contract.
- In the likely absence of significant new resources for commissioning of services, ICSs must have the freedom to re-allocate existing resources based on need which should be objectively assessed in partnership with Local Government in its public health role.

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

This needs to occur at multiple levels covering access to and availability of services; more uptake of services by the most needy; and broader and longer-term public health intervention.

Access to care is generally poorest in areas of greatest need and inequality. These areas must be targeted for the greatest support and intervention. In the absence of significant additional resource this will require re-allocation of funds to target inequalities for which ICSs should be held to account.

Uptake of services is, in general, lower amongst those with the poorest oral health despite services being free for many people within this cohort. Much is known from research about the complex reasons for this reticence to engage with services but more needs to be done to actually address these reasons and to design services in a way that encourages uptake.

Broader public health initiatives must be given higher priority also – the Public Health Grant to local authorities has been hugely reduced over the last decade meaning we are heading in the wrong direction. A number of oral public health initiatives have a high return on investment, indeed much higher than many clinical services delivered by the NHS. Early years intervention and support is especially important given the evidence on poor oral health in children and the stark SES gradient. Community water fluoridation is the single most cost-effective intervention we have – it should be pursued actively: everybody drinks water. More direct action on diet and especially sugar intake should also be prioritised by Government.

3. **Does the NHS dental contract need further reform?**

Yes. The current contract was introduced in 2006. It was intended to be a transitional step to longer-term arrangements with a greater emphasis on prevention and maintenance. It was not fit for purpose as a long-term vehicle then and is certainly not now.

The system of fixed payments by "Units of Dental Activity", or UDAs, provides simplification but it remains detested by the profession. It rewards quantity over quality, and fails to recognise that some patients cost more to treat. In addition, the huge variation in the value of UDAs, largely unadjusted since 2006, is perverse and unjustifiable.

The continued move into private sector provision, leaving patients without access to NHS appointments, demonstrate that change is needed. The existing contract is seen by providers as disincentivising taking on the care of those with poorer oral health. The goal should remain a move towards arrangements that facilitate and incentivise modern preventative care.
A national contract should also not be seen as the only option – alternatives including direct provision by the NHS should be considered in areas of particular challenge and shortfall. There are valid uses for a range of different payment models, from capitation to fees for activity and paying dentists through salaries.

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

This is partly an issue of incentives – more fundamentally, however, there is a need for a long-term plan for the dental workforce which should aim to develop the appropriate workforce for the longer-term oral health needs of the nation. This will need to include thinking about the full range of dental clinical and support workers, with a greater role for Dental Care Professionals (DCPs) beyond dentists, who should focus more on complex dentistry and leading teams from different disciplines. The University tariff should be revisited to incentivise training of dental professionals other than dentists.
A long-term workforce plan committed to, and funded, by government is necessary. This should take account of changing population need, changes in treatment technology, skill mix change and productivity improvement.
In the short-term making the NHS contract more financially attractive to providers is the main option along with international recruitment.

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