Written evidence submitted by the Association of Dental Groups (HSC0024)

Introduction

1. This submission from the Association of Dental Groups (ADG) responds to the Health and Social Care Committee call for written evidence for its pre-legislative scrutiny into the Government's White Paper on health and social care.

2. The Association of Dental Groups (ADG) is the trade association for large dental providers in the UK. Our members include 20 of the largest groups of dental practices in the country, representing over 10,000 clinicians delivering NHS and private dentistry to more than 10 million patients every year.

3. ADG members represent corporate, group and community interest companies delivering a wide range of oral healthcare, be this commissioned through General Dental Contract (GDS) services or local authority and community oral healthcare programmes. Our response comments on three separate sections of the White Paper of concern to the dental profession, namely Integrated Care Systems (ICS), water fluoridation and professional regulation.

ADG response on Integrated Care Systems

4. ADG members have welcomed the proposals for ICSs to be given a statutory footing from 2022 and agree this represents a step towards a more integrated health and care sector. The development of system working over recent years has reinforced the importance of collaboration and partnership working in the NHS. We agree that to imbed the ambitions of the NHS Long Term Plan statutory ICS bodies should be established with a full time Accountable Officer, as outlined in Option 2 of the recent NHSE consultation[1].

5. We believe that membership of new ICS Boards should be flexible and must be able to respond and build partnerships with providers to identified local needs. We welcome the stated aim within the consultation that wider clinical and professional leadership is needed to ensure a strong voice for the wide range of skills and experience across the systems, including dentistry. Further consultation with the profession is now needed to agree how this is achieved.

6. We believe this direction of travel is shared by the Chief Dental Officer (England), who has previously identified the need for a more comprehensive and cohesive approach to dentistry[2] as part of the NHS Long Term Plan.

7. We also recognise that there are significant constraints on integration of dental services to the wider healthcare landscape at the current time. NHS England have recently set new and challenging UDA contractual targets for January – March 2021, Letter 7 from NHS Dental services[3] to providers and given a clear indication of a desire that *"contractual arrangements will, by default, revert to normal in April 2021."* The pandemic and lockdown have highlighted again the constraints of the existing UDA contractual model for delivering access to NHS dentistry namely in scarcity of provision in many parts of the country and the lack of an effective preventative treatment framework.

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[1] NHS England » Integrating care: Next steps to building strong and effective integrated care systems across England

[2] The evolution and future of UK dentistry – Hospital Times

[3] Letter template (england.nhs.uk)

8. ADG members believe that NHS dental services commissioning must continue to rest with existing commissioning authorities and there is little desire at this time to incur unnecessary cost and complexity in commissioning wholly new care models for dental services when recovery of care remains a priority. Over the last 10 years, government net spend on NHS dentistry has remained stagnant with no increase with inflation, which in real terms represents a cut to NHS dentistry in the UK and existing budgets must be protected for oral healthcare needs. However, we also believe that there is an opportunity within existing contractual arrangements to introduce a greater amount of flexible commissioning at a more local level which responds to particular needs and aligns with the ambition of integrated care systems. We believe the group, corporate and social enterprise models of dental provision that have emerged in recent years (and are all represented in the ADG membership) are more able to adapt to such delivery.

9. A number of flexible commissioning pilots at regional level have demonstrated more integrated and preventative work which could be scaled up and aligned with the ICS model (oral health is part of the Enhanced Care in Care Homes framework[4]) to address identified *"place level"* oral health priorities. These have been recently highlighted in the OCDO work on "*Transition to a Better Future"* including case studies of delivery by ADG members. However, clear national frameworks and toolkits would be essential for local implementation.

10. We believe that a strategic shift by dental commissioning teams to implement such transformational programmes will re-focus care on the reduction of oral health inequality and improvement of oral health for at risk groups. This can be achieved within the existing commissioning framework and the expansion of the work outlined by the OCDO is a key first step in fully utilising the skills of whole dental teams and the appreciation of dental care in wider care systems.

11. Governance. We welcome the parliamentary question raised by the Chair of the Committee to the Secretary of State for Health about the transparency of Integrated Care Systems arising from the oral evidence session on Tuesday 2nd March 2021.[5] We agree that for the public to have confidence in ICS's there must be national outcomes and regulatory oversight in the manner of an "OFSTED style" rating system. We hope that this will be a clear recommendation from the committee's work. We also welcome the clarity given to the Committee on Tuesday 9th March that ICS are likely to be co-terminus with higher tier local authority areas.

12. Our members have raised a number of other concerns regarding governance of ICS which deserve further scrutiny. It is the intention that Primary Care Networks (PCN) will have some responsibility for setting local oral health priorities. For this to function successfully dentistry will have to be imbedded within the ICS governance with effective representation. No formal consultation has taken place with the dental profession as to how this might be addressed however, we are aware that the OCDO are looking at ideas which could include repurposing existing Local Dental Networks (LDNs). We would expect that all ICS Boards and PCNs would be required to call on a Dental Lead with clinical expertise in shaping place based oral health priorities to ensure they are able to respond and build partnerships with specialist providers in their localities.

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[4] the-framework-for-enhanced-health-in-care-homes-v2-0.pdf (england.nhs.uk)

[5] Covid-19 Update - Tuesday 2 March 2021 - Hansard - UK Parliament

13. ADG members noted with some concern that the NHS consultation on legislative proposals recognises and encourages the role of the charitable, community and voluntary sectors but did not reference social enterprises as providers referring to "*NHS providers, local government, primary care and voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods."* There was concern that the message taken from NHS England is that social enterprises will play a diminished or potentially no role in the delivery of services. This oversight of social enterprises in the consultation neglected their significant contribution to local communities and emerging ICS and we are pleased to note it has been addressed in the consultation response FAQs on NHS England and Improvements legislative recommendations[6]. Given that Social Enterprises collectively account for £1.5billion of health and social care provision it is important they are recognised in future guidance and legislation and this might be something the Committee would seek to ensure in its' recommendations.

Water fluoridation

14. Water fluoridation is the single most effective public health measure this Government could take to improve the oral health of future generations. Thousands of children could soon require hospital operations (waiting times for dental anaesthetic have been seriously curtailed[7]) to remove unsavable teeth due to the pandemic. Before the pandemic, hospitals in England were already carrying out an average 177 operations a day on children and teenagers last year to remove teeth, costing the NHS more than £40m[8]. Water fluoridation requires no behaviour change and the evidence shows it is highly effective in preventing dental disease. It is estimated by the British Society of Paediatric Dentistry (BSPD) that water fluoridation could reduce this by as much as two thirds in the most deprived areas[9].

15. Sadly, only a tenth of the UK currently has access to fluoridated water showing that the previous process for introduction of schemes was failing. Since 2013 local authorities have had the powers to propose and consult on fluoridation schemes with Secretary of State final approval. A major stumbling block for local authorities has been competing financial pressures due to budgetary constraints since they were given this responsibility. We welcome the proposals outlined in the White Paper for the Secretary of State to takes powers to directly consult and introduce new schemes as a clear resolution by the Government to act on water fluoridation following ministerial statements that they wished to do so.[10] However, we note that any new fluoridation schemes will still carry consultation costs, feasibility studies and potential new capital and revenue costs and provision for this will have to be made. Fluoridation schemes are not without critics and the Secretary of State may wish to consider the appointment of a suitable *"fluoridation czar"* who can provide leadership, co-ordinate consultation roll out and messaging to avoid the inertia that has set in previously.

16. Much of the work that would underpin identifying local oral health needs (for example, *Oral Health survey of 5 year old children*[11]) and water fluoridation priorities is undertaken by the Dental Public Health team which currently sits within Public Health England (PHE). As committee members will be aware, PHE is currently undergoing restructuring due to the establishment of

[6] C1127-faqs-on-ics-legislative-recommendations.pdf (england.nhs.uk)
[7] Waiting-times-for-dental-treatment-under-general-anaesthetic-150920.pdf (bda.org)
[8] 180 operations daily to extract children's decayed teeth – Dentistry Online
[9] BSPD Press Release - White paper 8 Feb 2021 final.pdf
[10] Covid-19: Dental Services - Tuesday 10 November 2020 - Hansard - UK Parliament
[11] Oral health survey of 5-year-old children 2019 - GOV.UK (www.gov.uk)

the National Institute for Health Protection (NIHP). It is currently unclear where the Dental Public Health team will sit as a consequence of the restructure and we believe it is important for them to be embedded closely with the ICS structure at a regional level with a national team not least to support the Department's future work on water fluoridation.

Professional regulation

17. The professional regulator for the dental profession is the General Dental Council (GDC), established in 1956. The 1984 Dentists Act[12] provides the legislative framework for its work which gives it powers to, grant registration to those dental professionals who meet its requirements, set standards for providers of dental education and training in the UK, set standards of conduct and ethics, investigate complaints and act when appropriate and require dental professionals to keep their skills up to date through continuing professional development. It maintains the current register of approximately 42,000 dentists and 70,000 dental professionals.

18. Many of the difficulties facing the GDC and hence the wider profession lies with the constraints they operate under in the 1984 Dentists Act. In their own response to the White Paper the GDC highlighted that they "operate within the limits of outdated and restrictive legislation which, in many instances prevents a flexible, efficient and proportionate approach to legislation."[13]

19. For example, for the past decade, approximately 17% of registered dentists have come from EEA countries. Now that Brexit has been completed, mutual recognition of EEA countries qualifications has a two year grace period until new overseas registration or recognition processes can be established. For non-EEA dentists to register they currently have to sit the Overseas Registration Examination (currently suspended due to Covid), which is tightly prescribed in legislation. Giving the professional regulator more discretion in how they administer professional registration and mutual recognition would greatly ease the current workforce issues in the profession and aligns with the stated intention in the White Paper to ensure the level of regulatory oversight is proportionate.

20. The ADG note the proposals in the White Paper for the power to abolish an individual health and care professional regulator and enabling a single regulator to take on the role of providing a function across some or all of the regulators. Whilst we note the superficial attractiveness of a single regulator overseeing core functions such as registers, we are unconvinced that such a role could include administering professional misconduct and unfitness to practice with confidence, and this may have the potential to erode the high public trust and regard for individual health care professionals.

21. The GDC is currently expected to take forward a number of important changes as a consequence of Brexit, not least the introduction of new schemes of overseas recognition and registration. The ADG believes that these should be the priority of the regulator over the next 18 months before any further consideration of reform to the number or composition of regulators.

Concluding comments

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[12] Dentists Act 1984 (legislation.gov.uk)

[13] GDC responds to Department of Health and Social Care White Paper Integration and Innovation: working together to improve health and social care for all (gdc-uk.org)

22. As stated in evidence to previous enquiries by the Committee the dental profession has seen a wave of unmet and rising demand for care as a consequence of the three month cessation of provision which has to be the priority for NHS Dental Services and the profession in the next 12 months. We welcome the inclusion of dentistry within ICS reforms as a step to the ending of the isolation of oral healthcare and believe that they can play a role in setting "place based" priorities through "flexible commissioning". Further consultation with the profession is required.

23. A national programme for water fluoridation is the single biggest preventative measure that could be taken to protect the nation's oral health in the future. Water fluoridation requires no behaviour change and the evidence shows it is highly effective in reducing dental decay and delivers the most benefit to the deprived. Clear leadership and resources will be required to avoid the stagnation of the past decade in this ambition.

24. In the spirit of the Government's recent consultation on "*Busting Bureaucracy*"[14] we hope the Department can work with the GDC to remove current restrictions which prevents a flexible approach to regulation and deters overseas recruitment.

March 2021

[14] Busting bureaucracy: empowering frontline staff by reducing excess bureaucracy in the health and care system in England - GOV.UK (www.gov.uk)