Health and Social Care Committee inquiry into dental services

Written evidence submitted by the Faculty of General Dental Practice (UK)

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About the Faculty

1. The Faculty of General Dental Practice (UK), based at the Royal College of Surgeons, seeks to improve the standard of care delivered to patients through education of the dental profession and the provision of evidence-based guidance and standards.

2. Around 95% of dental care in the UK is provided in the primary dental care setting, and the Faculty is the only professional membership body in the UK specifically for general dental practice, providing a national voice for over 4,000 Fellows and Members.

3. The Faculty's main reason for submitting evidence is to promote informed debate and decision-making in the shaping of reform of the provision of NHS dental services in England, so as to promote the delivery of dental care of an appropriate standard to all those who need it.

Executive summary

4. NHS dentistry is highly neglected and under significant strain, and does not align with the characteristics of other NHS services. Real terms funding is in long term decline, leading to a reduction in the amount of activity commissioned and in the unitary remuneration for NHS-contracted practices, which find it ever more difficult to recruit and retain staff. The significant financial constraints and contractual restrictions to the means of provision make NHS dentistry increasingly unviable and professionally unattractive, and increasing numbers of practices are closing or reducing their commitment to the NHS.

5. Government has been reluctant to acknowledge that problems exist, let alone address the underlying issues, and promotes a disingenuous fiction that comprehensive care is available to all those who need it. Many patients struggle

to access NHS dental care as the funding simply does not provide the universal offer they expect. Others stay away due to patient charges which have risen by 30% in real terms since 2010. The number of adults in England seeing an NHS dentist every two years has now declined to 50%, and only 60% of children see an NHS dentist each year. Lack of access is particularly acute in certain areas.

6. Fundamental political questions need re-considering. What dental services should the NHS offer? What can it afford? Truly universal access to NHS dentistry could only be achieved with greater funding. While access could be still be improved through better allocation of existing resources, difficult decisions would need to be made about the way they are targeted.

7. The current NHS dental contract in England is ill-conceived and not fit for purpose. The two most common oral health conditions are almost entirely preventable, yet the system rewards reparative rather than preventative care. The crude and ineffective payment system has perverse incentives which penalise practices which look after patients with greater need, placing those in areas of high deprivation under the greatest financial pressure. The amount of activity commissioned from each practice changes year to year, denying practices the certainty needed to invest, recruit and train to meet future needs.

8. A new contract should include a significant element of capitation, should re-introduce patient registration, and should reward preventative activity, minimal-intervention dentistry and out-of-surgery visits to less mobile patients. Annual contractual 'clawback' should be replaced with a multi-year cycle. The NHS should remove the outdated and unnecessary restrictions on the roles played by members of the wider dental team, and instead use the full extent of their clinical skills. The NHS should support the development of career pathways for general dental practice.

9. FGDP supports localised water fluoridation where necessary and appropriate as one means to help tackle dental decay in the most at-risk population groups, but policy-makers should also be cognisant of the availability of other means of delivering an effective level of fluoride either universally or to those that need it most.

<u>Inquiry questions</u>

Where does dentistry fit within NHS primary care services? What is the state of the relationship between the NHS and dentistry?

10. For most of the NHS's history, the manner of its provision of general dental care has differed significantly to that of most other forms of medical care, including

other types of primary care. The model is one of independently-owned practices, which pay for their own premises, salary costs, equipment, supplies, insurances and regulatory fees, commissioned to provide a fixed level of NHS activity. Most NHS-contracted practices also offer private services, and there is also a significant sector of private-only practices.

11. Since 1951 the model is also one in which most adult patients must contribute to the costs of examination and treatment, making dentistry one of only a small handful of exceptions to the popular political claim that the NHS is free to all at the point of delivery. Patient charges are set by government, and dental charges are notably high in relation to other exceptions such as prescription charging and eye tests. Patient charges do not relate to the cost of providing care, nor to the remuneration given to dental practices, which in itself is not commensurate with the provision of modern dental care and materials. Recent research by the Oral Health Foundation found that 36% of Britons, including 59% of young adults, forego dental examination and treatment for financial reasons.

12. All told, dentistry is an uncomfortable fit, and NHS dentistry is highly neglected and undervalued. There is a strong and unfortunate sense of NHS dentistry being separate from the rest of the NHS, not only among patients but among other healthcare professionals. This separateness is ultimately a consequence of the decisions of government and Parliament, and works against the interests of patients, many of whom would prefer to have a fully accessible service, free at the point of use.

13. The relationship between the NHS and general dentistry is increasingly strained. Real terms funding has declined by £550m per annum since 2010, leading to a reduction in the amount of activity commissioned and in the unitary remuneration for NHS-contracted practices. Income decline is exacerbated by increasing regulatory costs, and contract-holders are finding it ever more difficult to recruit and retain staff due both to dissatisfaction with the professional constraints of NHS work and the prospect of continued decline in wages. Many younger members of the profession simply no longer aspire to a career in NHS dentistry.

14. Many patients struggle to access NHS dental care as the funding simply does not provide the universal offer which the public expect. Others elect to stay away – or take their acute needs to their GP or A&E department. This is often driven by a fear of the cost, or inability to pay patient charges which have risen by 30% in real terms since 2010. Taken together, these factors mean that the number of adults in England seeing an NHS dentist every two years – the maximum interval recommended by NICE – has now declined to 50%.

15. Government has been reluctant to acknowledge that problems exist within NHS Dentistry, let alone address the underlying issues. The assertion that high quality comprehensive care is universally available to all those who need it is a fiction and utterly disingenuous. This narrative works against the interests of patients and undermines the relationship between the dental profession and NHS England. This is compounded by a lack of clarity around what NHS Dentistry should provide within the current funding restrictions. There needs to be an honest conversation that seeks to address the current mismatch between the public's expectations and understanding of the service they should receive, and the actual provision and delivery. It is often dentists, who stay in the NHS because they believe in its mission, who bear the brunt of the frustration this breeds, and it is not unknown for government to suggest that dentists are to blame when patients struggle to access care.

16. Fundamental political questions need re-considering. What dental services should the NHS offer? What can and should it afford? Are you content to accept that while the public can receive a comprehensive offer of general medical care, free at the point of delivery and with enough provision for all, a vast burden of oral disease goes unmet?

How satisfactory are the arrangements for the provision of dental services by the NHS?

17. Extremely unsatisfactory. The current NHS dental contract in England is not fit for purpose. It fails to deliver for patients; it fails to focus on prevention and drive improvements in oral health; it fails to incentivise the delivery of high-quality care; and it fails to deliver for the dental profession, as evidenced by practices' difficulties in recruiting and retaining staff for NHS work.

18. Access continues to be a problem in many areas of the country. The contract does little to promote prevention or incentivise high quality care, which begs the question – "access to what?" The current contract focusses on the delivery of Units of Dental Activity (UDAs), which are a crude and ineffective method of measuring activity. The system was ill-conceived and is entirely inappropriate for the delivery of oral health in the 21st century. This was recognised by the Health Select Committee in 2007, but the contract remains in place 12 years later. This has had a deleterious impact on the dental profession, which has continued to provide care as best it can within a flawed system. The effects of this have been clear, with increasing numbers of practices reducing their commitment to the NHS, thereby further reducing access to NHS care which often impacts most acutely on the most vulnerable in society.

Are current arrangements contributing to the widening of health inequality? Are there inequalities in access to dentistry services? If so, why, and what could be done to address them?

19. Yes, undoubtedly there are inequalities in access, and current arrangements are contributing to this. While oral health continues to improve - which must be acknowledged as a significant achievement - unfortunately the burden of disease is not evenly spread across society, and those in lower socio-economic groups continue to have high levels of disease. For a variety of reasons these vulnerable groups access the dentist less easily, and when they require urgent dental care they find it increasingly difficult to find an NHS dentist to deliver it.

20. Practices are less likely to be financially sustainable in poorer areas, and as they close or are unable to take on new patients, some poorer or more rural patients may have to travel miles to access a dentist. They may well not have their own means of transport, nor the time or money, or, given these barriers, inclination, to make the journey on public transport. Some patients need to be accompanied by a carer, and others need to bring children with them, again adding to the difficulty of attending if local provision is not available to them.

21. Lack of access to NHS dentistry is particularly acute in certain localities and regions. The South West of England is a prime example - recent NHS figures show that over 48,000 patients in Devon and Cornwall are on the waiting list to see a dentist, and wait on average 477 days for an appointment.

22. The contract also has perverse incentives which penalise practices which look after patients with greater need, who are in turn more likely to be found in socially deprived areas. A practice is remunerated the same for treating a patient who requires a single filling as they are for a patient who requires ten fillings, three extractions and two root fillings – yes, astonishingly, both courses of treatment count as the same number of UDAs and therefore attract exactly the same remuneration. Patients with high treatment needs, complex medical conditions or complicated social needs require time, but the contract simply pays on UDAs - not time, not prevention and certainly not care. Practices with less healthy patients therefore suffer through a payment system that does not discriminate between the need to perform ten minutes or two hours of work, so those in areas of high health deprivation – that is, exactly where the NHS needs to provide services the most - are under the greatest financial pressure.

23. At present, the NHS Contract does the exact opposite of what it should do; it acts as a barrier to those most in need, rather than focussing on them. The most vulnerable in society are being badly let down by the NHS, and oral health

inequality will continue to grow until there is a significant change in the way NHS dentistry is commissioned.

24. As funding is inevitably finite, if government and Parliament accept that a comprehensive and universal system is not affordable, difficult decisions need to be made about the targeting of resources. Are you prepared to target care at those who need it most, even at the expense of those, often with greater political agency, who need it less but have grown used to receiving it?

How could access to NHS dentistry be improved?

25. Truly universal access to NHS dentistry could only be achieved with greater funding. However, access could still be improved through better allocation of existing resources.

26. Notwithstanding our wider concerns about the UDA system's focus on reparative intervention rather than minimal intervention and prevention, it could be reformed even within its current focus to remunerate dental care far more proportionately to the time and material costs of the work. This would support greater provision of care in the areas of the highest need, which currently suffer from reduced access.

27. Paying dentists to provide domiciliary care, and to go to care homes, would increase access to care for less mobile patients.

28. Introducing targeted rural subsidies, or an equivalent - as are made available in some other areas of healthcare and public services - would help sustain rural practices, and therefore access for rural communities. Rural communities need access to dental care just as they need access to general medical care and pharmacy and a range of other public services where the costs of provision increase due to low population density.

29. In more deprived urban areas, dentists might be employed in community dental clinics, or within GP practices or polyclinics, and clinics are sometimes run through dental teaching hospitals. However, we are unsure whether such arrangements are cost-effective compared with simply ensuring that general dental practices in areas of higher need and lower access are able to be financially viable and recruit and retain staff.

What opportunities are presented by the development of primary care networks?

30. Huge opportunities would exist to work with GPs and pharmacists for the holistic care of patients if the appropriate infrastructure and funding were put in place. Dentists have strong relationships with patients because of regular contact and the trust that the profession engenders, as well as an intimate knowledge of their

medical and drug histories, and are educated well beyond the provision of what is often viewed from the outside as rather mechanical dental care.

What issues are affecting the wider dental workforce? What steps need to be taken to address them?

31. The significant financial constraints and contractual restrictions to the provision of the treatment make NHS dentistry increasingly professionally unattractive. Wholly or predominantly NHS practices struggle to offer competitive salaries to enable recruitment and retention of staff. Addressing these would require reverses to the real terms decline in funding over recent years, together with the contractual reforms we have outlined elsewhere in this response to enable dental professionals to deliver more effective long-term care. NHS dentistry would also become more professionally attractive if support were offered to enable practitioners to train and undertake reflective practice, and to provide more person-centred care with an emphasis on individuals taking an increasing responsibility for their own care and disease prevention. This requires a focus on prevention which is currently conspicuous by its absence within the present NHS contract.

32. The NHS also imposes outdated and unnecessary restrictions on the roles played by members of the wider dental team, i.e. dental nurses, hygienists and therapists, in delivering NHS dentistry, despite the General Dental Council allowing much wider scopes of practice. Dental therapists for example find themselves working as hygienists and are de-skilled very quickly after training.

33. The NHS should seek for these practitioners to be using the full range of their clinical skills in NHS dentistry, just as they do in private care. This would be in line with the recently-published NHS Long Term Plan, which commits to

    “Make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients”

    For this to happen in dentistry, the NHS should help develop a series of career pathways for general dental practice, and would then commission services in such a way as to make full use of the skills and competence of the full dental team.

    Doing so would not only aid recruitment by making NHS work more professionally attractive, but by enabling practices to deliver more cost-effective care, ultimately help more practices to stay within the NHS. There is also potential to move some treatments currently carried out in secondary care into primary care; this is also in line with current NHS thinking and could bring costs savings to the system.

34. FGDP is in the process of establishing an independent College of General Dentistry, one of the key aims of which will be to work with the profession to build a recognised career pathway for general dental practice. It would be a huge missed opportunity if the continuation of the NHS's outdated contractual restrictions meant that NHS colleagues were unable to participate in this development, and would accelerate the decrease in the professional attraction of NHS work.

35. Dentists also suffer from information overload, with practices subjected to an increasing administrative and regulatory burden, which is all the worse when practising under the NHS contract. Some of this is unnecessary, and even that which is necessary changes so frequently that practices struggle to keep up, diverting resources and attention away from care delivery.

What are the issues in commissioning and payment systems for NHS dental services?

36. The NHS contract rewards intervention rather than prevention. Yet the two most common oral health conditions, dental caries (tooth decay) and gum disease - the former being the most prevalent health condition of any kind among both adults and children - are almost entirely preventable.

37. The commissioning system creates a race to the bottom in terms of fees for UDAs, which puts significant pressure on practices' ability to devote the time and resources to deliver the care they would wish to. This is exacerbated by contractual penalties for under-delivering on the precise number of UDAs commissioned, and complete non-payment for any over-delivery. The number of UDAs commissioned changes year to year, but with a downward trend, denying practices the certainty needed to invest, recruit and train to meet future demand. The combination of these circumstances means many NHS practices find it difficult to take on new patients (particularly those with the greater or more complex needs), many are seeking greater stability by reducing their reliance on NHS work, and for some practices this has unfortunately meant closure altogether.

38. Commissioning also varies widely across the UK, with greater problems of access and provision in some areas than others.

How can they be improved?

39. A new contract is desperately needed to start addressing the issues we have outlined.

40. Ultimately, if Parliament wishes the NHS to provide for oral care on the same universal basis it provides for other medical care, significantly more funding would be required. Even if this were not deemed realistic, it should at least challenge the pretence by government that we have an adequate and universal service already, and demand a more honest conversation in which the limitations are acknowledged with the responsibility accepted by government.

41. However, even within current resourcing, there are huge improvements that could be made. NHS dentistry spending is not well targeted to meet the most pressing needs, and for the reasons already outlined, the NHS is not well structured to provide access to those patients in greatest need of support and treatment. The NHS spends too much on treatments with questionable health benefits while failing to provide basic treatment to many who need it.

42. Treatments are provided at disproportionate cost in secondary care, or by referral to NHS consultants' private practices, when they could be provided by suitably experienced and competent General Dental Practitioners, with secondary care reserved only for the most complex clinical cases.

What needs to be included in, or removed from, the forthcoming NHS dental contract?

43. The contract should include a significant element of capitation. This would enable dental practices to attract and treat those with the greatest oral health needs, but only if the UDA system is removed or reformed.

44. The capitation element should re-introduce patient registration to promote continuity of care, a key factor in delivering high quality care.

45. Preventative activity and minimal-intervention dentistry should be rewarded, with the aim of prolonging the working life of patients' natural teeth and the ability of their oral tissues to support them.

46. Remuneration should be offered for the time and on-costs of providing domiciliary care for less mobile patients, and care in nursing homes and other out-of-surgery settings.

47. Any continuation of the UDA system should remunerate dentists in a manner far more proportionate to costs, allow for a less compromised quality of care, and should replace annual contractual 'clawback' – which in any case diverts money away from dentistry - with a multi-year cycle enabling practices to recruit and train staff, and invest in services, with greater confidence and certainty.

48. To discontinue the race to the bottom, national UDA values should be set, with the ability for local health authorities to increase these to reflect locally identified priorities.

49. The payment system should be designed to reward the delivery of high quality care.

50. The contract should effectively use its full range of the dental workforce's skills and competence, and value and reward the time and care it provides over and above what it has hitherto defined as 'activity', so as to ensure that the NHS returns to being an organisation that dentists are proud to associate themselves with, and one in which younger members of the profession aspire to work.

51. There is no medical reason why the whole population's needs for examination and treatment should not be met in dentistry to the considerable extent that they are in other areas of the NHS – it is just a historical anomaly to which we have all become accustomed, the remedy of which has looked ever less appealing to successive governments as the cost gap increases due to the persistent decline in dental funding. While a comprehensive service would require both much more funding and a very different system to the status quo, within the current funding level the system could be better designed to identify and treat those with the highest levels of need, i.e. to identify and prioritise those at the highest risk of tooth decay, gum disease, oral cancer and tooth surface loss. Within a fixed sum however, it is likely that these priorities would reduce access to routine care for those at lower risk of oral ill health to a level below that recommended in national guidelines.

52. The system of fee-charging could also be overhauled. It acts as a barrier to many who need treatment to seek it, both those who have to pay charges and those who do not (who may be unsure, or fear a financial penalty for forgetting their exemption documentation, or fear administrative error by the NHS). The system is also a costly and bureaucratic form of administration. An alternative system might define a universal, national offer of priority services which are free to all, with other services incurring charges. Such a system could channel a large part of the administrative cost into spending on dentistry.

53. Emergency dental care should be freely available, and practices remunerated accordingly.

Is there enough focus on prevention in dentistry and what are the avoidable harms that could be addressed?

54. No. Tooth decay and gum disease are almost entirely avoidable conditions, but remain the most prevalent forms of oral ill health, with tooth decay the most prevalent health condition of any type among both adults and children. In England, a quarter of primary school children and a third of secondary school children have tooth decay, and 40% of children overall do not see a dentist each year.

55. Members of the dental team provide personalised preventative advice to patients as part of dental appointments, however in itself this is not remunerated, and the ability to do this is constrained by the appointment time which NHS practices can afford. There is limited incentive in the contract to provide preventative treatment, with the financial drivers continuing to place a clear emphasis on reparative interventions.

56. In essence, prevention has been undervalued and underfunded, and until the payment system is reformed, it will not be properly delivered. The monitoring of the delivery of preventative care is widely perceived as a barrier to reform, however we believe this can and should be addressed.

What more can be done to encourage prevention and what can be learnt from best practice in other parts of the UK and EU?

57. To encourage prevention, the NHS would have to commission it – i.e. the dental contract would have to reward it – and a truly preventative approach to oral health would have to go well beyond dental practices.

58. The adoption of a risk-based approach would enable the most effective use of the available funding, and proactive prevention programmes could be targeted at the areas of greatest need, for instance through the re-introduction of school dental checks.

59. Scotland has been very successful in recent years in providing preventative care for young children through its multi-faceted Childsmile programme. The NHS contacts families once children are three months old and makes an appointment for them with a local Childsmile-registered dental practice, with regular appointments arranged thereafter. All children are provided with a toothbrush and toothpaste at least six times by the age of 5. All 3 and 4 year olds in nurseries, and 5 and 6 year olds in the most at-risk 20% of schools, are offered daily supervised toothbrushing. Fluoride varnish is applied twice a year from the age of 2 in dental practices, and in priority schools to 3-6 year olds. Obviously there

needs to be serious commitment by government to fund such programmes, and the results do not appear instantaneously.

60. Wales has a smaller-scale programme, *Designed to Smile*, and England has recently started implementing the welcome but much less ambitious *Smile4Life* programme in a small number of local authority areas. In England, 40% of children do not see a dentist each year.

61. As well as direct provision of preventative advice and interventions, there are other levers available to government to encourage adoption of appropriate dietary advice to improve oral health. Put another way, a lot of preventative care and advice can be quickly undone by the lure of discounts and adverts for high sugar food and drinks. The average person in the UK eats three times the recommended maximum intake of sugar, and our bad habits start early in life. FGDP has strongly welcomed the introduction of the Sugary Drinks Industry Levy, and is encouraged by suggestions that this may be extended to high sugar milk drinks in future. We have also welcomed the government's range of proposals in recent months to restrict price promotions on unhealthy food and drink, and the Committee on Advertising Practice's increasing restrictions on the advertising of such items. These steps all encourage and empower people of all ages to make healthier choices, and we would encourage the Committee to recognise the oral health benefits of such policies as additional reasons to support them.

What should be done around fluoridation policy and what is the evidence base to support it?

62. Fluoride supports the mineralisation of tooth enamel and helps prevent its demineralisation, thus helping prevent tooth decay, the most prevalent health condition in England (and elsewhere).

63. There is sound scientific and epidemiological evidence that the provision of water which is either naturally or artificially fluoridated to around 1ppm is both safe and effective in reducing the incidence and severity of dental caries in a given population. A Cochrane Review in 2015 estimated that water fluoridation reduced dental cavities in children with no other sources of fluoride by 35% in baby teeth and 26% in permanent teeth. The effect is less pronounced in adults, however increased rates of decay have been observed where water fluoridation schemes have been ended.

64. Only around one in ten households in England receive tap water containing fluoride at the recommended level, and most of these receive it due to additive rather than naturally-occurring fluoride. Worldwide, fluoridation policies vary

significantly. The USA, Ireland and Chile provide fluoridated water to over 70% of their populations, while in mainland Europe artificial fluoridation tends to be low or non-existent, and in Sweden is even illegal.

65. However despite these huge variations in approach, over recent decades there has been a sustained reduction in tooth decay not only in England but across the developed world, which has been credited in significant part to the widespread adoption of toothpastes containing the recommended levels of topical fluoride.

66. But these overall reductions in the incidence of dental caries mask significant local and regional variation, and FGDP supports localised water fluoridation where necessary and appropriate in England as one means to help tackle dental decay in the most at-risk population groups, as well as the wider health and socio-economic problems that can arise from it.

67. In the context of the highly vocal opposition to be found wherever local water fluoridation is proposed, policy-makers should also be cognisant of the availability of other means of delivering an effective level of fluoride either universally or to those that need it most. Fluoridated salt is available and/or encouraged in Germany, France and the Czech Republic, and accounts for almost all household salt in Switzerland. Fluoridated milk can be provided in targeted locations, as happens at school breakfast clubs in Blackpool. Fluoride varnish can be applied to teeth, as is now recommended as standard for all children in Scotland, and high fluoride toothpaste is already prescribed to certain high risk patient groups in England and elsewhere. All these means should be considered alongside water, and used where appropriate to meet the identified need of a particular local population or patient demographic.