Dental Schools Council

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NHS England Improving Dental Care and Oral Health – A Call to Action
Dental Schools Council Response

1. Are (the objectives) the right objectives, and what others to those we have listed are necessary for a modern strategic framework for NHS dental services?

The objectives listed are sound and highlight the importance of consistent, high-quality care. High-quality care is dependent on effective commissioning of dental services provided by dental professionals educated to the highest standard. Dental education provides the bedrock for dental services as schools guide and support future dentists and dental care professionals (DCP) in developing skills and attributes, including professionalism, required to provide treatment to a diverse patient population. There is a need for commissioners, dental professionals, as well as clinical academic dentistry, to work together effectively.

2. What other actions, to those we have listed, will help us achieve our objectives for NHS dentistry?

It is noticeable that within the Call to Action documentation, there is no mention of the importance of research and the contribution made by clinical academic dentistry. The contribution of clinical academic dentistry will help ensure the progression of dentistry and help to develop the evidence base impacting on the quality of services received by patients. There remains an opportunity for NHS England to reflect on the importance of research, along with its sustainability. Research and innovation is a key mission of the NHS, largely exercised through NIHR. NHS commissioners should be mindful of the need to support research (and training) in primary care and this should be reflected in a flexible pricing structure.

The Dental Schools Council undertakes a regular survey of clinical academic staffing levels in UK dental schools. Analysis of clinical staffing levels in 2013 indicates a 19% decline in the number of Readers/ Senior Lecturers and Lecturers in post compared to 2000 (a decrease of 89 FTE). This poses a serious threat to oral and dental research and, in turn, to the health of the population and to the position of the UK as a leader in this field.

There is also a need to consider sub-specialities within dentistry. Hospital practice and academic dentistry is highly specialised, and covers the 13 specialties recognised by the GDC as well as Oral & Maxillofacial Surgery, where employed by the dental school, and Dental General Practice. The small size of the sub-specialties in dentistry makes them particularly vulnerable to change in staffing levels. There are six specialties numbering fewer than 20 FTE clinical academics (Dental & Maxillofacial Radiology, Endodontics, Oral & Maxillofacial Surgery, Oral & Maxillofacial Pathology, Oral Microbiology and Special Care Dentistry).

The provision of quality care in future is very much dependent on the translation of high-quality research into practice and flexible training pathways to progress with a career in clinical academic dentistry must be provided.

Reducing inequalities

3. What do you consider to be the main health inequalities, and how should the new commissioning framework for dental services aim to reduce them?

Health inequality has been found to be linked to levels of socio-economic deprivation and there are several factors influencing poor oral health, such as tobacco and alcohol use, diet and nutrition, as well as oral hygiene and access to dental services more widely.

Members of the dental team are in a strong position to provide wider health advice, such as smoking cessation and the importance of diet and nutrition; these topics are considered within the study of dentistry. A dental professional is trained in a wider health context to understand the relationship between oral health and the wider determinants of health and wellbeing, as demonstrated within the learning outcomes provided by the General Dental Council. These highlight the need for dental students to absorb wider social trends and the determinants of health, along with the effects of health inequalities.

A preventative approach should be adequately resourced and there is an opportunity to recognise that this will demand more time from the dental team. There is also an opportunity to consider how oral health is incorporated within wider health related initiatives.

4. How can we improve the oral health of people with particular needs (including issues of access and take-up of NHS dental services) such as: frail elderly people; children; mental health users; people from black and minority ethnic groups; seldom heard groups; and people with dental anxiety?

In supporting the oral health of those with particular needs, it will be important to reflect how changing demographics are likely to affect the wider population, and in relation, dental needs. For instance, it may be the case that that an ageing population will require increasingly complex restorations and it will be important that these changes are reflected in the provision of dental care through close relationships between commissioners, the dental team and dental education.

Information on oral health should be accessible and targeted to the needs of individuals. Dental schools work to develop communication skills in students so they are able to effectively communicate sensitively with a wide range of people.

Access

5. How can we further improve ease of access to dental services?

A major impediment to patients seeking dental case is concern and uncertainty as to how much treatment will cost. It may be that there is an opportunity to explore whether initial examinations can be provided free of charge as this will allow vital first contact with a patient. From this, it will be possible to provide wider early interventions on the effects of lifestyle choices on oral health, as well as providing an opportunity to reassure patients as to the cost of treatment.

This initial engagement may also be supported through developing informative resources on oral health which could be disseminated through social media channels, such as YouTube, on the best techniques to use when brushing teeth and other preventative activity. While such resources would not be as beneficial as one to one tuition from a dental care professional, they may help serve to increase engagement with dental services.

In most dental schools, dentists are trained in a multi-professional environment and recent generations of dentists are therefore aware of the advantages of working within a dental team. Increased and

appropriate use of the DCP workforce offers opportunities to improve access and choice for patients. There is a need to remove the legislative barriers to direct access for DCPs, and the NHS can support the private sector to provide easy access to dental services for those who wish to pay.

6. How should dental 'out of hours' and urgent care services be organised, and how do we ensure that access to these services is easily signposted for patients?

Many GDPs already provide a significant amount of service delivery out of hours. However in secondary care, particularly in the out-patient environment there is an embedded culture of 9-5, 5 days a week working. The NHS generally, and the commissioners in particular, should seek ways to incentivise dental hospitals to embrace a 24/7 culture. This would benefit patients, but also provide opportunities for teaching and training. Incentives should be evidence based and provide high quality care focused on long term solutions, this is how UK graduates are trained. This will require close monitoring with robustly applied quality measures.

There is also a difference between urgent care and emergency care. Emergencies such as trauma, haemorrhage and facial swelling should always be seen swiftly and this may need to be through A&E. It is suggested that there has been an increase in paediatric attendances at A&E, which is worrying for the profession as a whole.

Inspection and monitoring

7. How do we best describe the role of *NHS England* in monitoring safety and quality alongside the role of the *Care Quality Commission* and the *General Dental Council*?

NHS England, the Care Quality Commission and the General Dental Council all have a role in monitoring either dental services, or the individuals which provide them. It is important that the relationship between the organisations is made clear so that patients understand dental regulation, and, most importantly, where to go if they have a concern.

NHS England's role could be described as focusing on improving future patient outcomes. Consequently, NHS England it is at the foreground of developing the vision for dental services and the reconfiguration required to achieve improved outcomes. In this way, the role of NHS England is to understand current outcomes, as well as considering the improvements that need to be made. The link between commissioners, patients, the dental team and clinical academic dentistry is vital and NHS England's role could be described as a 'broker' between these agencies to ensure services are fit for purpose and can respond to future demands.

Innovation

9. How do we support and promote innovation in improving oral health?

Clinical academic dentistry plays a significant role in promoting innovation in oral health, high-quality research undertaken in dental schools contributes to the economy and directly influences the training environment in which dental students are educated. Furthermore, a strong grounding in research throughout their training will equip dentists with the skills required to ensure their future practice is evidence-based and can respond to progression in dentistry (see also comments under section 2).

This will ensure dentists have the skills to respond to technological developments throughout their careers, this includes awareness of the latest research, along with the ability to critically appraise and evaluate research findings. While this is something that is installed by dental schools, it is important that dentists are given the opportunity to further maintain these skills through Continuing Professional Development (CPD).

Furthermore, it is important that adequate training pathways are provided to those who wish to progress with a career in clinical academic dentistry and there should also be flexibility to move between an academic and an NHS career to strengthen the pipeline of clinical academic dentists.

Quality, prevention and integrated services

11. To what extent can dental services be safely and appropriately moved from hospital to primary care settings while maintaining quality and outcomes, and what are the barriers and enablers to achieving this?

While it is true that much of the work in a dental hospital could be carried out in primary care, the NHS needs to be mindful that hospitals are all partnered to a dental school and provide an important training environment. Most schools now provide some "outreach" training in primary care environments, but there is still a significant need (especially in urban areas) for students to learn their clinical skills in a properly supervised hospital environment. We would suggest that primary care should be considered according to how care is provided, and paid for, and not the building in which it is provided. When planning care pathways, managed networks and guidelines for commissioning, NHS England must remain aware of the need for patients to flow through the dental hospitals.

At the same time, dental schools are supportive of transferring appropriate amounts of service and teaching and training into primary care. However, the extent of this needs careful consideration and consultation, and the commissioners need to ensure that teaching and training are allowed for in the pricing structures.

Within the NHS Commissioning Board's document, *Securing Excellence in Commissioning NHS Dental Services*, section 4.14 highlights the co-dependency as to the income streams of dental hospitals and schools. When considering the movement of care, there is a need to consider the effects moving services will have on funding streams. One of the most important aspects in moving care from secondary to primary care is to establish the expectations of service provision within the primary care contract; this is not particularly defined at present.

12. How can we support dental services in providing a preventative focused practice?

The move towards contractual reform, intended to progress away from payment by activity to a focus on outcomes, will help embed preventative focused practice. As part of this, the evidence gained through piloting new prevention based clinical pathways should be considered.

Changes to future clinical pathways should be fully explained to patients to ensure there is an appreciation as to the importance of preventative focused practice to encourage patients to engage with this activity.

An additional consideration that comes from a focus on preventative practice is the effects of tooth wear, something likely to increase as the focus on prevention increases. In particular, there is an opportunity to consider how dental services can respond to this in future, as well as considering how the learning outcomes for those studying dentistry can respond to this likely growing demand. Consequently, teaching on occlusion, materials and restorative techniques will still have a major place in the dental school curriculum.

13. How can we ensure that supporting lifestyle change - so as to improve general and oral health - is an integral part of the work of the dental team?

Oral health both influences, and is influenced by, wider general health and related lifestyle choices. The dental team provides advice and guidance on lifestyle change and it should be recognised that this approach can be time-intensive. Consequently, it is important that services are configured in a way to allow preventative practice and are adequately resourced.

There is also an opportunity to consider how oral health is incorporated within wider health related initiatives. Health and social care professionals should present consistent messages regarding health risk factors, such as diet and nutrition, tobacco and alcohol consumption.

15. What contribution can dental professionals make to addressing a person's wider social care needs?

As previously suggested, dental professionals are in a strong position to provide wider information and advice to support general and oral health. There is also an opportunity for the dental team to provide broad signposts where patients would be able to access information and advice regarding wider social care needs. Nevertheless, it should be considered that some of these identified needs are likely to be very complex.

Workforce

16. What kind of workforce will be needed in the future?

The current and future dental workforce will be required to be flexible and adaptable, technological developments will mean that it is vital that the workforce keep their skills up-to-date, something reflected within the General Dental Council's reform of CPD.

Furthermore, it is important that the dental team of the future has the right skill mix to match demand. A focus on preventative dental services is unlikely to reduce demand for dentists; instead, it is likely that services will become more complex, with a likely increase in cosmetic dentistry and demand for implants.

Efficient and effective dental services in future will depend on ensuring the right skill mix within the dental team. While it has been suggested that there is an increasing role for dental care professionals, especially in the provision of preventative advice, it is important that robust modelling is undertaken to help inform workforce planning and ensure that the future supply of dental care professionals matches demand.

17. How do we support the workforce (current and future) in adapting to future needs?

Ensuring the workforce can adapt to future needs will require a clear articulation of what is needed from dental services and the changes required to achieve this vision. It is important that these messages are consistently communicated across the whole of the dental sector.

Undergraduate dental schools ensure future dentists are able to adhere to the standards of care and professionalism expected when accessing dental treatment and work to support dental students gain the skills to practise as a safe-beginner at the point of registration.

Dental schools are regulated by the GDC and are required to demonstrate how their programme will meet the Standards for Education through mapping the curriculum to learning outcomes. These are based on clinical skills, as well as the attitudes, values and behaviours required from a dentist in the future. Consequently, dental schools are well placed to respond to the future demands placed on the dental team and this should be supported by CPD throughout a dentist's career.

18. How do we support the move to a more integrated approach to working, within managed clinical networks?

It is important to recognise the relationship between oral and general health. The commissioning of dental public health through Health and Wellbeing Boards should be aligned to nationally commissioned services.

Clinical network arrangements, with consultants and specialists providing mentoring and quality assurance of a wider primary care team, are an appropriate and effective mechanism for safely and cost-effectively providing high quality care. In some areas, this can very effectively be provided in large practices or health centres; however the use of existing estates should also be considered.

Clinical networks will need appropriate training workforce at each of the three levels of the care pathway. At level 2 there should be flexibility in the requirements for recognition of 'enhanced skills". In particular, dental schools already provide a significant amount of training at this level through their

Masters programmes. We would wish to see this maintained and would work with NHS England to ensure that curricula are appropriately matched to the needs of the commissioners.

Information and communication

19. How can we improve the flow of communication and information sharing between dental services and health professionals, and dental services and patients?

It is understood that the NHS Business Services Authority intends to introduce the use of NHS numbers to support the integration of care. It is suggested that this will be achieved through strengthening the management of patient data which may present an opportunity to improve information sharing between wider health services.[1]

21. How do we ensure that patients who are considering purchasing private dental payment plans are provided with sufficient and accurate information by dentists and dental practices that enable them to make an informed choice on how they pay for their dental treatment?

The Office of Fair Trading's *Right to Smile* campaign was launched to support patients make informed decisions as to their private dental care, including their entitlement to NHS treatment.

The principle of providing accurate information on the cost of treatment should be the same whether the patient accesses treatment through the NHS or private practice, or through purchasing private dental payment plans.

Guidance already encourages dentists to provide upfront information, including the price of the initial consultation fee and treatment. There is an opportunity to also ensure that dental price plans are compared with the cost of accessing treatment via the NHS or privately. It may be the development of treatment 'scenarios' and the suggested cost to the patient via NHS or private treatment, compared to payment plans, could be produced. Nevertheless, this would need to take into account the variety of price plans, specifically regarding their cost and the treatment included in the plan. Consequently, it may be that a list of 'things to consider' could also be produced to assist patients when making a decision to sign up to a payment plan.

[1] Department of Health, 2014, NHS dental contract pilots – Learning after first two years of piloting.