To: NHS England

10 May 2014

Dear Sir or Madam

**Re: Improving Dental Care and Oral Health – A Call to Action**

I am writing on behalf of the British Society of Paediatric Dentistry (BSPD) in response to the request for comments on the above consultation, the findings of which will help NHS England develop a strategic framework for commissioning NHS dental services. Our Society, of around 600 members, is extremely concerned about the future of children's dental services and has formed a Task Group (details enclosed), with expert representation across primary and secondary care providers, to provide a strategic lead in all aspects relating to commissioning. This group, of 10 members, including a lay member, has collectively responded to 'Improving Dental Care and Oral Health' on behalf of BSPD. We are a key stakeholder in the provision of dental care for children and welcome the opportunity to highlight the need to prioritise future services for this important patient group. Our responses to the questions raised in the above document, and the accompanying evidence resource pack, are itemised below, and are limited to children's dental services.

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

**i.** We would support the overall objectives listed in the document but would comment that they are not clearly signposted. It is confusing that pages 4 and 5 have the headings 'Objectives' but these refer to the 'Call to Action' objectives rather than the overall objectives for a modern strategic framework.

ii. All objectives must be measurable with regard to process and particularly outcome.

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

i. In terms of contractual reforms, we would support changes in the current dental contract which created a target (UDA)-driven 'treadmill' which was not conducive to delivering quality care, especially to children with high caries experience. Some of our members are working under a new pilot dental contract scheme and report that, whilst it has the potential to address some of the negative features of the previous UDA-based contract, the system is overly bureaucratic and the processes for data entry and

monitoring place undue time pressures on providers and performers with potential to negatively impact on time available for clinical care. Lessons need to be learned from the medical sector to ensure the same target driven and paper trail driven methodology of working and monitoring is not transferred into the dental sector. The new contract must also ensure that dental practices which encourage Interim Care Management (ICM) attendances for high risk children (who are also known to be poor attenders) are not disadvantaged by a commissioning approach which simply rewards the registration of unique patients.

ii. Greater attention should be given to workforce planning so that children across the whole country have access to all members of the dental team. This will ensure that their needs are met by the person most appropriately skilled to deliver their care. Currently there is great disparity in the geographical location of specialists in paediatric dentistry which disadvantages children with more complex needs.

iii. Strategies for improving oral health outcomes must be incentivised at a 'higher' level and not just at the provider level. Whilst dental teams have a key role to play in oral health education and achieving a healthy mouth, population-level influences also have significant potential to impact on oral health maintenance. For example, local commissioning bodies must support healthy eating campaigns in schools which have oral, as well as general health, benefits. Health visitors and pre-school groups should also be fundamental to supporting optimum oral health self-management for vulnerable groups. Improvements in oral health require population-based initiatives, thus innovative, cost effective and evidence-based multi-agency approaches must be developed for the future. Notably, targeted water fluoridation schemes must be pursued as the most cost-effective and evidence-based caries prevention strategy for high caries populations.

iv. Evidence based protocols and care pathways should be developed for children from birth. Parents must be aware of these and their important role in the promotion of excellent oral health.

*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?*

i. There are clearly very high levels of dental disease affecting a significant minority of children living in socially disadvantaged parts of the UK. Poor oral health is often inextricably linked to other health problems, such as childhood obesity, diabetes, ADHD, with an ongoing impact into later life in terms of heart disease, cancer, Alzheimers etc. The new commissioning framework therefore needs to allow for local service development in response to local need, within clear national guidelines which do not allow individual trusts to interfere with contractual commissioning arrangements and budget-setting.

ii. The new commissioning framework for dental services must target geographical areas where children have the highest level of dental decay and provide appropriate resources and innovative community-based schemes to cater for these children from birth.

*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?*

i. Young children (pre-school) with high caries experience, from socially disadvantaged families, represent a particularly high need group. These children are more likely to have safeguarding concerns, or come from black and minority ethnic groups who require the support of interpreter services. It is paramount that these children have ready access to a local community dental service which is best placed to look after them in the first instance. Referral systems need to be transparent, simple and widely publicised so that other medical and social services can readily refer these patients to the most appropriate dental service. There should be an expansion of community dental services so that these needy patients are not subject to excessively long waiting times prior to being accepted for care. Interventions such as school-based fluoride applications and the Childsmile programme, which have proved highly successful, should be more widely adopted.

ii. There is currently a great disparity in access to appropriate and high quality dental care. For example, children in certain parts of the country have no access to a specialist-led service for dental treatment under general anaesthesia, which may have significant consequences in terms of the child requiring a repeat GA because of a non-comprehensive assessment and treatment plan at the first attendance. The commissioning framework must ensure that access to all levels of dental services (as indicated in the Department of Health's Care Pathway for Paediatric Dentistry) is available to every child, irrespective of their geographical location.

iii. Whilst general dental practices are extremely good at providing dental care for the majority of children, there is a significant need for a complementary community dental service where staff have additional more specialised skills to look after those patients who are not 'economically viable' for treatment within the general dental service. For this reason it is absolutely not appropriate that the community dental service should be target-driven and performance-measured along similar lines to the general dental service (which is certainly what is happening in some areas).

iv. Social deprivation is primarily associated with dental disease. A multi-disciplinary team approach may begin to address those families who fail to engage with dental services. Preventive oral health care, via a care pathway should be implemented from the antenatal period onwards. All health care professionals should offer advice and encourage engagement with dental services. Whilst families should be encouraged to take responsibility for themselves, health professionals should liaise when families are known to be at high risk. Specialists in paediatric dentistry should oversee provision of the clinical care pathway for those children known to be at high risk and/or medically compromised. This should be provided locally where possible with home visits from members of the dental team to reinforce the oral health messages, offer topical fluoride and encourage regular examinations as required.

v. The aim should be a joint partnership between parents and professionals to ensure the best possible outcome. Outcomes should be measured: preventive advice offered, treatment provided, reasons why disease has been left untreated. The care pathway should include actions to be taken for those families who choose not to engage particularly when dental disease is present.

vi. Failure of vulnerable families to bring their children for necessary dental treatment is a great area of concern and the reasons for this failed attendance need to be explored more thoroughly so that more appropriate measures and resources can be put in place to address this problem.

vii. Another area of concern is transition. Children who have been looked after by a specialist paediatric dentistry team until the age of 16 are not always offered a seamless transition to an adult specialist service as there is a lack of these services in all areas. Care pathways need to be developed for children with special medical, behavioural or dental needs to ensure they receive ongoing high quality care on reaching the age of 16 years.

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

i. Local dental services should be better publicised to user and professional groups. For example, all hospital Emergency Departments should be aware of follow up services for children presenting with a dental problem. Pre-schools, health visitors, medical practices, community groups and social services should all be readily updated about how children's dental services can be accessed in their area.

ii. There should greater availability for 'walk in services' for irregular attendees. Practices or access centres which provide this service could adopt a similar approach to GP surgeries with vacant slots made available every day at 8.30am for urgent appointments. Children with high needs need to be identified through these services and appropriate follow up arrangements made for them.

iii. More local clinical networks should be established to facilitate ready access to the most appropriate dental service according to patient needs.

iv. Referral to a specialist /Consultant in Paediatric Dentistry should be simple and accessible for all children. Families should be aware of all service provision available to their child. Furthermore, acceptance criteria should be universal across the country to specialist and consultant services. Currently there is great disparity between secondary services in their protocols and referral criteria for accepting children single items of treatment, shared care or sole care.

v. Shared facilities (medical and dental practices on the same site) could encourage communication between Health Professionals and may help to improve access to dental care for vulnerable children.

vi. Greater use of social media could be utilised to provide patients with regular updates of where, why and how they can access dental care for their children.

*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?*

i. Provision of appropriate and high quality 'out of hours' and urgent dental care is a recognised area of need for children. Young patients with complex dental trauma or rapidly progressing dental infections require access to an 'out of hours' services within a paediatric-dentistry managed clinical network, to ensure that they receive appropriate care. Numerous studies have identified that children with acute dental trauma are often poorly managed at first attendance which adversely affects the future prognosis of their injured teeth. It is imperative therefore, that such services

are quality assured by the input of a paediatric dentistry specialist or consultant within a managed clinical network.

ii. Data from accident and emergency departments at children's hospitals also show that children are attending inappropriately to these sites, with dental problems that would be better managed within primary care settings. Thus provision of more appropriate out of hours dental services for children would reduce the burden on other medical services.

iii. Telephone triage services should be available to direct patients who require actual treatment in an urgent situation to centres with a dental chair and dental professionals who can provide definitive care. The telephone service should have multiple 'access' points, through NHS 111, through the GP out of hours services, it should be signposted at pharmacies and advertised on all practice doors. Out of hours services should only be commissioned if there is evidence that they have adequate facilities and staff to provide 'proper' treatment other than simply placing a temporary dressing or giving a prescription for antibiotics (which may be inappropriate for the presenting complaint.

*7) What data do we need to support commissioners and providers in focusing on improving quality, outcomes and access?*

i. Provision of simple caries data (dmft and DMFT), as given in the accompanying evidence-based pack, is wholly inadequate for commissioners to compare and monitor quality of care and any improvements in oral health. Data relating to the care index (proportion of decayed teeth which are restored) as well as the quality of the restorations placed should be taken into consideration. Child-reported outcome measures, as well as clinical outcome measures, should be developed within dentistry in order to fully capture the patient experience and thereby measure quality of care.

ii. Data for repeat dental General anaesthetics are a good example of a child-specific outcome measure that should be monitored to ensure the quality of care. Experts, such as the BSPD should be consulted to advice commissioners on the most appropriate outcome measures for children's dental services.

iii. Regional and national audits with common themes should be encouraged in different provider settings so that comparisons are facilitated.

iv. Databases that are correctly maintained (e.g. CRANE) are only helpful if manpower is available to input and analyse data reliably. Furthermore, we should focus on key data to reduce the burden of trying to capture every clinical detail.

*8) 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?*

i. NHS England should not overlap with the remit of the GDC or the CQC and clear areas of responsibility should be identified to avoid unnecessary duplication of roles with respect to monitoring safety and quality. NHS England should primarily be concerned with commissioning a high quality service and ensuring that it is delivered.

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

i. A number of paediatric dentistry research programmes are currently being funded by The National Institute for Health Research (NIHR) and other funding bodies. High quality research is therefore being conducted in the area of children's oral health and experiences of dental treatment in this country. However, the findings are not readily translated into primary care due to a lack of support at the commissioning level. For example, findings from a randomised controlled trial show that preformed metal crowns have significantly better outcomes at 5-years than do intra-coronal restorations, but commissioners are failing to support the use of this restoration in primary care. Communication between researchers and commissioners should be facilitated so that evidence-based and cost effective interventions can be applied to primary care more expediently.

*10) How do we best develop consistent standards that can be used to monitor safety and measure quality across all dental services?*

i. The General Dental Council has already proposed clinical and professional standards, to which the whole dental team should be working, and these provide the overall framework in which safety and quality should be measured. It would be burdensome and confusing to develop further standards, although these could be greatly simplified. Thought needs to be given to how these standards are actually measured across the different dental services.
ii. Validated and universally applied service evaluations should be adopted in both primary and secondary dental services to allow meaningful comparisons between these services. However, time and resources should be properly funded to allow for this.
iii. Audit and peer review are also fundamental to ongoing quality assurance and should be practiced meaningfully within all dental 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?*

i. The majority of dental care for children could and should be provided within primary care settings. However, as indicated by the Paediatric Dentistry Care Pathway, hospital dental services will always be necessary for a small number of patients who require multidisciplinary dental care and/or support from medical specialities. The simple barrier to moving more children's dentistry to primary care is the lack of a workforce, who has the necessary competencies to provide more complex care for children. Furthermore, functioning clinical networks are not present throughout the country to support such a shift in service provision. Lack of appropriate remuneration, recognising the specific needs of children, is also a great barrier to a high quality service for children in primary dental services.
ii. Commissioners should ensure that specific services, such as out of hours dental trauma care, are provided by the teams most qualified to ensure good clinical and patient outcomes and not fund services which are providing substandard care. In this case it is not the setting that matters, but the competency of the dental team.

iii. It should be reinforced that GA services for children can only be provided within a hospital setting and should be led by a specialist or consultant in paediatric dentistry. Commissioners must recognise this as the required gold standard for safety and quality of care.
iv. It should also be acknowledged that dental hospitals also play a fundamental role in providing dental undergraduate, DCT, postgraduate and specialist training. Thus, provision of an appropriate case mix within a hospital setting, where the majority of clinical academics work, is an overriding consideration.

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

i. Through a National unified message as in the case of other conditions such as childhood obesity.
ii. Lobbying of government to reduce the availability of sugar containing foods and drinks to vulnerable groups.
iii. Promoting National campaigns aimed at schools, play-centres, ante-natal visits etc to educate mothers in improving their child's oral health from an early age.
iv. Care pathways should be more efficient and streamlined.
v. Identified good practices, such as evidence-based patient-centred information resources should be widely disseminated to dental providers.
vi. 'Non-threatening 'support from other professionals such as health visitors or school nurses should be readily available for children whose families are not engaging well with preventive advice and interventions.
vii. In order to accurately diagnose the caries risk status of a child, and thus provide appropriate prevention, it is essential that intra-oral radiographs are taken at appropriate time intervals. The systematic failure to take such radiographs in general dental practice must be addressed by commissioners.
viii. There is great scope to increase the role of DCPs in preventive-focussed practice and they should be supported and rewarded accordingly. Dental nurses could take a greater role in provision of topical fluoride application, preventative advice and oral hygiene instruction. Nurse-led clinics, particularly for ICMs should be optimised for children with high caries risk.

*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?*

i. Undergraduate and postgraduate curricula should focus more on newer techniques such as motivational interviewing training so that the dental team is more effective in encouraging lifestyle changes. Adequate time and resources should be made for this evidence-based intervention.
ii. Identify 'beacon' dental practices to demonstrate to others how they work as a dental team to support lifestyle change and then facilitate the training to do this. e.g. in some practices receptionists are given information about the prevention needs of the patient and are able to reinforce advice regarding any prescriptions (for high fluoride toothpastes) at this point of contact.
iii. The impact of healthy diet and lifestyle is significant in terms of general and not just oral health. There is a duty of Government to challenge the food industry regarding

the high levels of sugar added to many foods, which is undoubtedly contributing to significant increases in the incidence of several major diseases.

iv. Suggested lifestyle changes should be incorporated within the examination template and recorded eg smoking cessation advice.

*14) Should we develop more widely the integrated role of dental professionals in the identification and management of chronic or acute disease?*

i. The dental team is already well placed to identify acute or chronic diseases that may manifest orally. Routing screening for other diseases would have considerable cost implications and may impact negatively on already strained dental services. With respect to children, the dental team could have a greater part to play in identification of disorders to growth and development, especially obesity. Height and weight measurements are frequently undertaken by specialist paediatric dentistry providers, but not so in general dental practice.

ii. There needs to be better communication between medical and dental colleagues, especially at primary care level to ensure that a consistent health message is given to patients. E.g. nutrition advice for special needs children may conflict with dental advice which leads to confusion for carers.

iii. Conversely, we would argue that GPs and paediatricians also have a role to play in identification and management of dental disease. There is scope to better educate and equip, GPs, paediatricians, accident and emergency staff, to identify and appropriately refer children with unmet dental needs.

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

i. The role of the dental team in safeguarding children is key to holistic care. There should be a named dental protection lead who is readily available to provide advice in every local professional network.

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

i. A more appropriate skill mix of level 1,2 & 3 dentists and more dental care professionals are required to deliver an accessible and equitable service to all children. There is a severe shortage of paediatric dentistry specialists within the community dental service following recent loss of posts. In addition, there is currently no trained workforce at level 2 (dentists with additional competencies). It should be highlighted that 'Securing excellence in commissioning NHS dental services' stated, with respect to community dental services (section 4.5) that '*The NHS CB will inherit responsibility for commissioning community dental services, which primarily provide specialist-led special care and paediatric dental services for people with additional care needs*.' We would support this but point out that currently, many community dental services do not have specialists in paediatric dentistry, which must be a priority for commissioning.

ii. BSPD must stress that specialists in special care dentistry are not trained as paediatric dentists and should not be viewed as 'dual' function workforce who can

also look after high needs children. A specialist in paediatric dentistry has very different skills and knowledge to a special care dentist.

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

i. More flexible training and employment options are required to accommodate those with families etc.
ii. Community dental services must be specialist-led and there needs to be an expansion of posts to allow specialists to work outside the hospital setting.

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

i. We need to ensure there is protected time for lead clinicians to provide training and support within their job plans.
ii. Every NHS dental service provider/performer from oral health educator to the dentist needs to have a nhs.net email address and there needs to be a web based method of communicating easily and freely. Information must not just be given to a contract holder (who is often not present in the actual practice) but disseminated to all associates/performers.
iii. Lead paediatric dentists within a managed clinical network also need to engage with modern information technologies to support colleagues in primary care when they have queries.

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

i. We need to encourage the use of more evidence-based and modern information resources for patients to facilitate patient self-management (such as phone aps, decision aids, on-line cognitive behavioural therapy resources for dentally anxious children). Good practices should then be more widely disseminated.
ii. Resources should be aimed also at providing better information prior to a dental attendance to facilitate the first dental visit.
iii. Tracking child attendances at hospital emergency departments would assist the dental professional in identifying children at risk of abuse/neglect and facilitate any safeguarding enquires.

*20) How do we ensure that patients easily understand the NHS dental charges system and exemptions, and are provided with accurate, timely information in this regard by dentists and dental practices?*

*i.* Not applicable to paediatric dentistry.

*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?*

i. Not applicable to paediatric dentistry.

*22) Please tell us anything else you feel is necessary for us to know in meeting our objectives of improving dental care and oral health.*

Response prepared by the BSPD Task Group for Commissioning Children's Dental Services:

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