NHS Dentistry: The Challenges Facing Children’s and Adult Oral Health Services

A joint meeting by the All-Party Parliamentary Health Group and the Faculty of Dental Surgery

Tuesday 19th April 2016, 9.00 – 10.30am, Jubilee Room, Palace of Westminster

Chair: Lord Hunt of Kings Heath

Agenda

9.00 – 9.10 am Refreshments
9.10 – 9.15 am Introduction by the Chair, Lord Hunt of Kings Heath
9.15 – 9.25 am Professor Nigel Hunt, Dean of the Faculty of Dental Surgery, Royal College of Surgeons
9.25 – 9.35 am Dr Mick Horton, Dean of the Faculty of General Dental Practice, Royal College of Surgeons
9.35 – 9.45 am Eric Rooney, Deputy Chief Dental Officer
9.45 – 10.25 am Question and Answer session
10.25 – 10.30 am Closing remarks by the Chair

Overview

The APHG’s joint meeting with the Faculty of Dental Surgery of the Royal College of Surgeons provided an opportunity for Parliamentarians and the wider health sector to hear about the challenges currently facing NHS dentistry. It is a subject which is often overlooked in the debate about the delivery of NHS healthcare and yet oral health is integral to overall health and important for wellbeing. Dental services remain a vital part of the NHS - and of critical importance to patients of all ages.

Good oral health is important in preventing tooth decay and tooth loss, and dentists are also ideally placed to spot the signs of other diseases such as oral cancer. Nonetheless, in the past decade, the number of adults and children visiting the dentist regularly has not improved and the incidence of oral cancer has risen by a third. Declining children’s oral health is of particular concern, with a Faculty of Dental Surgery report, The State of Children’s Oral Health in England, published in January 2015, finding significant regional and social inequalities in children’s dental health, and almost a third of five-year-olds suffering tooth decay. In fact, tooth decay is now the single most common reason why five- to nine-year-olds are admitted to hospital, many of whom are having multiple tooth extractions under general anaesthetic - and this despite the fact that tooth decay is almost entirely preventable.
The cost of removing decayed teeth in children and teenagers has risen by 61 per cent over the past five years to £35 million, an increase thought to be linked to the consumption of sugary food and drink.

The APHG was delighted to be able to hold a joint meeting on NHS dentistry with the Faculty of Dental Surgery, with three distinguished speakers from the field. The Faculty of Dental Surgery is part of the Royal College of Surgeons and its members are specialist dentists who treat complex dental problems in children and adults, including advanced tooth decay, gum disease and mouth cancer. The event looked at the challenges facing NHS dentistry today, and what the future priorities should be, including reducing the variability of patient outcomes and addressing the problem of tooth decay in young people.

Following an introduction by the Chair, presentations from our high-level speakers began. Once the speakers concluded their talks, an extended Q&A session followed to allow Parliamentarians to ask further questions about the topic. The Q&A was then extended to the remaining attendees.

Key problems and challenges identified by the speaker

- Although there has been a general improvement in oral health over the last decade, this is not the case amongst children. Around 1/3 of five-year-old children suffer from tooth decay. In 2014-2015 the removal of carious teeth amongst children cost the NHS £35 million.
- An ageing population who are retaining their teeth for longer. Such patients on the whole have higher levels of decay, higher levels of periodontal problems, higher levels of oral cancer and more complex treatment needs, combined with reduced dexterity, and often reduced cognitive skills; they need more personal, complex treatment and may often be in a care environment, which can pose difficulties in terms of access to dentistry services.
- A lack of access to dental care exists in some areas, with geographical inequalities in levels of access to dental services. This is a problem that has been aggravated by a recent increase in patient charges.
- Young dental professionals are extremely fearful of litigation and concerned about potential fitness to practice issues. There is a need for a shift from a culture of blame, towards an environment more suited to learning.
- Dentists currently have to do a certain number of procedures (fillings, crowns, bridges etc) otherwise they may suffer financially; there should potentially be a greater emphasis on looking after the patient as a whole.

Desired outcomes that emerged from the meeting

- Prevention must be a system-wide effort, from high level policy changes such as the sugar tax, right down to the work a dentist carries out in the surgery.
- Building on pilot schemes, dentistry contracts should include an element of pay related to success with regards to prevention. This would better incentivise professionals to promote prevention, rather than solely paying them to undertake procedures such as fillings etc.
- Public health education must be improved in the area of prevention, including by dental health professionals and local authorities, aimed at both children and parents.
- Local dental networks should be established to help push clinically-led commissioning that is responsive to local population needs.
- There should be a clear plan to increase the fluoridation of water supplies in the UK.
Good morning everyone! It is nine o'clock, so I think I'll make a start, and we'll definitely finish at 10:30am. I've been a part-time Treasurer of the All-Party Health Group, and it's a great pleasure for me to welcome you to this morning's discussion on oral health. We're delighted that we are holding this jointly with the Faculty of Dental Surgery, and it's great to have you here and to do this in partnership.

I think oral health it would be fair to say doesn't always get a fair share of attention, both publicly and certainly at Westminster, and I for one am delighted that we're having this opportunity to discuss a number of important issues in relation to NHS dentistry. It also happens, fortuitously, to be occurring five days after a very interesting report by the Local Government Association which looked at oral health amongst children and teenagers, which it said had risen by 61% – that is decayed teeth – over the past five years, and an increase thought, they say, to be linked to consumption of sugary food and drink. I think we have a representative from the LGA here today who hopefully I can later on ask to take part in the discussion, because as the Deputy Chief Dental Officers have reminded me, of course, at the local level, local authorities, through the Health and Wellbeing Boards, have prime responsibility for the oral health strategy, so I think that the fact that the LGA, the Local Government Association, is taking such a close interest is something to be really welcomed and built upon.

What I'd suggest we do is hear from our three speakers for 10 minutes each, and then we'll throw it open for discussion and debate and we'll see where we get to from that. I hope this will also perhaps be the foundation of some further work in the area of oral health and dentistry, because there are actually a lot of very important issues that need to be discussed and tackled over the next year or two. So, Professor Nigel Hunt is going to kick off; it's a great pleasure to have you with us and over to you.

Professor Hunt

Thank you very much, Lord Hunt. Can I just start by saying on behalf of the Faculty of Dental Surgery a very big thank you for giving us the opportunity to meet here today. I think it's fair to say that although there has been a general improvement in overall oral health over the last 10 years or so, that's far from the truth when it comes to children's oral health.

Just to set the scene, I think it's fair to acknowledge that nearly a third of five-year-old children are suffering from serious tooth decay, on average at least three cavities per child in this age group. If we take that together with a statistic that, in the region of 40% of children have not seen a dentist in at least the last year – at the moment we only record data every two years, so it could actually be even worse than that – we've got a very potent cocktail really for a recipe for disaster. Because children's decay can spread rapidly, it can go from a child who is experiencing no pain at all initially, to one where we've actually got the development of abscesses with their associated facial swelling, high temperatures, and all that goes with a very distressed child in terms of hours of lost sleep, hours away from education, days away from school. Add to that, that they're not seeing a dentist early, so that these problems can be identified and eradicated early, then what's happening is that many of these children are being admitted to hospital for a full-
blown operation under general anaesthesia for the removal of multiple carious and destroyed teeth.

Now, if we just put that in some sort of perspective, we can see here (slide) that if we look at the number of admissions for tooth decay throughout the whole age spectrum, we can see two important points I think. Firstly, if we look at the five-to-nine-year-old group, this is the area which has been circled, you can see this dramatic peak in that particular age group. In fact, dental extractions in the five-to-nine-year-old group is the number one reason for admission to hospital for operations. In fact, if you look at the figures – and these are perhaps not the very latest, we are due for some more figures in the near future – certainly in the order of approaching 30,000 operations are undertaken every year to remove multiple carious teeth in this age group, and that is the number one reason why they’ve been admitted to hospital.

Just to give you a context there, the second most common reason is to have tonsils removed, and you can see that we’re approaching a figure which is 2.5, getting on to three times that amount for dental extractions. The second important point to note from the graph is that, year on year, there has been an increase in the number of children being admitted for this very reason, and in fact over the last four years we have seen a 14% rise in this particular age group.

If we expand that and now look at the whole age group, from birth through to the 18-year-olds – and these are the figures which Lord Hunt was referring to, that came out from the Local Government Association – then we can see once again, year on year, there is a dramatic increase in the number of extractions which have been undertaken for the removal of teeth, particularly carious teeth. Back in 2010/2011 we had figures of around 32,000, but the most recent figure is approaching 41,000.

Now, of course this whole problem of a distressed child being admitted to hospital with pain, swelling and a high temperature to have a full general anaesthetic is probably their first introduction to the world of dentistry – what an introduction that must be. Imagine the dramatic effect that this has, not only on the child, but also on the rest of the family. They’re the ones who will have to cope with the sleepless nights, they’re the ones who’ll have to take time off work to take these distressed children to hospital and to go through the appalling trauma of seeing this age group child being submitted to extraction surgery under general anaesthetic.

But it’s also a cost to the health service, and that’s what I really want to draw your attention to here. Again, from the figures from the LGA, we can see that, back in 2010 we were talking in figures approaching £22 million a year spent on removing carious teeth, and yet by 2014-2015 this figure had risen to just over £35 million a year. If we add the cost together over a five-year period, we’re getting to a figure approaching £140 million over that five-year period. I’m sure we can all agree that avoiding that situation, not only for the child but also for this demand on health service resources, must be something that we’ve got to address.

The worst thing of all, having set that scene, is that dental decay, as we know, is 90% preventable. Should we not be addressing this issue at this stage? We do know that there are regional inequalities. Sixty-four per cent more children are likely to have teeth removed and dental decay in the North West compared to the South East of England, and this is very definitely related to areas of social deprivation. All these factors we need to look at, and we at the Faculty have produced over the last year, two I think important documents: one was stating the condition of children’s oral health, particularly in England, and the second one the actions that we suggested that the Government could take to improve oral health. At that stage, we did secure very major press and media coverage, and Stephen Fayle, one of our board members, and
 myself actually attended numerous press and media interviews with regard to this particular issue.

So, what should we do? We are calling for, at last, a national, coordinated strategy to try to improve the oral health of our children, and whilst this is not just a single aspect that needs to be addressed to give a quick fix, we do need a coordinated approach, and just for ease of presentation I’ve divided this into three areas. Firstly, we need to improve access. That means to say we have a significant proportion of parents and their children who are not seeking dental appointments. Yes, in some areas there are difficulties of getting appointments, and that’s something, again, that we need to address. Interestingly, more children attend in the North West of England than they do in the South East, and yet the caries experience is still rife in those areas. We need to have a better understanding of the factors which do affect children’s oral health and the access to dentistry. We need to look at the geographical inequalities, and I am suggesting that there are very good local schemes operating through the Health and Wellbeing Boards in different parts of the country that we need to share, but why don’t we hear what those good practices are? Why don’t we bring them together as a coordinated response? And although I don’t want to get into this area, because it’s not our area of responsibility at the Faculty of Dental Surgery, we do need changes to the dental contract, to try and give more emphasis towards prevention of disease.

Secondly, we need to improve our education and training, and I would certainly commend the fact that Public Health England did sterling work in getting dentistry and children’s attendance at dental surgeries recorded for the first time in the child’s personal health record when they’re born; up to then, up to last year, there was very little, if anything, on dentistry in the so-called “red book”. But we also need to focus on those early years. If we can get the children and the parents educated when their children are newly born, in terms of the importance of good oral health and how to secure that, then we need to better educate the midwives, the health visitors, the community nurses, school nurses, etc., and we are working very closely with those groups now to bring oral health education into their curriculum.

We also need to give better advice to parents. How many times do we hear the news that they are totally confused as regards what does constitute good oral health? How do you match the “five a day” fruit intake without creating problems with the amount of sugar it contains? We can clarify that, and, Mick Horton from the Faculty of General Dental Practice and ourselves, we are producing a document for parents in this particular area. And finally, prevention. We’ve got to push the need for sugar reduction, not only as a means of reducing obesity, but the intricate relationship of sugar reduction, obesity, oral health, and as a consequence general health, needs to be maintained and brought together. The Government’s obesity strategy, which we are promised soon, must include reference to oral health in relation to child decay.

It may come as some surprise that if we look at the five-to-nine-year-old group, the average five-year-old eats his own weight in sugar in a year – sorry, I don’t mean to be gender-specific: his or her own weight in sugar per year. So, we certainly will be tackling or trying to promote oral health as part of the obesity strategy, but that’s just a start. We feel that the sugary drinks tax is very welcome, we support that, but there are other areas such as price promotions and restrictions on advertising and better labelling of the sugar content of foods that needs to be undertaken, and we at the Faculty are very strong proponents of the call for sugar-free schools.

And finally, of course fluoride; we mustn’t forget the all-important fluoride. The evidence regarding the improvement in children’s oral health and reduction in decay is overwhelming in that we have a dramatic reduction in caries in children in fluoridated areas, so we’d encourage local authority fluoridation schemes.
It’s time for change, and oral health can no longer be the poor cousin of medicine; it needs much greater and serious support, and we all need to work together – the Government, the politicians and others within the NHS – to try to secure better oral health. Let’s achieve the situation on the right, and not that, on the left (slide). Thank you. [applause]

Lord Hunt

Thanks Nigel, that was certainly a passionate call to arms, and I’m sure we’ll come back and raise a number of issues with you. So now we’re moving on to Mick Horton, and Mick, it’s a great pleasure to welcome you again to one of these sessions.

Dr Mick Horton

Thank you very much. Whilst Nigel and I haven’t collaborated in any way in what we’ve got to say today, you will hear echoes of what Nigel said; there are common themes that will loom throughout. There are clearly a lot of important issues, and one of them that was mentioned is access. Without access to a service, we can’t possibly hope to improve the oral health of the nation, so we need to actually look at access and why there are these differentials in the access in various parts of the country. Recent figures show that 50% of dental practices are not currently accepting new NHS patients, and that overall only 60% of the population actually visit a dentist.

Now, those figures alone sound quite damning. However, when you actually put that in context and actually say that the contractual arrangements often within local practices prevent those practitioners taking on new patients, then that is something that we need to actually look at, and if the LGA, through their strategy, need to look at that, then so be it. But you cannot lay blame solely on practitioners actually saying, “We do not wish to see patients.” Sometimes they do wish to see patients, it’s just they cannot.

You also need to look at what message we are sending out to patients, when there’s just been a 5% increase in patient charges. This isn’t a 5% pay rise for dentists, it’s a 1% pay rise for dentists in line with the normal pay awards. But there’s a 5% increase in patient charges this year and there’s a 5% increase in patient charges next year. That’s overall a hike for a Band 2 treatment, which is fillings, extractions, that sort of treatment, from £51.30 last year up to £56.30 next year. If people are actually saying that cost is a factor in preventing people [from accessing treatment], then why are we actually increasing, disproportionately, patient charges, and that’s a question that you need to ask yourselves as well.

Patients need to be provided with appropriate information in order to make informed decisions on their oral health. The dentists are tasked with prevention of oral and dental disease, along with treatments of the damage that’s actually caused by that disease, so that’s our remit and that’s our patients’ remit; that was actually a BDA statement. Nigel earlier actually discussed the state of children’s oral health and the challenges facing that. We should recognise that 95% of dentistry is actually carried out in primary dental care - in primary practice. Increasing the levels of treatment available to adults and children doesn’t address the issue. What we actually need is to start looking at a comprehensive preventative plan for these patients. It’s no good just treating disease; if we continue treating disease, disease will continue to happen.

What we actually need is to look at a preventative plan, appropriately remunerated, that can be delivered in response to local need. If we continue measuring the number of fillings that we provide, then that’s what we will provide, because that’s what we have to do to fulfil a contract.
So we need to actually look at what we’re doing in the overall mission that we have, in terms of reducing tooth decay and improving the oral health of the nation. It’s hoped that Eric will possibly discuss some of the factors that may be brought into account later on.

The improvements that have been made to oral health in the last 30-40 years shouldn’t go unnoticed. The percentage of the population over 65 has risen and soon it will reach 20%; in line with this, they are retaining their teeth longer. When I qualified 30 years ago, 30% of the population over the age of 45 had no teeth at all; dentures were the name of the game. That figure has altered dramatically and now it stands at around 2%. In the over 65s, there’s been a change which is even more dramatic: in 1978, 80% had no teeth, whereas by 2009 this figure had reduced to 30%. Retaining our teeth in an ageing population carries with it its own challenges. The group often sees a rise in decay patterns, as well as a high incidence of periodontal problems, in the surrounding gum tissue of the tooth.

The reasons for this increase are numerous, but often there’s a decrease in dexterity, there may be neuropathic changes such as dementia, and more systemic disease such as diabetes. Medication that is used to treat those diseases can often cause a dry mouth, it can cause its own specific problems, altered taste sensations. People tend to sit there; they can’t taste their food so want more, stronger-tasting foods, with mints; mints are incredibly high in sugar. The loss of a spouse can sometimes result in a laissez-faire type attitude to how they wish to look after their own health; numerous factors that can actually affect the way that we go. The complexity of the treatment of these patients actually increases exponentially. One in four adults over 55 requires what is classed as “complex treatment”, and there are multiple reasons behind this, as I’ve actually listed.

The Faculty of General Dental Practice is currently discussing with a number of groups about how we can make dementia-friendly practices and label people dementia-friendly so that we can actually have a lead within our practices who can actually help programme a plan for patients within their practice to actually help and support carers and their families and the individuals themselves. The team recognise that often applying fluoride, high-fluoride and specific intense prevention will actually reduce the need for complex treatment later in life. It’s no good trying to treat the caries later in life, it’s very difficult to do that; we need to actually prevent it before it happens.

In terms of the current payment system, prevention is an integral part of the examination, but it is not an individual treatment, and maybe what we need to look at is how we actually reward practitioners, practices, the dental team and other organisations for actually providing prevention. We don’t currently do that, we just say, “It’s part of the bigger contract.” What we do is reward people for doing restorations and extracting the teeth; we don’t reward them, individually, for preventing it.

Daily within practice you face conflicts. We’re told, “Let’s provide higher-fluoride toothpaste,” so we merrily write up prescriptions for all these patients to try and reduce their decay, and then somebody comes to us and says, “Excuse me, you’re writing too many prescriptions.” We can’t do it both ways. We need to actually have a coordinated response, that we all work together for the same goal, and as long as we all understand what we’re doing then we can actually do something that’s of use. When we carry out dental examinations, professionals assess all aspects of the mouth. We don’t just look at the teeth; we look at suspicious lesions which may be cancerous or pre-cancerous, and it’s important to understand the role that we have. I just want to give some figures from 2013; this is just the difference in teeth atrophy of the population, as it
The ageing patient has higher levels of decay, higher levels of periodontal problems, higher levels of oral cancer, more complex treatment needs, with a reduced dexterity, and often reduced cognitive skills, they need more personal, complex requirements and they may also be in a care environment, and we need to consider all of those factors. On oral cancer -in 2013 there were 7,591 new cases, making up 2% of all cancers: almost half of those are diagnosed in the over 65s. The incidence, startlingly, has increased by 92% since the late 1970s. That’s something that we really need to look at. Early detection clearly reduces morbidity, and the primary care dental practice is often the best place to identify suspected lesions. They’re not the best place to treat them, but they’re certainly the best place to identify suspected lesions, so we need to actually consider that. Occasionally a patient will say to myself or a colleague, “There’s no need for me to have a check-up. I’m having no problems, and all you do is count teeth.” I long for the day when all I do is count teeth. What we’re really doing is actually trying to get patients to understand why we do what we do, and that is education, that’s a responsibility of us all.

I’d also like to briefly take this opportunity to discuss quality and patient safety. This is something we all wish to progressively improve, and in order to do this we need to understand the risks. The patient’s expectation of their journey through dental care has increased exponentially; if this leads to a better understanding of how they care for themselves, then I applaud it. However, to place that burden completely within the profession without the patients actually sharing in that journey is akin to wading through treacle, it just will not happen. When I discuss with undergraduates and postgraduate students, newly-qualified, their hopes and fears over their career, overwhelmingly they are fearful of litigation and fitness to practice, overwhelmingly, it’s the first thing that they say. And that is at a time when they should be happy to join a profession which has got high standards, there’s quality training, and many other areas of the world actually look and aspire to achieve what we’ve achieved within this country.

We are now in an environment where we seek to apportion blame, either through patient complaints or litigation, for everything that occurs to us. What we really need is a learning environment, an environment where we educate and mitigate the risk by understanding why those events occur. Until we share those experiences, good or bad, through a no-blame culture, we’ll never truly understand why things happen. The Faculty of General Dental Practice, in discussion with the Chief Dental Officer and various other bodies, is proposing an anonymous national significant event database. This is where we can learn from our experiences, in a no-blame environment. It’s got the support of many professional bodies; it now needs the support of the Department and some funding to actually get this off the ground, just to actually start this.

It’s my hope that ourselves, our sister faculty, other faculties and colleges throughout the UK, will lead on the standards and guidelines for the profession, and in consultation with other relevant bodies –the Dental Association, NHS England and the Chief Dental Officer – will shape the future of dental health improvements for the nation. A final thought for you: the children are our future; in the future, those children will be elderly, they will get old – let us not forget them. Thank you. [applause]

Lord Hunt
Eric Rooney

Thank you very much, Lord Hunt. We have a new Chief Dental Officer, you may be aware, called Sara Hurley. Unfortunately, she was unable to come this morning because she’s committed herself to travelling around the country to meet people involved in dentistry, in order to get a really good understanding of how it is out in the areas across the country and how members of the profession, members of NHS England, local authorities, etc. are feeling, and to identify some of the, as Nigel said, good practice which is going on, but also to identify the issues which are of concern. So, instead of Sara you have me this morning, and I represent the office of the Chief Dental Officer. We are employed inside NHS England but have a role to provide professional advice to the Department of Health, to NHS England and to Health Education England.

So, as far as the big NHS is concerned, you may well be familiar with this document, the Five Year Forward View, which sets out the approach to the health service over the next five years. I think what is of interest and I think what in a microcosm you’ll hopefully see by the end of what I say – in fact, it’s already been said by Mick and Nigel – is that I think we would like to move to a position where, as we have here (slide), a whole range of organisations across the bottom of the slide, working in collaboration and signed up to a vision and a way forward for the future, I think we would like to see something similar for dentistry, where we may well have Nigel’s organisation and Mick’s organisation and other professional organisations signed up to an approach to deal with the issues which have been very nicely laid out by my two colleagues.

So, the Five Year Forward View itself is about a sustainable plan for the NHS. Undoubtedly we are in difficult economic times, and the NHS feels the brunt of that. We’ve had the explanation of the increasing elderly population, the increasing demands on the NHS going forward, and the Five Year Forward View sets out an approach to deal with that.

There is a strong emphasis on the joined-up approach, which is what I’ve just said. But also, the very first chapter is about prevention, and for me that is one of the most important parts of all of this, if we think about the strategy going forward. There is also an opportunity of course for wider collaboration. Nigel has mentioned obesity and sugar and so forth, but a recognition - and I think if you look at what’s happening with, for example, the combined health and social care system which is developing in Manchester, where the budgets are pooled and where the responsibility has been devolved in political terms to that area to organise the health services - we have to recognise that whilst we do have a National Health Service and a national system, we will need to operate I think in an environment where there is national consistency – because we do need a consistent approach to things - but with the opportunity for local flexibility in order to ensure that our services develop in a way that is appropriate for our needs. So the way of delivering a set of standards, as Mick said, in the middle of London, the practical way in which we do that might be quite different and probably should be quite different to the way that you do that in a much more rurally dispersed population. And as I’ll come back to at the end, it is an opportunity I think for us all to work together on this going forward.

So, in our early days Sara [Hurley] and Janet [Clarke] who is the other Deputy, and myself have begun to think about what is the vision if you like, what is it that we would really like to see, and this is our starting point. We would like to see a health and social care system that supports good oral health – so I’m not just talking about the health system, I’m talking about the social
care system as well. It provides timely access – access has already been mentioned – to dental care, and when necessary, when people need care and treatment, that they have a streamlined patient journey, they have a smooth run through the systems that we put in place, that’s supported by specialist advice and delivered to nationally expected standards of care. So that’s our kind of high-level statement that we are beginning to work on.

But it’s not an easy process, in the sense that the way the system operates and the partners or the multiple players in this system make the delivery of that quite complex. Now, I don’t expect you necessarily to be able to read from the distance at the back there all of the detail on this slide, but there are a number of key players. Obviously one tends to think of NHS England, but actually the Department of Health is responsible for the policy direction. Public Health England was created and supports particularly the local authority dimension and the more public health focused preventive activities. Health Education England, another separate body in terms of - if we’re going to have change – and we will have change because of the changing needs of the population – the jobs that need to be done. Mick showed how complex some of the potential care for older people is. We need to continue to train existing dental care professionals and new dental care professionals, and Health Education England is the responsible body for that.

We have our professional organisations who have a part to play, our Colleges here on the left-hand side as you look at it, and the BDA, the British Dental Association, who have a role in providing advice and also negotiation around the commercial arrangements that are put in place to support this. We have our regulatory system that’s already been mentioned, the Care Quality Commission and the General Dental Council, who are there to ensure, or assure, that the services that are delivered are safe. So it’s a complex picture, and different partners have different parts to play in the approach that we need to take.

If I can just go to prevention, because I think this is really important: Nigel has spoken about particularly for children, the statistics around the amount of decay which exists, particularly in the poorer and more deprived populations, and the consequence of that in terms of the number of general anaesthetics, and the costs and the emotional aspects of that as well. But what we really need to do is - we know that particularly caries, dental decay is preventable - we need to operate across a whole stream, and the academic approach to this is to think of what’s called upstream policy, so really high-level things – regulatory things, fiscal things, laws – in order to try and help with prevention, right down to the very detailed thing that a dentist might do in a surgery, by applying fluoride varnish or spending time giving advice to a family about what they should be doing in terms of their diet on a daily basis and use of toothpaste and so forth, and there’s a whole range of things in between.

And we have examples; Nigel mentioned the sugar tax which would be up at the higher level of this, and we have more detailed, evidence-based guidance at the lower level, and this approach and the supporting of this really falls to Public Health England. Public Health England have produced, helpfully, a couple of different documents, one of them in association with the specialist society, the British Association for the Study of Community Dentistry - and that the one that’s headed ‘NHS England’ there [referring to slide]- because really that operates mainly in NHS England’s domain in the dental surgeries, and provides the evidence base for dentists and dental nurses and therapists and hygienists to communicate with their patients and to give the right messages, and also to apply the right medicaments in terms of fluoride varnish and those sorts of things. And the other is, again, on children and young people, but it is for the benefit of local authorities, and sets out for them the range of things that they could potentially do and the evidence base for them as part of their responsibility, which they have, to deliver what I call dental public health activities, and those are two key documents. There is a third which was published just the other week, I think it was Nigel who mentioned fluoridation, a very similar document for local authorities which sets out some of the background to water fluoridation and
the evidence base and also – because it’s quite technically complex in terms of who is responsible – the necessary methodology for consulting with the local population, etc. on water fluoridation, and that was published just the other week.

So, that’s the preventive bit, which for me is really, really important, because whilst undoubtedly access is important and it’s important to give preventive messages, what people do on a daily basis for themselves is the most important thing in terms of having good oral health, and if we can, through the variety of mechanisms – with using health visitors, using local peer educators in children’s centres and in the poorer, deprived areas where our main problems are, then we have opportunities to really nip this in the bud and stop children ending up in the position that Nigel has identified.

However, access – again, Mick started by saying access is important – and having prevention in the arrangements that we have for general dental practice is also very important. Since the review of the existing contract – which Mick has talked about, the independent review led by Professor Jimmy Steele, the group of which I was a part – since then we have had a number of pilots, testing out a new system in terms of a contract which is more heavily focused on prevention, and intended to allow dentists to do, and their teams, to do what we now believe is the appropriate kind of care for patients, given the changing needs of the population. That’s led by the Department of Health, not by NHS England, it has input from us and PHE, and within that there is a clinical pathway which is very much focused on delivering that better oral health prevention document.

Throughout the pilot period, evaluation has been done and the evidence from there supports the view that there has been a change in people’s risk status, particularly for dental caries, during the pilot period. Patients and practitioners who’ve been involved in this have, by and large, accepted that this is a better way of delivering care and prevention and have felt that it has been better than the existing system. We’ve now moved into a further phase which is really not so much testing that clinical pathway but testing the commercial arrangements that support that, so a move away from the current system, which is purely focused on delivering the number of items, if you like, or units of dental activity delivered, to a combination of capitation and units of dental activity, and a small element associated with the quality of care provided.

I know we’ve got many of my dental colleagues here, but for those who are unaware, basically, the focus is on carrying out a really good assessment of the patients’ oral health and an identification of their risks, so to do with their diet, how their intake of sugar currently is and various other things, medical conditions that may affect their oral health. So a really good assessment, then that preventive advice, and a risk rating in terms of a red, amber, green approach, and then that preventive information. But obviously people do get problems and do need to have treatment, and they need to have it, not just from general dentists, but also from more specialist dentists, so this [slide] just tries to encapsulate that over a patient’s lifetime. One would expect them to go to the dentist and have this pathway approach that I’ve talked about, but they may need to go and see a specialist. A youngster perhaps with more crooked teeth needs to go and see an orthodontist; they will go and see a specialist, either in the high street or in a hospital, if it’s particularly complex and severe.

Similarly, for the extraction of teeth, some teeth are very complex to extract, the way the roots are, the fact that there’s no tooth left in the mouth, and it needs to be surgically removed, etc. in a more complicated way. And as Mick said, particularly on the restorative aspects… we know older people are keeping their teeth longer. Keeping them in good repair and in a functional state is becoming more complex, and particularly with treatment planning, the thinking ahead over the next 15 years, when one realises that someone has been diagnosed with Alzheimer’s or
something like that, what is the best thing to do. That's not an easy thing, and so we recognise that specialist input is required there.

In order to help support that movement and anticipating that those will be the needs going forward, NHS England has produced a number of specialty commissioning guides to try and help with this issue that I mentioned before, which is to provide some degree of national consistency and direction, but accepting that the way that that is practically delivered locally needs to be locally led. There are a number of commissioning guides which had been developed, and we’re in the process of publishing three more, one of which is on paediatric dentistry which will in part address some of the things which Nigel has mentioned. And I think for me, the good thing about that is that the working groups who’ve produced these were chaired by clinical leaders within those particular specialties, and that’s a model that I would hope personally we can work with as we go forward in a number of these areas in the future.

Nigel mentioned local initiatives. Sara is finding, and I know from my previous experience, there are good things going on out there in terms of people trying to put into place some of these new ideas, but we do struggle with being able to mainstream them and to fast-track them and get them then picked up by other parts of NHS England, and so one of the things that we want to really push on is... local dental networks. NHS England has a structure across its administrative areas of local professional networks, one of which is for [ ] and we really see those as being key to helping to disseminate what is going on and to help really push clinically-led commissioning going forward, so understanding the local needs and providing that advice locally.

One of the things that always helps in terms of moving things forward is when you have an outcomes measure that is public and is visible, and there are two new outcomes, indicators which have been introduced for the NHS. There was already a public health one which was the proportion of children with decay at five-years-old, but in the NHS there are two new ones: one is decayed teeth which is in its first year, it’s just in a phase where we’re testing the methodology for that, and then extractions in secondary care for children, which will further provide data as an adjunct to the issue that Nigel has picked up already.

So, our approach to commissioning then, which is really important to support this direction of travel. Currently all of the dental pathway, whether it’s in primary care or secondary care, is commissioned by NHS England directly, not by CCGs. We can see that there is a move towards, with the devolution and with things like Greater Manchester, a much more locally case-based commissioning arrangement. You may be aware that in the wider health system, sustainability and transformation plans are being developed for local geographies, mainly based around the acute sector and the hospitals for mainstream healthcare, and they're being led by the CCGs. Now, dentistry isn’t currently really well-stitched into that, and that’s where we want to build on our local dental networks, give them the support so that they can begin to operate and play within those local healthcare systems which we can see developing.

So in summary, we know that inequalities exist in oral health and in access to dental services, and my colleagues have set those out. We’re clear that the two main dental diseases, so that is dental decay and gum disease, can be prevented. We also know – Mick picked up on the oral cancer – that the risk factors for oral cancer are common to many of our other killers, alcohol and smoking being two key examples, and we can minimise that risk as well, if we really focus on prevention. We need to ensure that that’s prioritised across the system. We need to provide ready access to simple and complex treatment in a more consistent and equitable manner than is the current case. We need to evaluate the commercial approaches to the prototype contracts, so that is the next phase of learning around the prototype contracts which are in place. The
prevention bit and the nature of the clinical delivery I think is well-supported; the commercial bit needs work.

We want to develop our local networks so that they can play a part in the local development of care. And finally, as the other two speakers have said, we need to build a consensus of support for this direction of travel, and we need this complexity of people who are involved all to play their part as we go forward. Thank you very much. [applause]

**Question and Answer Session**

**Lord Hunt**

Okay, thank you very much. I think you'll agree we've had three excellent presentations which have given a very clear focus on where we need to be going in relation to oral health. So, by tradition, we give Parliamentarians first go at Q&A, so I’ll take three together, so if I can ask my colleagues if they care to make a contribution. I see Lord Ribiero and Baroness Walmsley and Lord Colwyn.

**Q. Lord Ribiero**

Thank you very much, Lord Hunt. All the presenters today referred to prevention, and I’ll give you a clinical trial based on my own children. I have four children. The first two were brought up in an area of fluoridation, five to seven years, and they’ve had no dental caries or problems going into their 40s; the other two were brought up in an area without fluoridation, and they have. Now, we all know there are big problems about introducing public health initiatives naturally, but where is the inertia? We’re talking about 40 years plus of this argument around fluoridation. There’s no point putting it in the toothpaste because often children won’t use it anyway. And it may be because children don’t drink water anyway now, they drink fizzy drinks, that the focus is on fizzy drinks, but surely something needs to be done now to get this fluoridation argument sorted. [applause]

**Lord Hunt**

Thank you. Baroness Walmsley.

**Q. Baroness Walmsley**

Thanks very much. Joan Walmsley. I’m the Lib Dem spokesperson on health in the Lords. I had a question for each of you. Professor Hunt, my ears pricked up when you said that children in the North West have more teeth problems than other children across the country, because I come from the North West, but you also said that they visit the dentist more often. I wonder if the two things are linked, that the reason they visit the dentist more often is because they’ve got terrible teeth. It’s a good thing you’re collecting the information, but are you collecting information about the severity of what they’re presenting them with when they go to the dentist, because that would tell us if those two things are linked.

Can I ask you, Mick, you talked about prevention: absolutely, and I really value going to the dentist twice a year to make sure that all the things that you mentioned are checked, apart from dental caries, so things can be picked up at an early stage, but you also wanted dentists to be paid for prevention. Now, it occurs to me that the more successful we are with prevention, the more people of my age will still have their teeth, and you also said that people of my age have more complex dental problems, which strikes me that that’s a lot of work for dentists, and dentists are professionals. So, don’t you think it’s part of the responsibility of a professional to do prevention? Why do you need to be paid separately for that?
And finally, Eric did mention schools. Before I was health spokesman, I used to be education spokesman and I took a particular interest in early years life and used to visit nursery schools, where in those days they had a thing where they all brought their toothbrush to the nursery and they learnt how to clean their teeth. If you teach kids to clean their teeth regularly several times a day, that’s a habit that’ll go right into the rest of their lives, it’s just ingrained. So, what are we doing now with the very, very youngest children; and are we making sure that it is done all over the country?

Lord Hunt

Thanks, Joan – three for the price of one there. [laughter]

Baroness Walmsley

Thank you.

Lord Hunt

Lord Colwyn.

Q. Lord Colwyn

Thanks very much. I enjoyed the presentations and I’m delighted to see all of you here. On the other hand, I have to say, I was awfully disappointed. I qualified in 1965, and we have been discussing this, day on day on day, ever since... certainly since I qualified, and nothing ever happens. We have fluoridation which could actually solve all the problems that we’re talking about, but it never happens. I think we’re about to get compulsory folic acid, I think Philip probably knows...

Lord Hunt

I don’t think we are actually. [laughter]

Q. Lord Colwyn

Or it’s been talked about. But that will go through without a problem. Fluoridation has not gone through, and would certainly I think be a very important factor. As I say, I qualified in 1965, and I spent the first 20 years of my professional life doing a lot of National Health Service extractions for these children who had got broken teeth. I can tell you that until you've had to do that, until you've had to hold a six- or seven-year-old down, get a needle in the arm and take the teeth out, you haven't really seen the unpleasant side of it. I mean, I still have dreams about those awful days when we've had to hold a kid down to get his teeth out. Finally, we talked about the Five Year Forward Review. I’d like to see that. I haven’t got a copy of it myself, but I think that’s looked very eminently important, and I’m sure that will take us forwards. Thanks very much.

Lord Hunt

Okay, thank you very much. Look, can we kick off with fluoridation? Nigel, I don’t know if you want to pick it up first, because I think Joan’s question about the North West must be very much linked to that. What I noticed from your chart, of the regional variation, is that it was mainly socioeconomic, the reasons for the difference, except the West Midlands appears near the better end, and that look clearly as if it is down to basically a very farsighted Birmingham City Council quite a few years ago. [Laughter] But, I sense that we’re on the edge of a new push on fluoridation, with a number of local authorities actually seriously interested, and with Public Health England seriously prepared to do what they need to do. Am I foolishly optimistic there?
Professor Hunt

Well, I hope you're right. I'm not entirely certain that is correct. In fact, just looking through the audience I can see one or two people shaking heads here even today. Of course we are very much pro-fluoridation; the evidence really is quite overwhelming in terms of the improvement that fluoridation gives us in terms of dental oral health. We know that 45% fewer children have teeth extracted in areas of fluoridation compared to those which aren’t, so I would support the push for fluoridation. I hope it is the case, but I'm not quite so confident that it will be accepted by local authorities as well as you perhaps anticipate.

Could I pick up also on the question that Baroness Walmsley mentioned, regarding people attending dentists and also the number of extractions in the North West? It comes down to the volume of the problem here, that although we're still getting increased access, there is just an overwhelming tide of decay that is facing us. Yes, we are pushing for agencies such as the Information Centre to try and get more detailed information regarding age groups, severity of problems, geographical locations, and also down to aspects such as cultural differences in areas as well, because there are important differences in that in terms of access to care. So we're trying to get that data, and hopefully in the near future we'll be able to provide that.

Lord Hunt

Okay, thank you. Mick, I know you want to pick up fluoridation, but can you also really come back to the question of the contract, and why you think it needs to be more orientated towards prevention?

Dr Horton

Yes, sure. With regards to fluoridation, I don't think anybody on the evidence can argue against fluoridation. I think the issues are that there are multiple organisations responsible for actually delivering that. You've got local government, you actually have the water authorities, there's lots of different people that are involved in actually delivering this. And it's also very difficult with the water network to actually say, "We can do it in one area but not in an adjoining area," because often they actually share supplies, so there are multiple factors. The evidence is there. I think what needs to happen now is the debate needs to actually come to some form of conclusion; we cannot be debating this in 40 years' time again, and I think that is the main thing. Regardless of which way you come down, you cannot just continue debating it over and over – make a decision.

With regard to the contract... it's more a case of, as professionals we will never ignore giving preventative advice, that is a fact. We will give that preventative advice, we wish to do the best for the patients – yes, absolutely. There are parts of the population that require more intensive preventative advice than you or I may require, because we already look after our dentition. These people that come in need multiple, complex pieces of work, not just a 10-minute “This is how you should be brushing your tooth, this is what you need to do.” They need intensive treatment, and I'm afraid that that time... If we were just to do that for nothing, eventually there would be no dental practices working within the NHS, and that is just a fact, I'm afraid that is business. I'm sorry about the harsh fact of business, but I make no apology for making money.

Lord Hunt

Okay. So Eric, can you pick up early years first, and then we'll come to Lord Colwyn's crunch question?

Eric Rooney

So, I said before that there are various things going on around the country, but they're not being mainstreamed or fast-tracked. And there are examples, and I can talk from my own experience...
up in... not quite from the North West, but in Cumbria and Lancashire, where we have something called Smile for Life, which is a programme which is embedded within what were originally the Sure Start children’s centres, and the objective is to ensure that the environment in the children’s centre is, as we would describe it, conducive to oral health. In other words, things like... if you think about the sugar in the diet aspect, we might be having little children's parties every other day, with biscuits and stuff and all that kind of thing, then in line with the wider guidelines around healthy eating, then the policies being adopted in those children's centres - and there's an award scheme, a bit like for tourism, three crowns or whatever - then they adapt their policies.

I think if you were to put a map up of all the areas, concerning the five-year-old information and data, and you look at Barrow-in-Furness, which is one of the most deprived local authority areas in the country, the decay rates are incredibly high there, and we do actually have supervised toothbrushing in the nursery schools in that particular area. The other interesting thing is that in getting some traction with that, with the local authority, we have some local authorities who still do directly provided services if you like, so their children's services are effectively employees of the local authority, so there’s a degree of control around the introduction of something like that. If the local authority feels this is what they want to do, they can command that and say that is what we want doing, and their children's centres do it.

We’ve also, of course, got in a number of places a much more contracted out sort of arrangement, where children’s services and children’s centres are delivered by organisations who’ve bid to deliver them, and in that circumstance we managed to get Cumbria County Council to write into the specification for the children’s centre provision that the oral health program would be something they would be required to deliver as part of that contract. So it is possible. There’s a difficulty in a sense, and it comes back to a similar issue really with fluoridation, which is, a political decision has been taken that issues of, if you call that, public health have been devolved to individual local authorities, and therefore being able to direct that in a more centralised or all-England approach is incredibly difficult.

But what we can do is, as in a couple of those Public Health England documents I’ve set out, is put up the shortcuts as to how to do this, the best ways to do it, but we are then relying upon local professionals – whether it’s the local dental network, whether it’s the BDA, whether it’s local bits of the two faculties – advocating locally for those things. And potentially, for the Parliamentarians here, your councils are aligned to you in one way or another, and if you feel strongly, there may be opportunities for you to help push some of these things on a more lower level of government basis.

Lord Hunt
Okay. Mick, you just want to comment on early years, don’t you, and then I’ll come back to Eric.

Dr Horton
Yeah, just very, very briefly. I practice in Wales. Within Wales they have a thing called Design to Smile, and the fissure sealant programme and high-fluoride toothpaste programme which is actually delivered through the community services. Wales has recently seen the largest decrease in child dental problems ever recorded, and I think that’s worth noting, so it may well be worth looking and sharing information.

Lord Hunt
Okay, that’s fine.
Eric Rooney

Lord Hunt, could I just make clear: and that is great and it’s the same in Scotland, there is a programme is Scotland as well. The situation in England is that in the Health and Social Care Act, when that was put through, the money for that type of approach is no longer with NHS England, it has been devolved to local authorities. So, our position is different to the other two countries, and I think it’s just important to make that point, because it does introduce that level of complexity, and local government associations here - maybe they can help corral people into a more common model on a local basis, when the resource is up against, older people in social care needs, etc..

Lord Hunt

Well, clearly the interest the LGA has taken in oral health in young people is something to be very warmly welcomed. Eric, can I come to Tony Colwyn’s question, which is essentially that we have been discussing a lot of these issues for a number of years, and we now have a very complex set of arrangements which you’ve described. I suppose the question to you is in the work that you’re now taking forward, are you confident that you can come up with a plan which also kind of deals with the complexity of organisations, so that in the end people like us can point to someone and say, “Well, in the end they’re responsible for making sure we do get a lot of this laudable stuff actually into action.”

Eric Rooney

I think what we have recognised and what I tried to portray this morning is – and this is a personal view, but I think it is supported by the evidence, if you kind of look around and see what’s happening – we are in a number of fields, and we mentioned them this morning, moving to a much more, in terms of governance, a much more devolved arrangement. I mean, we did it big style, not we as the NHS, but as a country, we did a big style with Scotland and Wales, we’ve talked for a while about regional government. We’ve now got, because of the needs of the population, an understanding that health and social care are inextricably linked, and we’ve got pooled budgets in the Manchester arrangement, where, given the squeeze that as a country we are under, we’re looking to make the most of our public service activity, and therefore giving local people a control of and determination of what goes on, for me, seems to be the direction of travel.

So, if we’ve recognised that that is the case, then I think in terms of our stewardship if you like from the office of the CDO, we can provide the advice and the guidance and the evidence and the tools, as you’ve seen there from Public Health England. There’s other things we can do in NHS England around the more clinically focused things, and we can try and build an infrastructure in NHS England through that local professional dental network, which gives dentistry a profile locally – whilst it’s within NHS England centrally at the moment – such that we build an infrastructure which can then handle dentistry, but is supported by these more nationally-developed pieces of information: evidence, guidance, perhaps even specialist colleagues and things at different times, so that those local groups can play [a role], in what I believe will be an increasingly more locally focussed health system, and I think if we fail to do that, then we will end up in the position again that Lord Colwyn has outlined.

Lord Hunt

Okay, thank you. Let me open up some more debate. Steve Bedser there, and you sir.

Q. Steve Bedser

Good morning. My name’s Steve Bedser, I’m the newly-elected Chair of the British Fluoridation Society, and I had expected to come here this morning to bang the drum for fluoridation [laughter], eloquently done by hers. To be very clear, the British Fluoridation Society is a
modestly-funded, but completely voluntary organisation, so I sit here as a lay person who does this on a voluntary basis, including getting up at 5:30am this morning to be here, and of course I came here from Birmingham. The reason I’ve chosen to commit time to this is because I was the Chair of the Health and Wellbeing Board in Birmingham. I’m no longer in elected office, but in Birmingham, the city and surrounding areas of the Black Country and Solihill, we’ve halved the problem of dental extractions under general anaesthetic. By my reckoning, that’s a saving of £17.5 million, if you extrapolate to the national figures, and 13,000 preventable general anaesthetics amongst children.

I’ve lived in Birmingham all of my adult life and have accepted fluoridation as that’s what happens to the water. When I discovered it wasn’t universal and when I learnt about the impact it has on populations, in particular deprived populations in urban areas, I was frankly scandalised, and that was the motive for me to want to do more, to just apply common sense to fluoridation. We’re in danger that the debate around fluoridation will be one on the Twittershpere by a small number of ‘lunatics’ in my view. They’re the same people that argued against MMR; they’re probably the same mindset that advocated the medicinal benefits of smoking.

So, there is a decision for us to take. I’m newly-elected and I’m determined that the British Fluoridation Society will corral all of the bodies to make a decision about resolving the debate, Mick. I lived all of my adult life in Birmingham; I just can’t see why this debate can’t be solved. And devolution isn’t about dereliction, devolution is really positive. I think devolution of public health to local authorities was one of the finer aspects of the Health and Social Care Act, but there are things that we need to do in a coordinated fashion nationally, to support elected members, to help them through all the plethora of tough decision-making that has to happen in local government, to make positive decisions for their populations, and I think now is the time. Really there’s a perfect storm in terms of media coverage and the interest we have. Now’s the time, and my offer to the room is that the British Fluoridation Society will continue to support...we have a highly renowned and respected expert body who will support local authorities and support clinicians to introduce fluoridation in areas where we know it will make a difference, and it will save money and it will prevent needless general anaesthesia in children.

Lord Hunt

Thank you. Mick Armstrong.

Q. Mick Armstrong (British Dental Association)

Quite clearly fluoride [is not only good for] teeth, but it confers great wisdom as well. The debate is over with fluoride, the debate is won; what we lack is the will to implement it. Devolving it to local authorities is a big mistake. The national spec for water must contain fluoride – end of story, debate over, implementation goes ahead. Have the guts to do it, in my view. We all know what the dental problems are, we all agree. In the NHS dentistry is unique in that it has a trained workforce that can deliver it; what we don’t have are the tools to do the job. For 10 years we’ve had an underfunded, target driven contract which doesn’t allow us to provide the prevention to the people in need; that funding only treats approximately 54% of the population. You’ve got to take the cap off, you’ve got to use it in the best way possible, and that requires some innovative thinking and removal of obstacles at DOH and civil service level, okay?

Finally, you nearly did it. With the sugar tax you almost saw the link, and then you bottled it at the last minute by not directing any of that tax revenue to dental problems, and we got an
apologetic call from the Treasury, saying “Yes, we know, but we can't say that dentistry needs more money.” So I think the problem doesn't lie with the profession, it lies with the politicians.

**Lord Hunt**

I’ve never known the Treasury say anyone needs more money, I must say. [laughter] If you pull that off, you really will have achieved something. There’s a gentleman over there.

**Henrik Overgaard-Nielsen**

Thank you. Henrik Overgaard-Nielsen, BDA. I just want to comment on the contract. Baroness Walmsley said that why do dentists want to be paid separately for doing prevention? It’s actually not that we want to be paid separately for doing it, the problem is... in my opinion, what we need with the new contract is that the best way of treating your patients should be decided with the patient at the dentist’s. I think that’s the way forward, that’s the way it should work. Unfortunately, that’s not what we’ve got at the moment. What we’ve got at the moment is that the dentists have to do a certain number of fillings, crowns, bridges, whatever, and unless they do that, they will be financially penalised, and that’s the problem.

What we actually need is for the dentists to decide, together with the patient, the best treatment, not to be paid separately for doing this, that or the other, but to be paid for looking after the patient. The problem we’re facing with the new contract, the contract reform, is that the Treasury and Department of Health still want something to count. They’re not willing to count prevention at all, they want to count something else, which would generally be more fillings, more bridges, more dentures, whatever. That is not the way in this day and age to actually pay professionals to treat patients. We need to have the best interests of the patient at heart and we need to be paid to look after the patient. Paid reasonably obviously - I am from the British Dental Association - yes, we would like more money, but we need to be paid reasonably for doing it, and that’s what we need to be paid for, not counting bridges everywhere.

**Baroness Walmsley**

Can I just ask, do you mean just paid per capita?

**Henrik Overgaard-Nielsen**

Yes.

**Baroness Walmsley**

Okay. Because it strikes me as, the more teeth you pull out, the more you’ve failed really.

**Henrik Overgaard-Nielsen**

Yes, I absolutely agree.

**Baroness Walmsley**

So it makes no sense then.

**Henrik Overgaard-Nielsen**

What we don’t want is to tick boxes and targets; what we want is just to be able to look after our patients.
I'll take just one more question from Sir Cyril Chantler, and then we need to wrap it up. You want to come in?

Q. Sir Cyril Chantler

Thank you very much, Chair. There was a paper in PLOS One [PLOS ONE gives researchers a faster path to publishing in a high-quality peer-reviewed journal], an observational study in March 2016, showing a six-fold in cognitive decline and Alzheimer's disease in people with periodontitis. I can remember 20 years ago when I was on the NHS policy board, we discussed the proposal that if we couldn't afford a free national dental service for adults, we have one for children of course, we might be able to afford at least a regular hygienist visit for everybody. Now, we haven't heard the word “hygienist” at all this morning. I'd be grateful if you could comment on that.

Lord Hunt

Thank you. I will try and take just two more, because... Yes sir, over there... If you could be just brief, because we've got 10 minutes to finish – thank you.

Q. Mohammed Zaman

Very brief, yes. I'm Mohammed Zaman, I'm from the children's charity 4Children because you mentioned the earlier years. We'd been given a grant by [Public Health England] to roll out supervised toothbrushing nationally in nurseries. We run 40 nurseries ourselves. We've paired up with Bright Horizons and [____]. We've also paired up with some childminders and what we're doing is looking at supervised toothbrushing in nurseries. The report will come out in the summer, and if you're interested, or if the the All-Party Health Group is interested, we can pair up with you at that time and we can share the findings with you.

Lord Hunt

Thank you, that's great. Yes, sir. And then finally, finally Baroness Gardner.

Paul Saper

I’m Paul Saper, LCS International Consulting, and I’ve got sort of three questions, different points to run through. First is, obviously, under the contract, the unforeseen consequences, in that individual dentists, and corporates and employees of corporates are not incentivised to actually necessarily always want to treat more children, or particularly older people, or persons with mental healthcare challenges. That's going to have to be looked at again, because otherwise the problem's going to go on. There is a real problem: if you can't get out of your own home or you're in a care home, there's no longer the money to actually persuade a dentist to leave his practice and actually go and visit the home, and that's still I think a problem. There's a problem around dental labs, because dental labs are actually making things to put into people's mouths. This is not actually covered by CQC at the moment, there's a bit of a hole here, and there are a lot of problems because a lot of the dental labs don't meet minimum standards of the Dental Lab Association, and that's something that's actually got to be looked at.

The last thing, I want to ask Eric Rooney is about, when you were talking about the vision going forward. What I see in other countries is that they now recognise the digitised X-rays, the digitised notes, intra-oral cameras. People are able to actually control the quality from a central position and not actually have to visit the dentist. They can actually see, review what's actually happening, and actually therefore try and push up quality. I was just hoping that now that we're in the digitisation age, that that ought to be some part of the future.
Lord Hunt

Okay, thank you. Finally, Baroness Gardner.

Baroness Gardner

My apologies, I got stuck in traffic on the way here. I’m interested and delighted with the fluoride response – you know that’s a big issue from my point of view. I would also mention that one of the first things when I got into the Lords 35 years ago was to campaign for retaining free dental examinations, and I asked people in the Lords library to come in and listen, and they did and I won the vote against my own government. Then it went to the Commons where they attached financial privilege and reversed it, and it came back to us and we could do nothing more, and I think that’s where the National Health Dental Service went wrong. We’re throwing out free examinations because people did come, and the people that you mentioned about the oral cancer, I think that’s a terribly important point.

I’ve been pushing and campaigned recently, and the medical people are the ones that really need to push it, that anyone who presents for any sort of treatment in casualty, someone should say to them, “Do you have any problem with your mouth or anything unusual?” and it would only be a matter of seconds almost for someone to look in that mouth and just say, “You need to be referred on.” Because really, I know of just one patient whose life we saved, but even if it’s only one, every referral is very important, and, as you say, people don’t go for routine checks anymore. So, I think there should be more pressure from the medical profession to really encourage someone who’s seeing people; even GPs could follow it up. There needs to be more publicity attached to that.

Lord Hunt

Okay, thank you. My colleagues have got a tremendous task to try and respond to six contributions in about two minutes each, but I know they’ll rise to the challenge. Mick.

Dr Horton

With regard to dental hygiene – absolutely. Dental hygiene is an integral part of all treatment for all patients. We measure the periodontal status and the periodontal health and the periodontal structures that support the tooth, that is what we’re trying to improve with dental hygiene – absolutely, it’s an integral part of dentistry. Targets, measures: we like to think we’re a relatively intelligent bunch of people; as dentists, if you put a target or a measure in front of us, we will achieve it. Therefore, any target that you give us, we will actually work towards that target. If you tell us that you want us to produce more dentures, we will produce more dentures. What you need to do is actually give us the freedom to treat patients according to their needs, not according to targets, and that is where I’ll probably stop with that one.

And then the last bit is with regard to children. Regardless of the cost, the cost was mentioned about general anaesthetics and people attending secondary care. What you also need to remember is 1 in 100,000, approximately, general anaesthetics results in a serious consequence, and that may actually mean the death of the child. It doesn’t matter how much it costs – let’s stop doing it.

Lord Hunt

Thank you. Nigel.

Professor Hunt

Well, regarding hygienists: yes, I entirely agree with what’s been said. I mean, who is better placed to go into schools and care homes, etc. than the hygienist to try and provide oral health
advice? And they can also of course undertake the oral cancer checks and so on. Just on that point, I think another important group are the pharmacists. I think anyone who goes to repeated pharmacy visits, taking out Bonjela for ulcers or whatever, is an ideal person to work in that respect. Just one final point I would like to make, and I know that Eric will not mind me saying this because we’ve discussed it before, but a lot of what we’ve said has revolved around guidance. What we’ve got to do is to move away from guidance and get into policy, and that’s when things will have a difference. Guidance gives let outs, and that’s what we’ve got to change.

**Lord Hunt**

Thank you.

**Eric Rooney**

Okay. So, in terms of the contractual matters, the fund that dentists have, in the versions of the prototypes that we’re trying out at the minute, there has been a shift in the resource, away from the delivery of treatment items, towards a bigger proportion of the pie if you like, the fund that the dentist gets under that new arrangement, to be focused on prevention, so I think that’s a positive thing. There are two versions of the commercial deal, one of which has a much larger capitation element than the other, and the third element, as I mentioned before, was about measuring outcomes. I think probably most people would recognise that one of the things that perhaps payment ought to be linked to is keeping children free of disease and having good oral health. If that is what the outcome of what our system is, then perhaps linking something of the pay to that, is important.

The second issue - I won’t pick up in terms of hygienists, that’s been dealt with by the two others - but coming to the question at the front here, I think you make the point about the increasing elderly population, the need for domiciliary care, different models of care. That is clearly envisaged – in broad terms, but not specifically for dentistry – in the Five Year Forward View - new ways of working. But again, I am aware that there are parts of the country where recognising that that is an issue, local flexibility and adjustments to the existing contract have been made to allow practitioners to support their local nursing home or some of those kinds of things. So it is possible, it’s just not consistent and not very well promoted at the current time.

Your last point I think is an important one too, around the use of IT, in all its forms. You mentioned it, particularly, in terms of almost an ability to monitor the quality of what’s going on, and to an extent we’ve begun to see that a little with, when patients are referred to the specialists, people like Nigel and so forth, using a much more standard referral system with a triage element in it, where radiographs are automatically sent, they’re seen first, and then a decision made on whether the person actually needs to come into a hospital or to go to a specialist. It saves the patient wasted time if in fact it’s not required, it saves the NHS money, and improves the quality of the patients’ experience going forward.

So, I think we are cogniscent of it, and I didn’t mention it, but you’re quite right that digital technology has an important part to play, along with on the preventative front, the use of apps. That is something which I think we haven’t exploited and there is great opportunity. There is a brushing app for children where you can have your favourite songs off iTunes playing for the two minutes, to help children to remember to brush for longer. There’s lots of opportunities there with information technology.

**Lord Hunt**

Well, there’s a thing, eh? [laughter]. Well, thank you very much indeed. This has been an exceptionally well-informed and at times passionate debate, and my sense is that there is an appetite out there and in Parliament to actually have some more extensive debates around dentistry and oral health, and I’m very encouraged by what we’ve heard and the number of
people who’ve come today, and I hope that this is a start perhaps of a long-term relationship between the APHG and various bodies in the dental world, and very great thanks to the Faculty for their support for this event. So, could I on your behalf thank our speakers, I think they did brilliantly – thank you very much. [applause]

End of Transcript

Note: [ ] = missing words or short words added to help the flow of the text.

This transcript of the meeting is as accurate a representation of the discussion as possible, within the limits of the audibility of the recording.