Health and Social Care Bill

Response to Health Committee call for evidence

Mr Keith McBride
Clerk, NI Assembly Health Committee
Room 419 Parliament Buildings
Stormont
BT4 3XX

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Dear Keith

The British Dental Association (BDA) is the professional association and trade union for dentists in the UK. Our members work in all spheres of practice including general dental practice, salaried primary dental care services, hospitals and universities and the armed forces and include dental students.

Thank you for the opportunity to provide our views on the Health and Social Care Bill. What follows is the BDA position that has been compiled on behalf of NI Council, with input from our craft committees.

Clause 1 -dissolution of HSCB

1. An unclear picture

Our starting point is that we have not been provided with sufficient information to have a clear picture of what the full implications of this Bill are likely to be for dentistry, and dentists.

There has been no direct engagement with BDA to date to offer that level of detail and insight on the changes we can expect to see particularly to how dentistry will be administered after March next year.

Dissolution of the Regional Board will be significant in its own right. However, it will be the new administrative arrangements put in place to facilitate the winding up of the Board and transfer of functions which are of primary importance to us.

BDA's overarching message in this response which is supported by each of the BDA NI committees, is that this unique opportunity to completely overhaul how dental/oral health services are administered in DoH must not be wasted.

Clause 2 -functions and oversight roles to transfer to DoH

2. Independent Dental Contracts

Under Clause 2, independent General Dental Practitioner (GDP) contracts will transfer from HSCB to become the responsibility of DoH from March 22, as among the duties and responsibilities that were previously held by HSCB being placed directly with DoH in the main.

Despite this obvious impact, to date there have not been communications with GDPs directly, or discussions with BDA as their recognised Trade Union in relation to this. We would expect to have the opportunity to input and be consulted on these new arrangements.

Similarly, access for dental practitioners to a new independent appeals process is referred to in Clause 2 of the Bill. What will this look like? When will we be consulted/have an opportunity to input into proposed new process?

Clause 3 -transfer of assets

We note the provision under this Bill to transfer HSCB staff to BSO, retaining their HSC terms and conditions, but 'under the direction of DoH and led by a senior civil servant'. Significantly for General Dental Services, we understand that this will include dental advisors currently working in HSCB.

'The mantra, *'same staff, but directed by DoH'* has been rolled out. However, what is unclear to us and of high significance is who will direct those former HSCB dental staff in DoH?

Public administration of dentistry in Northern Ireland has been fragmented, severely lacking in capacity, and without a clear direction in the absence of an up to date Oral Health Strategy/policy underpinning. We lack a clear overarching plan for advancing oral health outcomes for the population, and our GDS contract needs to be reformed to become more prevention focused, and less fixated with treatment.

The role of CDO has been downgraded over recent years in DoH, with no deputy CDO, and the CDO sitting outside of GDOS staff responsible for dental policy. While we must state that current postholders are doing a remarkable job with the extremely limited resources they have, the system is disjointed and severely lacking in whole time equivalents dedicated to dentistry.

We question what will the new organisation chart look like for the administration of dentistry within DoH, after HSCB staff are under the direction of DoH?

How will dentistry feature sufficiently highly as a DoH priority to ensure there is an unbroken chain of command which ensures dentistry and oral health is integrated fully within DoH policy priorities? We give just one example where the recently published DoH Health Inequalities Report made absolutely no reference to Oral Health/inequalities. This demonstrates what happens when dental input is insufficient within DoH.

Where does the office of CDO fit into these new arrangements? Will the CDO be the senior DoH official to direct former HSCB dental advisory staff brought into DoH, or could the CDO be under the direction of the senior civil servant?

BDA's preferred approach would be to bring administration of dentistry under a new dental unit to be created within DoH, headed up by the aCDO, who would himself report directly to the Permanent Secretary and would have a seat at the top DoH Management Board. This would address the previously disjointed structures between HSCB/GDOS and CDO, and would help streamline dental administration by bringing together policy, strategy and dental services together under a common aim -of improving the population's public health.

Representation and prioritisation of dentistry/oral health

It is a fact that dentistry has been deprioritised in DoH in recent years, including the downgrading of the role of CDO by removal from the DoH Board. Current administrative arrangements means that the office of CDO is disconnected from colleagues in GDOS who set Departmental policy for dentistry, and from HSCB dental advisory staff who hold contracts with GDPs. Northern Ireland has no deputy CDOs to spread the considerable workload -unlike the situation in all neighbouring jurisdictions.

The current CDO office consists of an acting CDO with no deputies to draw on for support. This compares unfavourably with all other devolved regions with deputy CDOs who can specialise in particular areas such as dental public health, primary care, and hospital services. This is an important prerequisite to ensure capacity for dental outreach into other DoH policy areas to deliver the advances in population public health we all want to see.

This lack of current staffing combined with uncertainties about what changes will result from HSCB closure constitutes major barriers to being able to undertake the strategic work required in dentistry. Perceptions of dentistry's standing within DoH among the dental profession has also been seriously eroded as a result of administrative challenges in recent years.

A new dental unit within DoH?

Our ask is for a new dental unit to be formed within DoH in the wake of the Bill, comprised of former HSCB dental advisors; GDOS dental team, and under leadership of CDO reporting directly to Permanent Secretary, accountable to the Minister.

The alternative of an entire dental team reporting not to CDO, but to a deputy Director with a non-dental background could be problematic, and would perpetuate the concern dentists have of not being represented by a dentally qualified colleague in tune with dentistry on the top Management Board.

What policy framework/strategic context will guide the work of the enlarged number of dental staff within DoH, particularly since the Oral Health Strategy 2007 is defunct, resulting in dentistry becoming disconnected from mainstream DoH policy context/priorities? This needs to be urgently addressed.

Dental Policy framework

Streamlined structures will be of no benefit without a new, fit-for-purpose dental policy to provide a focus on, and to guide oral health/commissioning of dental services.

We need greater accountability on how dentistry/oral health provision is currently administered by DoH. Dentistry has stagnated under current administrative arrangements,

including the downgrading of CDO role by detachment from DoH Senior management/non-representation on DoH Senior Management Board.

A lack of an up-to-date Oral Health Strategy/meaningful policy context to link dentistry/prevention in with key DoH policy priorities has coincided with a time of significant oral health inequalities exemplified by shocking Child GA extraction figures (which were not included in DoH Health Inequalities 2021 Report).

COVID has had an enormous impact on dentistry, firstly with the complete cessation of Aerosol Generating Procedures, followed by revised standard operating procedures that impose new levels of infection prevention control measures, including enhanced PPE. Activity levels in dentistry have consequently reduced to around 40% of what they were pre-COVID. Dentistry across all crafts needs considerable attention to be rebuilt.

We have an antiquated activity-based GDS contract that was broken pre-COVID, and post-COVID, requires significant reform. And we suffer from a lack of dental personnel in DoH to be able to devote the necessary time to deliver the reforms required.

A considerable backlog of care, and huge waiting lists for many dental services -CDS, hospital and oral surgery, as well as in general practice -has worsened significantly during the pandemic. Now more than ever, joined-up working and a single lead approach via a dental unit is needed to address this issue for the benefit of patients. It will also facilitate the innovative cross-service working solutions that will be needed to deal with the backlog.

In addition to pressing oral health challenges, contractual issues and the impact of COVID, we face the very real prospect of a complete phase-out of dental amalgam being imposed by the EU, which would apply to Northern Ireland under the NI Protocol. This will create a huge imperative in its own right to move to a prevention based model.

New structures must be fit for purpose to navigate the pressing oral health and contractual issues that exist within dentistry.

A joined-up approach to dentistry, involving CDS, GDS and HDS

By bringing HSCB personnel under the direction of the Department, there is potential to see more of a coming together in how the range of dental services -GDS; CDS; HDS are delivered to achieve better outcomes in line with the PfG's Outcomes Based Approach (OBA) aspirations, rather than previous silo arrangements.

For dentistry to be more integrated across primary care through secondary and tertiary care, across all the services and stages of training, an overarching and fit-for-purpose oral health policy framework is required.

Having 'a one-stop-shop' for dentistry within DoH could help address some of the current back and forth between HSCB and DoH when seeking to resolve issues that arise, such as within Community Dental Services.

We also point to the need to reinstate a strategic committee to advise DoH policy to the Trusts and NIMDTA on manpower and training needs within the Hospital Dental Services (HDS) and joint appointments in dentistry, akin to what was formerly the strategic hospital and academic services statutory committee HSC(D). It is key this would have regional input. That way, the development of the HDS and joint appointments is taken forward in a co-produced way with equity across the region, and provides governance support to the

decisions of the Dental Postgraduate Dean on foundation and specialist training. This would also act to balance increased centralisation of policy at DoH.

Adequate resources to safeguard Health Service Dentistry

The future sustainability of GDS/Health Service dentistry is in the balance. New administrative structures, and adequate resources in terms of sufficient numbers of personnel to ensure the significant work needed to reform the commissioning of dental services will be carried out, including creating a new GDS contract that moves the focus from treatment to prevention, and delivering improved oral health outcomes. Administration of dentistry within DoH needs to be significantly bolstered to ensure we move to OBA/improved patient outcomes.

How dentistry is administered, how services are commissioned (GDS Contract), and the overarching policy context is ripe for transformation. Creating a 'dental unit' that is adequately resourced is key to reforming and modernising dental administration in a joined-up way, and to deliver improved oral health outcomes for the local population.

Clarity around finances: within dentistry, particularly GDS, there has always been a lack of clarity and transparency around the management of the budget. End of year underspend reallocations by HSCB away from dentistry, despite significant pressures facing practitioners to make HS dentistry financially viable, and the high level of unmet need among the general population including significant oral health inequalities, has been commonplace. The absence of a policy direction from DoH to direct spend was often the reason for underspend rolled out by HSCB, yet we continue to see children having teeth extracted under GA at three times the rate of children in England.

Full transparency around the new commissioning process, including who is ultimately responsible and accountable for budgets, and the policy they are working towards needs to be an important consideration of the Bill.

Local input

LCG replacement, and the importance of having a mechanism to facilitate engagement on dental and other services at a local level is key. From a dental perspective, LCGs have worked in the recent past to highlight concerns about gaps in provision of oral health among the elderly in care homes, as well as raising concerns over lack of PPE provision to GDPs during the pandemic.

There is a concern that the more powers away from HSCB/LCGs to DoH become centralised, the less opportunity to influence and input into the process. Mechanisms must be put in place to ensure DoH becomes more accountable going forward, with increased local input, not less.

We would like clarity on the future role of Local Dental Committees (LDCs) after the Bill comes into force, specifically in relation to their current consultative role with HSCB on local issues. Local dental input should continue post HSCB.

Conclusion

- A lack of engagement/consultation with BDA to date on what the full range of implications will be for dentistry from the Health and Social Care Bill means the future of dental administration remains unclear.
- The BDA position is clear that dental administration in DoH requires a complete overhaul. The Bill provides an opportunity to facilitate new structures and increased personnel capacity to undertake the significant reforms that have been overdue in dentistry for years, including a new GDS contract, and a new revised Oral Health Policy.
- Dentistry/oral health has been deprioritised and become detached from departmental priorities over recent years. A new dedicated Dental unit within DoH, properly resourced that can integrate all personnel directly involved in dental administration, including former HSCB dental advisors. A new Dental unit should be headed by the CDO, and with CDO having a seat at the DoH Management Board. This would go a long way to bolstering dental administration in DoH. This in turn would help dentistry to be more outward facing, and to better integrate oral health policy objectives into wider DoH and PfG priorities, such as childhood obesity and cancer.
- The severe shortage of staff within the CDO office -currently no deputies -within DoH must be addressed. A number of Deputy CDO's need to be appointed to create a CDO team that can lead on the important strategic work, in particular around oral health improvement. In addition, the older age profile of dental advisory staff currently employed in HSCB also needs careful planning to avoid a detrimental impact on dental services in future years.
- A revised oral health policy is necessary to provide an overarching context to guide how oral health/dental services are commissioned in line with moving to an outcomes-based approach, as per Programme for Government.
- It is important to recognise that there have been some good examples of collaboration between GDOS, HSCB, and CDO over the past year, with input as appropriate from BDA committees during the course of the pandemic. This should be built upon, and formalised in the new post-Board era, to deliver streamlined administrative structures for dentistry.
- Challenges within dentistry and oral health provision in Northern Ireland were significant pre-COVID; post-pandemic, dentistry needs a rebuild, and the appropriate structures and personnel to take this work forward, in close consultation with BDA as the profession's representatives.

We trust the committee will find our submission insightful. We do hope the Bill can lead to much needed improved administration arrangements for dentistry and oral health within DoH.

BDA would be delighted to brief members on any of the points contained within this paper during Committee Stage, if this would be considered helpful.

Yours sincerely

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