Improving Dental Care and Oral Health – A Call to Action

The Optical Confederation represents the 12,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of five optical representative bodies: the Association of British Dispensing Opticians (ABDO), the Association of Contact Lens Manufacturers (ACLM), the Association of Optometrists (AOP), the Federation of Manufacturing Opticians (FMO) and the Federation of (Ophthalmic and Dispensing) Opticians (FODO). As a Confederation we work with others to improve eye health for the public good.

As sister professions and partners in primary care, we welcome the opportunity to contribute to this Call to Action. Provided below are responses to those questions where we have legitimate interests or believe we can add value from the wider primary care perspective.

Our objectives

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

A.1) Yes. Most of the parameters of this Call to Action apply across the whole of primary care, including for the community optical sector.

As a partner sector, we welcome and fully agree with the recognition that dentists working in the general dental service are not NHS employees viz "They are independent providers from whom the NHS commissions services. They are responsible for whom they employ within their own [teams] and for the management of their practices".[1] This is equally true of community optometrists and opticians working in the general ophthalmic service.

We also agree that "It is common for [practices] to offer both NHS-funded and private services".[2] Exactly the same principle applies in community optical practices with one important difference. Whereas two thirds of sight tests are NHS funded, the majority of vision correction (spectacles and contact lenses) is supplied through the private sector (with a contributory funding grant/voucher scheme from the NHS for those on certain means tested benefits or with especially high prescriptions).

[1] Improving Dental Care and Oral Health – A Call to Action, NHS England, February 2014, p.2
[2] *Ibid*, p.2

Reducing inequalities

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

Innovation

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

A. 3 & 9: We very much welcome the establishment of Local Dental Networks (similar to Local Pharmacy Networks and Local Eye Health Networks) as the vehicle for commissioners, providers, public health and patient groups to work together, and with Health and Wellbeing Boards, to assess and meet needs especially of those patients at risk and seldom heard groups[3] and to promote and evaluate innovations in care. However in our view these networks need to be more joined-up across primary care to improve the quantum, quality, efficiency and outcomes of care.

We welcome the move towards greater inclusiveness in this Call to Action, particularly the specific invitation to participate with "everyone who works in health and social care or who uses the NHS".[4]

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

A.4: We fully support the principle that "primary care must provide more personalised, accessible community-based services for patients, particularly for older people and those with multiple long term conditions".[5]

We welcome the recognition that dentists cannot do this alone (any more than any other profession) and that this needs to be done in partnership with the rest of primary and community care[6]. The solution here is for far better joint-working to support individuals and groups by primary care as a whole (including cross-referral between any specialism or service provider) rather than the past silo working models.

Access

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

A.6: We agree with the general statements in the Call to Action that "routes into urgent care are too variable and often obscure to patients" and that access to urgent care "should be clearly and accessibly sign-posted" so that A & E departments do not continue to have to deal with patients who will be more appropriately treated in

[3] *Ibid*, p.18
[4] *Ibid,* p.4
[5] *Ibid*, p.6
[6] *Ibid*, p.24

the community.[7] This is something that NHS England as the sole commissioner in this case should easily be able to rectify.

The problem is even more acute in the eye health sector where urgent services outside hospital have to be commissioned by 211 CCGs and where the absence of such services in many places[8] mean that over 3% of Accident and Emergency admissions are still patients presenting with visual or eye health problems.[9] As many as 78.1% of cases attending eye casualty are deemed 'non-serious'[10] and could be more appropriately, conveniently and cost-effectively treated in the community.

Quality, prevention and integrated services

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

A.10: We fully support the ambition of "consistent care pathways across England" to ensure that all patients "receive a consistent approach to assessment and treatment, according to clinical need and complexity".[11] This is a welcome change from the direction of travel of the NHS in recent years which has gone inappropriately against national standards for national services and added to NHS and provider costs without commensurate benefits.

Unjustified local variations in commissioning, and many variations are unjustified with slightly different pathways in different areas for the same conditions, not only have added to transaction costs for the NHS and providers, but also have increased risk, which undermines the first principle of a consistent national service.

Workforce

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

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

A.16 & 17: This is a dental matter on which we have no view other than to note that in future professionals in all disciplines will need to take more of a shared responsibility for individual patients, cross-referring horizontally within and across primary, community, social and voluntary care where appropriate, as well as vertically to hospital within their own disciplines, e.g. an older person who presents for oral care but who clearly has a sight problem should be advised to attend/be referred to an optometrist and vice versa.

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[7] *Ibid*, p.20

[8] Atlas of Optical Variation – Community Eye Health Services in England, *Local Optical Committee Support Unit (LOCSU)* - http://tinyurl.com/o9zeuzh

[9] Accident and Emergency Attendances in England, 2012-13: Tables – Table 14 - Ophthalmological conditions, *Health and Social Care Information Centre* - http://tinyurl.com/lhk6vap

[10] Vernon SA, Analysis of all new cases seen in a busy regional centre ophthalmic casualty department during a 24-week period. J R Soc Med, 1983 Apr; 76(4):p.279-82.

[11] Improving Dental Care and Oral Health – A Call to Action, NHS England, February 2014, p.13

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

A.18: As with previous Calls to Action, we welcome the recognition that quality of service depends on how "well information flows through the health system for the benefit of patient care between [primary care] and other health professionals; between [primary care] and hospital services; and between the NHS and social care services". [12] This applies not only within each separate primary care discipline, but also even more importantly also across the whole of primary care.

If the Government and NHS England are to achieve the aims of re-invigorating, re-vitalising and re-establishing primary care at the heart of the NHS, we need to invest in better information flows across and between primary care sectors and practices to support people outside hospital and to maintain their independence, well-being and quality of life in the community and to reduce health inequalities.

We too would wish to understand the scope for extending the NHS health check model to include oral health, vision and hearing[13]. These three aspects of life, together with continence, medicines compliance and mobility, are the most important factors in maintaining independent living, well-being and social participation amongst older people.

We also welcome the commitment to shared care between hospitals and primary care across all the Calls to Action so far.[14]

Whilst we recognise that patient registration[15] is a sensible approach for general medical and dental practice, we do not believe this is entirely appropriate for pharmacy or optical services. These latter two sectors operate under a more competitive, market-driven model where competition acts as a significant driver for quality and outcomes driven by patient choice, rather than the more costly market substitutes of inspection and micro-management. As there are important principles of choice and accessibility at stake, the rare exception to this should be where there is unambiguous evidence that patient registration would significantly enhance care.[16]

Information and Communication

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

A. 19: We applaud the openness of the Calls to Action in asking about how to improve the flow of communication and information sharing across primary care. This is in line with the NHS's Vision for 'any-to-any' referrals in the new e-referral

[12] *Ibid,* p.16
[13] *Ibid*, p.23
[14] *Ibid*, p.24
[15] *Ibid*, p.16
[16] The vision for NHS Community Pharmacies – The path to improved patient care, Pharmaceutical Services Negotiating Committee (PSNC), August 2013, p.3 http://psnc.org.uk/psncs-work/psnc-vision-and-work-plan/

service[17], which will allow a wider range of health care professionals to refer patients across technological and organisational boundaries.

From our perspective, this would mean central investment in IT infrastructure to enable all parts of primary and community care to communicate about individuals (with the patient's or their carer's permission) so that all parts of primary can take on a wider responsibility of working together to support vulnerable and non-vulnerable adults and children more effectively in community settings.

In community eye health services, the Optical Confederation has submitted effective proposals to bring this about, in part to catch-up with medical, dental and pharmacy colleagues. However, there is a long way to go in all areas and joined-up thinking across the whole of primary care is what is needed, not only to deliver better outcomes for individuals and populations, but also to achieve best value for money for the NHS.

Other

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

A.22: As with previous Calls to Action, the Optical Confederation welcomes the emphasis on outcomes but regrets the persistent absence of any mention of the Public Health Outcomes Framework – where oral health features prominently – or of the Social Care Outcomes Framework – where dentistry and oral health clearly have important roles to play. This is regrettable as all parts of the NHS have important contributions to make in achieving the health and social care outcomes set for the Nation by government.

As we also repeat the point we have made previously and over many years that the five NHS domains of the NHS Outcomes Framework[18] regrettably omit the sixth important domain of using health skills to enhance the quality of life and wellbeing for everyone, i.e. not only those with long term conditions. This is particularly true in the areas of oral health, vision and hearing, where young people and working age adults can have their quality of life significantly enhanced by better oral health, better vision and better hearing without necessarily at this stage suffering from any other long term conditions.

Moreover, the public does not necessarily recognise poor oral health or oral health neglect as "a long term condition", and neither do other primary health care practitioners. The omission of a domain covering this area is a significant weakness in the NHS Outcomes Framework which NHS England is charged with delivering.

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[17] NHS e-Referral Service – Vision and key messages: Making paperless referrals a reality, June 2013, p.13 http://systems.hscic.gov.uk/ers/future

[18] Improving Dental Care and Oral Health – A Call to Action, NHS England, February 2014, p.9