



Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

British Dental Association
Northern Ireland

11 February 2010

NORTHERN IRELAND ASSEMBLY

**COMMITTEE FOR
HEALTH, SOCIAL SERVICES
AND PUBLIC SAFETY**

British Dental Association Northern Ireland

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Members present for all or part of the proceedings:

Mr Alex Easton (Acting Chairperson)

Mr Thomas Buchanan

Mrs Dolores Kelly

Mr John McCallister

Mr Conall McDevitt

Mrs Claire McGill

Ms Sue Ramsey

Witnesses:

Ms Claudette Christie) British Dental Association Northern Ireland

Mr Seamus Killough)

The Acting Chairperson (Mr Easton):

The next item on the agenda is an evidence session with the British Dental Association (BDA) Northern Ireland. I welcome Mr Seamus Killough, who is the chairperson of the BDA's Northern Ireland council. I also welcome Ms Claudette Christie, who is the director of BDA Northern Ireland. I invite the witnesses to make a 10-minute presentation, after which I will invite members to ask questions. I will allow one hour for questions before the session closes.

Ms Claudette Christie (British Dental Association Northern Ireland):

I will first set out the British Dental Association's background. The BDA has existed for 130 years. It is the professional association and trade union for dentists who practise in the UK. Our

23,000-strong membership is engaged in all aspects of dentistry, such as general practice, the salaried community dental service, hospitals, academia, research, the armed forces, and the association also includes dental students. The BDA represents more than two thirds of the profession in Northern Ireland. I will hand over to Seamus Killough, who will provide an overview of dentistry in Northern Ireland.

Mr Seamus Killough (British Dental Association Northern Ireland):

I thank the Committee for Health, Social Services and Public Safety for inviting the British Dental Association to today's meeting. We welcome the opportunity to brief the Committee on the work of Northern Ireland dental services. I hope that it will provide a timely focus on matters of oral health.

I live in Ballycastle, and, although I am retired from the clinical treatment of patients, I still own a practice in Cushendall, which delivers Health Service dentistry to wonderful people in a beautiful part of the world. During the 36 years in which I have been involved in general dental practice, I have sought to use my skills and those of others to bring dental care to the local community. I now represent dentists and seek to demonstrate how the BDA, as the professional association and trade union for dentists, tries to promote oral health among the population. I do the same as I did previously, but on a much grander scale. As the Acting Chairperson said, Claudette and I are happy to take questions and comments after the 10-minute presentation.

The BDA commits itself to promoting initiatives and actions to bring about improvement in the oral health of the population of Northern Ireland and reduce inequalities in our society. The association's strength lies in its representation of all dentists across the sector. The Committee and the wider Assembly has a broad interest in dentistry, having debated and taken evidence on dentistry several times in recent months and years. We hope that today's evidence session will provide an ideal opportunity to build on the Committee's existing — by now, possibly, extensive — knowledge of dental services and hear, at first hand, about the key issues and the progress that continues to be made.

Many members are aware that Northern Ireland's record on oral health is particularly poor. Our 12-year-olds have some two and a half times the level of tooth decay of children of the same age in England, and 60% of our five-year-olds have tooth decay. Tooth decay is preventable, as is the pain and suffering that accompanies it. Although our teeth are not as bad as they were 30

years ago, our oral health experience continues to fall well short of that of our neighbours in the rest of the United Kingdom and Ireland and sets an unenviable legacy for the future.

The key priorities that the BDA believes must be addressed, with input from the Committee, are: the promotion of good oral health and the eradication of oral health inequalities; the harnessing and development of the expertise of all dental staff to ensure that local services are available; the creation of a system that meets the needs of patients, works for the dental profession and delivers on prevention for the future; and the safeguarding of the future of all dental services whether they are based in hospitals, trusts, academia or on the high street. As we explain and discuss those priorities, we hope to give the Committee an improved understanding of dental services in Northern Ireland.

Dental services are made up of three main strands: high street practitioners, the salaried community dental service and hospital dental services, the final two of which are based in the trusts. The largest strand is on the high street, which comprises 357 practices that are based in communities across Northern Ireland and all of which are small independent businesses. A total of 843 dentists and a large cohort of additional skilled staff such as dental nurses, hygienists, therapists and practice managers work in those practices. They provide almost one million courses of dental treatment each year, and almost 900,000 people are registered as Health Service patients.

Most people attend a dentist on the high street; those patients must be registered with a dentist to receive Health Service treatment. In turn, treatment will be given, offering what the Health Service makes available. The Health Service is the route that most people choose, and, as I said earlier, some 900,000 people have visited a Health Service dentist in the past 15 months. Given that registration with a dentist is temporary and lasts for a maximum of two years, the figures indicate a high level of activity by dentists in Northern Ireland. Indeed, those figures are rising. It is important to remember that, for dental care, the Health Service is not always free at the point of delivery. Broadly speaking, people who are not eligible through benefits or through being below the age of 19 and in full-time education must pay the specified charge for Health Service dental care.

The current dental service focuses on treatment. It was developed over 60 years ago in an era in which patient choice and prevention of disease were not the watchwords of the Health Service;

thus today's dentists and patients find themselves caught in a system that drives towards treatment in the absence of prevention. However, change is in the offing. The BDA is negotiating a new contract with government for Health Service dentistry. This Committee and future Committees must ensure that the drive towards a new service continues and that the legislative framework and funding arrangements that are in place can bring about a new dental health service that has care, quality and prevention at its heart.

The high street dentist is complemented by the salaried community dental service that is based in trusts and health centres. The equivalent of 80 full-time dentists play a key role in the provision of dental care for people who have special needs or who are socially disadvantaged. It is a highly specialised and dedicated service that looks after the most vulnerable people in our society. The role of those dentists is of paramount importance in ensuring that health inequalities can be addressed.

The third strand of dental services in Northern Ireland is the hospital dental service, which comprises more than 70 highly skilled dentists. The hospital service deals with complex conditions such as oral cancers, surgical cases and cleft lips. Along with Queen's University, it trains our next generation of dentists.

The mouth can be described as a window on the body. Oral diseases are among the most common to affect mankind. Poor oral health has a negative impact on general health and the quality of life enjoyed by our population. It serves to compound the existing inequalities experienced by disadvantaged people. Northern Ireland has high dental needs, and tooth decay is preventable. The reasons for that are related to lifestyle and deprivation.

The 2007 oral health strategy for Northern Ireland states that we spend more money on sweets, cigarettes and fizzy drinks, we eat less fruit and vegetables, and we brush our teeth less often than our neighbours in the rest of the UK. We are more deprived in earnings and employment, and that in turn leads to a society that is not only at greater risk of developing oral diseases but has lower levels of dental attendance. The lifestyle and deprivation described does not extend to all our population; instead, there is a gap between those with the best and worse oral health. That gap has not reduced.

One outcome of poor child dental health is expressed by the many children who need to have

teeth extracted under general anaesthetic. Each year in Northern Ireland, up to 6,000 children will have multiple teeth extracted under general anaesthetic, which leads to lost days at school, lost time in the workplace for parents and carers, not to mention the pain of a sore tooth felt by those children. All that evidence points to the need to change the dental service to help to prevent much of that dental disease.

The BDA welcomed the Minister of Health, Social Services and Public Safety's decision to find a solution that best meets the needs of Northern Ireland. As a result, the BDA, together with the Department of Health, Social Services and Public Safety, is negotiating a new contract for Health Service dentistry. The aim is to develop and introduce a responsive dental service that can target prevention with increased vigour. Although that is still some way off, the concept of the new contract is now clear and progress has been made. The Government have given a commitment to test the changes before implementation. It is important that the testing should be meaningful and the lessons of those pilot schemes properly evaluated and understood.

It is essential to have the right people with the right skills for any dental service. The training of dental personnel requires significant investment from the individual, the public purse and the workplace. Although we are fortunate to have high-calibre dental graduates and first-class dental teachers, our universities and workplaces of the future must be properly resourced to maintain Northern Ireland's supply of dentists and to make careers across the dental sector attractive. Dentists are vital front-line Health Service providers. They bring their skills to whatever their workplace and often provide much more by way of small businesses, investment, local employment, development of skills and, of course, dental services.

Members are aware that Northern Ireland has a growing population. That will place more challenges on the entire dental sector — high street, community and hospital. In future, the sector will have to care for more patients, many of whom will be older. Therefore, it is paramount that the dental profession, now and in the future, has the support that it requires to meet the growing needs of the population and the high standards that modern care demands.

The key priorities that the BDA believes must be addressed, with input from the Assembly and the Committee, are to promote good oral health and eradicate oral health inequalities; to harness and develop the expertise of all dental staff to ensure locally available services; to create a system that meets the needs of patients, works for the dental profession and delivers on

prevention for the future; and to safeguard the future of all dental services, whether in hospitals, trust-based services, academia or on the high street.

I thank the Committee for giving the British Dental Association the opportunity to present evidence today.

The Acting Chairperson:

You provided some shocking statistics, especially the 6,000 children who have had multiple teeth extractions. That is quite scary.

How do you find the relationship between the Department of Health, Social Services and Public Safety and the Department of Education in trying to teach primary-school kids about dental hygiene? Is there room for improvement?

Ms Christie:

That issue draws attention to the fact that, although we are here from the British Dental Association, talking about what we can do and about our relationship with the DHSSPS, there is only so much that the dental profession can do. However, you allude to the need for a host of wider strategies because poor oral health, social deprivation, education and children are serially linked. It is about interlinking a host of strategies to ensure that broader public health can meet the wider health need in respect of diet and lifestyle. It is also about ensuring that sustained efforts are made to tackle issues of lifestyle and circumstances that damage health. It is about Departments' interlinking to develop that. The dental profession can lobby various Departments to do that.

The Acting Chairperson:

That is good to know.

Mr McDevitt:

I have a query on some figures that Mr Killough mentioned. Did you refer to 387 dental practices, or did I mishear you?

Mr Killough:

There are 357 dental practices.

Mr McDevitt:

Therefore, there is one additional practice than is stated in your briefing paper. Are all those practices inside the Health Service contract?

Ms Christie:

It centres on the fact that dentistry is about delivering dentistry, which can be delivered inside the Health Service contract. It is important to be aware that Health Service dentistry is bound by a series of rules that describes Health Service dentistry. Dental care through the Health Service is described in a series of items that dentists can do. Each of those items has a description and a fee that is set by government. If a patient pays, there is also a fee.

There is a host of other rules about the time between certain items, the mixture of items, and so on. Health Service dental care is a closely prescribed mechanism that is set up in a series of rules. Dental care can be provided by a dentist inside those rules, in which case it is Health Service dental care, or, if it does not fit inside those rules, it can be provided outside them, in which case it is private dental care. However, a dentist or a dental practice would describe themselves as a dentist or a dental practice.

Mr McDevitt:

Do all those 357 practices deliver some NHS dental care?

Ms Christie:

Yes, they do.

Mr McDevitt:

Do some practices not currently deliver any of that Health Service work?

Ms Christie:

No. The Business Services Organisation provides figures on the number of dentists who operate inside the Health Service. There are currently 843 dentists, which comprises pretty much all of Northern Ireland's dentists. You were, perhaps, alluding to the fact that it is important to note that, because dental practitioners are self-employed, independent contractors, they can decide how much work to do inside the Health Service.

It is also important to note that Northern Ireland's dentists are highly committed to the Health Service. Just under 900,000 patients are registered for dental care, and, last year, some one million courses of dental treatment were carried by Health Service dentists. The broader figures show that over two thirds of dentists in Northern Ireland do at least 75% of their work on the Health Service. Most of our dentistry, therefore, is carried out inside the bounds of the Health Service.

Mr McDevitt:

It may be the case only in the part of Belfast that I represent, but, in that part of Belfast, the vast majority of dentistry is not delivered through the Health Service. In fact, none of the dentistry in that part of Belfast is delivered through the Health Service, and even being able to register with a dentist has become a massive issue for many people, particularly for children.

Therefore, I wonder whether there is an under-supply of dentists. Do you think that enough dentists are practising and whether they are well enough spread across the region to meet current demand? I note your figure that the majority of the 843 dentists do 75% of their work on the NHS, but my experience and that of my constituents is of great dissatisfaction when it comes to being able to access an NHS dentist or even being able to register with one.

Ms Christie:

It is important to note that responsibility for people to have access to an NHS dentist does not lie with dentists. Dentists are the suppliers of dental services, and the demand for dental services outstrips the supply that is available. It is the role of government to ensure that the public and population can access a dentist. Dentists are constrained by the set of NHS rules. If a dental practice is full and someone asks it to care for him or her, it is difficult to provide that care without having the space.

Mr McDevitt:

Do you believe that there is an under-supply of dentists in this region and that more dentists are needed?

Ms Christie:

As you highlighted, in some areas of Northern Ireland, the demand for dental services far

outstrips supply. The Minister recognises that, and he has worked to ensure a supply of additional dental services. Dentists work hard to meet the demand, but they can work only at the capacity that is available.

Mr McDevitt:

I am trying to get to the bottom of the BDA's position. Does the BDA believe that more dentists are needed to practise in this region?

Mr Killough:

The answer to that is that the Minister has —

Mr McDevitt:

No, I want your opinion.

Mr Killough:

I will come to that. The Minister has targeted a new initiative at the areas in which access is a problem. The question concerns whether there are enough dentists to supply the demand. Dentists from Northern Ireland are trained not only in Belfast but in universities elsewhere in the United Kingdom. Is there a way to make it attractive to all those dentists to want to practise in Northern Ireland? Is the infrastructure in place, and is the money available to do that? That is difficult to answer when talking about a specific society.

Mr McDevitt:

You conceded that, regionally, dentistry is demand led so demand outstrips supply.

Mr Killough:

If you were a patient in my area —

Mr McDevitt:

I am asking whether you are in favour of increasing the supply of dentists.

The Acting Chairperson:

One at a time, please, so that we can all hear.

Mr Killough:

I am sorry. If you are saying that people in your specific area do not have access to dental services, are you also saying that there is no availability outside that area?

Mr McDevitt:

The evidence in my area shows that there is no access to publicly funded dentistry. That is simply the case. Given that you concede that supply outstrips demand regionally, do you believe that we need to increase the supply of dentistry at a regional level? That boils down to more dentists: yes or no?

Ms Christie:

That is one way of looking at the issue. Seamus said that the main focus of the BDA's work centres on the negotiation of a new contract, because it is widely recognised that there are oral health issues. We have a dental service that was developed 60 years ago, and the desires, needs and wants of patients and the profession are not meeting one another. That goes back to the need to negotiate a new contract, which we are undertaking. Government will have to ensure that the new contract provides access to publicly funded dentistry.

Mr Killough:

There is no question that the BDA's main objective is patients' well-being throughout their lives. It is the responsibility of government to provide health treatment for the public. If there is a shortage, that is the Government's responsibility.

The Acting Chairperson:

Are you happy enough with those replies, Conall?

Mr McDevitt:

I may come back to the subject.

Mrs D Kelly:

Your briefing paper refers to links between tooth decay, poverty and health inequalities, and it refers to lifestyle choices. Dare I reopen the fluoridation debate? I recall statistics that suggest that child dental decay in Derry is one of the highest on the island of Ireland or in GB. What is the BDA's opinion about fluoridation? There have been stories — some would say

scaremongering stories — about the adverse effect of fluoridation on health and well-being. Has there been any recent research to validate or dispel that argument? The statistics that the Acting Chairperson quoted about the number of tooth extractions for children aged eight and under were quite startling.

Your paper also refers to developing a new contract for dentists. The earlier departmental witnesses spoke about the GPs' out-of-hours contract and other contractual changes that were intended to bring efficiency savings but which cost three times more than expected. The Committee wants assurances that any changes to dentists' contracts will lead to greater efficiency and money being invested at the front end.

You spoke about universities and teaching hospitals. Do many of our young people have to travel outside Northern Ireland for a university place?

Ms Christie:

Fluoride is recognised as having a role in the prevention of tooth decay, and the BDA believes that fluoridation of the water supply is the single most effective public healthcare measure to enable a significant reduction in the number of children who suffer from tooth decay.

You spoke about the high levels of tooth decay in Derry, and UK and Irish league tables confirm that to be the case. A survey of children's teeth in Northern Ireland and the Republic of Ireland was carried out in 2003. In the Republic of Ireland, 71% of the region has a fluoridated water supply. The survey compared children's dental health, north and south of the border. A key finding was that the oral health of children and, indeed, adults was substantially better in communities in which the water supply was fluoridated. That evidence comes from the closest place to home that we can examine. I understand that it is an emotive issue for political parties and for individuals. People have views on fluoridation. However, that is the BDA position.

Mrs D Kelly:

Are there any adverse scientific and research findings on areas in which water has been fluoridated?

Mr Killough:

I am fanatical — perhaps that is the wrong word — and extremely keen on the massive benefits

that fluoride, in all its forms, has on the population's dental well-being and oral health.

Your question is relevant and valid. I got my head round it some years ago. I will use an analogy: we could spend a five-set tennis match going backwards and forwards with statistics and counter-statistics. I am a healthcare professional, and my colleagues, by definition, are concerned with the population's health and well-being. Why would that type of person want to promote something that was not beneficial to the health of the population?

Four hundred million people worldwide, and, nearer to home, people in Newcastle upon Tyne, Birmingham and Southern Ireland, have had fluoridated water for more than 30 years. In my lifetime, I have yet to see a headline, television programme or massive event that goes on for days and weeks on something being caused by water fluoridation or fluoride in toothpaste.

That is my simple way to try to get over the backwards-and-forwards statistics. Fluoride works. The massive benefit of water fluoridation is that it removes bias in healthcare promotion. Everyone, and particularly the socially disadvantaged people whom we mentioned, has access to that healthcare initiative.

Mrs D Kelly:

You describe it as something of a no-brainer —

Mr Killough:

No. I am sorry for interrupting you. I respect and understand —

Mrs D Kelly:

When my children were small, I bought fluoride drops. Has research ever been commissioned on people who buy fluoride drops and have, therefore, decided, as many parents do, not to be concerned about other statistics that suggest that it is not good?

Mr Killough:

I have three sons and three daughters, which never sounds as many as six children. They range in age from — this is embarrassing — 28 to 36 years of age. They have an average of 28 teeth each, and there is not one cavity among them. They were given fluoride since day one. Again, that is simply an individual example of my experience. Would I want to do something, about which I

was not comfortable or confident, to my children?

Mrs D Kelly:

Thank you.

Ms Christie:

You asked about graduates and undergraduates. I can talk only about Northern Ireland. We are fortunate that we have a dental school on our doorstep. Dentistry is a popular course with local school leavers and undergraduates. Before UK graduates can work in the Health Service, they must undertake a year of additional training. Northern Ireland also has a good scheme for that. The number of places on the scheme is matched to the number of graduates from Northern Ireland. That is not to say that those places are for local graduates only: legislation dictates that they cannot be. It is about matching what is available to ensure that the graduate cohort has the opportunity to have the correct number of training places. Does that help?

Mrs D Kelly:

There is much competition for places in the North. Some young people have to leave because there are not enough places. It is often the case that young people who get grades lower than A at A level go to universities in England that turn out exceptional dentists and other professionals. However, the demand here is such that young people who achieve A and A* grades have to compete for places. There is much pressure on young people to get the vocational career that they want.

Ms Christie:

Dentistry is highly competitive at undergraduate level.

Mrs D Kelly:

Do young people have to go to England, Scotland or Wales to train because places are not available in the North, and the grade requirements are lower across the water?

Ms Christie:

The BDA could not help you with that.

Mrs McGill:

There is a rising demand for cosmetic dentistry. Is that taken into account in dentists' contracts? It is a lucrative industry, and dentists could find themselves going down that route rather than pulling one tooth after another, which does not bring the same rewards.

I want to respond to Conall's point. In my view, the Minister moved to address some of the difficulties as best he could, particularly in areas where inequalities exist. The picture is not yet complete, but in my area, where there have been problems, a new dental practice opened within the past week. That might happen in Conall's area. There is a list.

Ms Christie:

Seamus referred earlier to the Department's oral health strategy, which was introduced in 2007 and which was followed by the primary dental care strategy. In the latter strategy, the Department sets out clearly the treatments that are delivered through the Health Service and those that are not. The strategy provides clarification about the treatments that are related to health and those that are related to appearance, given that appearance is not about health. Does that help?

Mr Killough:

The new contract is at the negotiating phase. The template is for a wide-ranging contract; fortunately, prevention is included as a major element of the new contract. It includes what are called "essential services": the Department will prescribe the essential services that will be available under the new Health Service contract. Services that are not prescribed in the contract will be provided to patients on a private basis, as they currently are. The government prescription will define what constitutes essential services, and as Claudette said, those will be clinically effective and cost-effective.

The Acting Chairperson:

Claire, we could write to the Minister to ask him for an update on NHS contracts for dentists. Is there is a timescale for resolving the contract? One principle of the contract is prevention. What are the other principles?

Ms Christie:

The concept of the contract has been agreed between the Department and the BDA. The Department has given an undertaking that the contract will be tested through piloting, and the

focus is now on putting the pilot scheme in place. That will be the true test of how the contract will develop. That is as much as I can tell you by way of an update.

Mr Killough:

We want to promote good oral health and eradicate oral health inequalities. We want to harness and develop the expertise of all dental staff to ensure that all services are available locally. We want to create a system that meets the needs of patients, works for the dental profession and delivers on prevention. We want to safeguard the future of all dental services, whether those are in hospitals, trusts, academia or the high street.

The Acting Chairperson:

On behalf of the Committee, I thank you for your fascinating presentation. We will undoubtedly see you again at some stage in the future. All the best.

Mr Killough:

I appreciate that. Thank you.

Ms Christie:

Thank you.