NORTH DEVON COUNCIL

Minutes of a special meeting of Policy Development Committee held at G107, 1st Floor, South West Institute Development Building, Petroc, Barnstaple - Petroc College on Thursday, 18th July, 2024 at 6.30 pm.

PRESENT: Members:

Councillor L. Spear (Chair).

Councillors Bishop, Bushell, Clayton, Jones, Patrinos, Wilson and Worden.

Officers:

Representing North Devon Council:

Chief Executive.

Representing Torridge District Council:

Head of Legal and Governance (& Monitoring Officer).

25. WELCOME AND HOUSEKEEPING

The Chair welcomed the panellists, Members and the public to the meeting. She outlined the format of the meeting, how it would work in practice and reminded all parties to be polite and respectful to each other at all times.

She advised that as the special meeting was being held jointly with the External Overview and Scrutiny Committee of Torridge District Council, both Committees would need to address their formal items on the agenda front pages prior to opening the meeting for joint discussion.

NORTH DEVON COUNCIL – CONSIDERATION OF ITEMS 1 TO 4 ON THE AGENDA:

26. APOLOGIES

Apologies for absence were received from Councillors Bulled, P. Leaver and Williams.

27. DECLARATIONS OF INTEREST.

There were no declarations of interest announced.

TORRIDGE DISTRICT COUNCIL – CONSIDERATION OF ITEMS 1 TO 4 ON THE AGENDA:

The Chair of the External Overview and Scrutiny Committee of Torridge Distract Council took her Committee through items one to four on their agenda.

28. DENTISTRY. TO CONSIDER AND DISCUSS DENTAL PROVISION IN THE NORTH DEVON AREA.

The Committee collectively noted the responses to the pre-submitted questions under item 5 on the agenda at appendices A-D.

The Chair introduced Councillor Patrinos to the special meeting and invited him to address the Committee.

Councillor Patrinos outlined the proposed format for the meeting, identified the reasons behind the calling of the special meeting, which involved addressing public concerns regarding the lack of dental provision at local level.

He outlined the following key points to the special meeting:

- Securing a dentist, especially an NHS one, was extremely difficult.
- To better understand the problem both District Councils decided to meet jointly to discuss any potential solutions to the ongoing problem.
- Both Committees fully appreciated that as local district Councils the commissioning of dental provision was not a responsibility that sat within their remit.
- As district Councillors they regularly responded to the concerns expressed to them by their constituents.
- There were many heart breaking stories, which all seemed to follow the same pattern:

    - Many people had no dentist.
    - Some with children as old as 8 that had never seen a dentist.
    - Members of the local community who had moved to Devon from other parts of the country regularly had to travel to their previous dentists in other parts of the UK to receive ongoing treatment.

- This was not just a local but also a national problem.
- The aim of the special meeting was to better understand the causes of this growing problem and to identify ways in which local district councils could potentially provide assistance.
- The invited panel consisted of three experts and whilst other representatives from NHS Devon and Healthwatch were invited, they were unfortunately unable to attend.

- The fourth panellist representing Mydentist, which owned a number of dental practices across the UK initially agreed to attend. However, two days prior to the special meeting the Clerk to the Policy Development Committee at North Devon Council was advised that they were no longer able to attend the special meeting. They were however happy to answer any questions by email, which the Clerk would facilitate after the meeting.

Each Member of the panel was invited to introduce themselves and provide a brief overview of their role together with their employment background.

The Policy Development Committee members of North Devon Council asked follow up questions of the panellists and received the following responses:

1. **A figure of £2b had been quoted to get the dental provision back to where it should be, was this a true figure?**

   - **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** In terms of the contract, £2.9 billion was currently spent on NHS dentistry in the United Kingdom. However, that was only sufficient to fund dentistry for half of the population of England, and it didn't reach those in greatest need.

   - **Specialist Orthodontist, (Bude):** The current level of manpower and funding in NHS dentistry could not provide the service that was demanded or required. On many occasions the private sector had to be relied upon to deliver many of the other services. The issue was not only financial but also a decline in the personnel available to deliver the provision and service required to address the problem and the current contract required revision.

   - **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** The core service was being delivered at the present time. However, it was not being delivered to those in most need. To address the problem, conversations were required at a much higher level as the NHS was losing dentists to private dental practices.

2. **This was not an issue in the UK 15-20 years ago, why was the problem now so critical? Had there been an impact following BREXIT if dental professions had decided to leave the UK?**

   - **Specialist Orthodontist, (GDP providing orthodontics):** As part the introduction of the new NHS Dental contract in 2006, the government introduced a pilot scheme in 2005. However, when the final contract was introduced in 2006 it was completely different to the pilot. As part of the new contract, treatments under the NHS were provided under certain bands one, two and three know as Units of Dental Activity (UDAs). These units were used as a measure of activity and dentists were paid on the number of UDAs that were delivered. The system was fundamentally flawed in that it failed to incentivise prevention or reward dentists for

treating patients with high needs. The UDA system awarded dentists the same number of UDAs for three small fillings, which equated to five UDAs on a child, which was the same amount awarded for five extractions, six fillings, two root fillings, and three visits to the hygienist (five UDAs). Working within that system was very frustrating and unable to provide the quality of dentistry that I was required I retrained as an orthodontist. The contract had continued to deteriorate over the years and now a complete overhaul of the whole system was required.

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** NHS access for dental treatment had been declining for many years and the introduction of NHS dental contract in 2006 had effectively stopped new registrations. The result being that patients were now paying more for a poorer service. Workforce patterns had also changed over the years with more dentists working part time, dentists were also leaving their names on the General Dental Register even if they were not living in the country, which then distorted the data. There was also a growing requirement to provide better support for international dental graduates.

- **Specialist Orthodontist, (Bude):** In the 1970s a number of dental schools were closed, this combined with dietary changes within the general population had increased the demand for dental services. Dentists were also seeing an increasing amount of young children presenting with dental decay, which had significantly increased in recent years. Preventative measures such as regularly brushing teeth were therefore required to mitigate problems for children in future years.

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** Really important to focus on the oral health of children aged between five to nine years, which was the age category that saw the vast majority of hospital admissions for tooth extractions with 21% of five year olds having had visible decay. From the statistics available for the Plymouth area in 2021, the figures for decay within children varied greatly depending on the areas in which they lived:

    - 56% decay in the most deprived areas.
    - 7% decay in the most affluent areas.

3. **Were some privately owned dental practices profiteering from overcharging patients for their private health treatment? Having recently learnt of two patients, one NHS and the other private who underwent exactly the same treatment and whilst the NHS patient was charged less than £100.00, the private patient was charged close to £1,000. What are your thoughts on this?**

    - **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** By in large no and it was dreadful to hear stories of that nature and often patients within the middle ground took the largest financial hit. Healthcare was

expensive to deliver and high quality healthcare was even more expensive to deliver. However, it was difficult to comment on individual cases without knowing the full details.

- **Specialist Orthodontist, (Bude):** Had been made aware of patients who had been in contact with the Mydentist practice in Barnstaple to enquire about orthodontic treatment and been offered it privately when they were still operating the NHS contract. There were some dentists who charged extortionate rates for different levels of service and some dentists would charge higher prices for their time as their costs continued to rise. There were not enough dentists providing care and there were some dentists who would use that as an opportunity to push their prices up.

4. **Quite obvious that the oral health of the population was deteriorating. What was the major cause of this deterioration? Was it related to diet and high sugar content in food and drinks?**

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** Oral health was not deteriorating across the board but in certain groups of patients dentists were seeing deterioration. Particularly for patients who were unable to access care or perhaps didn't brush their teeth regularly together with the inequalities within our society. The NHS should be there to address inequality and provide an appropriate level of care to its patients. However, the current NHS contract contributed towards inequality of patient care. Many dental practices were closed in the 1970s and 1980s. However, those closures hadn't taken account of the lifespan of the population in that people were now living a lot longer than they would have in the past.

- **Specialist Orthodontist, (GDP providing orthodontics):** The recruitment and retention of dentists was an issue in the North Devon area with many newly qualified dentists completing their foundation year in practice and then moving out of the area to secure employment. This had a knock on effect for the recruitment process to fill a vacancy when a dentist decided to move on.

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** The results of a recent survey of dental practices within the North Devon area of the 56% of the responding practices had a dentist vacancy and 48% had a dental nurse vacancy. There were ongoing difficulties with persuading dental practices to commit to being NHS training providers with two practices dropping out of the training scheme within the last 12 months. There was a real need to promote North Devon to encourage dentists to live and work in the area.

5. **How could the Council promote North Devon to make it more attractive and encourage dental students to live and work in the area?**

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** Lobbying the government for improvements to the dental service together with the promotion of oral health within schools.

6. **Could we establish a training link for dentistry between Petroc and Plymouth University to expand on the existing partnership that was already in place for other qualifications and degree courses?**

    - **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** If there was the opportunity to explore this further happy to explore options.

The External Overview and Scrutiny Committee members of Torridge District Council asked follow up questions of the panellists and received the following responses:

1. **Do you think that dentistry had the political incentive that other areas had? For example planning applications for housing developments provided no provision for health. Were a lack of available premises also a contributing factor to the issue?**

    - **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** Dentists do not want to practice within the NHS system anymore. There was a growing need to inspire the next generation of children and young adults into the profession and acknowledge the difficulties for patients to access dental provision.

2. **There was a real inequality of care within the North Devon area and that must have some impact as one of the most deprived areas in the country? Were higher than average house prices also a contributing factor for recruitment in the area?**

    - **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** Lack of accommodation was a real issue for dentists moving to the area and many struggled to find affordable rental properties. Often many graduates returned to their family homes as they were unable to afford to rent or purchase property within the local area. There were massive inequalities in care within North Devon and often residents who moved to the area from other parts of the country had access to their own private medical care. There was a hidden rural poverty that visitors to the area didn't see.

    - **Specialist Orthodontist, (Bude):** The current NHS contract for dentistry didn't align with being able to provide a good level of care or payment for the time that was spent on treatment. Reform needed to be made at NHS contractual level together with more personnel to deliver the service and an overhaul of the current NHS contract to be able to provide better care across the board.

- **Specialist Orthodontist, (GDP providing orthodontics):** There was a requirement to attract graduates to the area and one of the options currently being explored was to tie graduates into a post within the NHS for two years after qualification. The whole system required reforming to make it a more attractive option to graduates to encourage them to work within the NHS for a number of years where there was still a huge demand for NHS care.

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** The introduction of a compulsory tie in for graduates to work and complete their training within the NHS formed part of the long term NHS workforce plan. However, this was not necessarily the right mechanism to encourage a motivated and sustainable workforce. The new government was also interested in exploring options to potentially offset student debts as a way of encouraging graduates into the NHS.

3. If there was one thing that both Councils could do to support the dental profession to achieve a better service for the public, what would that be?

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** The most important thing was for both Councils to lobby government to ensure that the North Devon area as a whole had a voice at government level.

  In the short term, there were a few solutions that could be introduced:

  - Undertake a mapping exercise of dental practices and vacancies in both areas.
  - Engage with dental practices and seek their guidance on how the Councils could better support them with their recruitment and retention of employees.
  - Actively promote the areas of North Devon and Torridge as a place to live and work.
  - Ensure that sufficient level of support was given to international dental graduates to enable them to settle and feel welcomed to work within the NHS in our local areas.

  In the longer term:

  - Promote and support dentistry within local schools and colleges.

The Chief Executive, North Devon Council explained that if lobbying was required at Devon County Council (DCC) level the district councils could work with DCC to support this.

In response to a question regarding measures or steps that both councils actively take, he explained that both councils could work in partnership and collectively with other district councils in Devon and through the recruitment process to try and

encourage graduates to live and work in the county.

- Lobbying in relation to both the regional and national picture, which could be facilitated through North Devon Council's ex Leader and now North Devon MP. Devolution was also on the horizon, which would provide greater powers to local authorities and dentistry could feed into the process.

In response to a further question regarding an evidence base for dental practices across North Devon, he advised that joint health and wellbeing would be considered as part of the Local Plan review and that dentistry would be picked up through that process.

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** There was a requirement to promote oral health within schools and the Labour manifesto indicated that they would introduce tooth brushing in schools as part of the curriculum. Dental practices had access educational resources to promote oral health with information on the importance of tooth brushing together with the impact that diet could have upon teeth and gums. There was a requirement to ensure that a mechanism was put in place to enable visits to schools as there were a few areas that were currently falling under the radar.

4. The Chair of the External Overview and Scrutiny Committee of Torridge District Council asked the following questions of the Panel:

a) Had there been an increase in the number of cases of oral cancer?

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** There had been no increases in incidents for oral cancers. However, dentists were seeing an increase in later presentation. Areas of deprivation were the most susceptible to the disease. Responsibility for dental access stopped in 2006 following the introduction of the general dentistry contract in 2006.

  He explained that the introduction of the new dental contract in 2006 meant that patients were no longer registered with a dentist. Registration was removed in 2006 which meant that access to a dentist was based solely on capacity, and not whether a patient was registered or not. This often led to confusion as patients often thought that they had been "deregistered" or "removed from a dentist's list". However, this was not the case, it was simply how the dental contract had been designed and it was very different to the GPs contract.

- **Specialist Orthodontist, (Bude):** Whilst mobile dentistry was a good idea it was not the best way to treat a large number of people and it was always better to take the patient to the service and there were

patient transport services available to take people to appointments. The NHS contract needed to be reviewed and improved to provide the appropriate level of care within the most deprived areas. If it was possible to review the NHS contract it was vital for commissioners to consider the tenders carefully and to also be mindful of who they awarded the contract to as access to the service and good patient care should be paramount as part of the tender process. If you looked at smaller dental practices, they often subsidised care to a degree to ensure that they secured better funding. The current corporate model did not reward dentists in the way that it should, which in turn provided a poorer continuity of care to the patient. NHS dentistry should be commissioned appropriately together with the correct level of employees to target the areas in the greatest need. To ensure that this was delivered it was vital that a revision of the dental contract was lobbied at government level.

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** The responsibility ultimately lay with the Commissioners NHS England South West and Devon ICB.

b) Operators for the NHS 111 number referred patients to the emergency dentist number. However, why was there was no-one to answer the calls on the emergency line out of hours?

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** Prior to the introduction of the 2006 NHS contract local dentists were on call until 10:00pm at night during the week and over the weekends. They removed the responsibility and took it in-house to the primary care trust. In 20026/07 there was sufficient employee provision in the dental access centres in Barnstaple, Exeter and Torbay, Plymouth and Tiverton. However, conditions with workforce and funding meant that the provision was reduced over time and eventually ceased. So, now 111 was the referral service; and patients who struggled to obtain out of hours care often presented at their local Accident and Emergency (A&E) centre as a result.

  There were also ongoing issues with both a depleted workforce together with reduced levels of funding.

c) Campaigns to save rural libraries and public transport, would there be any benefit of having a mobile dentistry travelling around the area?

- **Specialist Orthodontist, (Bude):** Public transport would be a great service if it was sufficiently funded and accessible. However, this was not the case for either and often local residents didn’t utilise the public

transport services that were already available.

- **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** There was a shift within the NHS to centralise services, and whilst hubs worked well in large city centres. Rural areas such as North Devon would not benefit from the same model as many of those most in need of treatment relied on public transport to attend dental appointments and accessing central hubs, many of which were a great travelling distance from where they lived would penalise those patients in the greatest need of treatment. He cautioned that care would need to be taken when looking to close down small practices in favour of central hubs. He added that a better course of action would be to have a hub and spoke model, which was not as cost effective but value for money for those having to access treatment.

RESOLVED:

a) That Standing Orders be SUSPENDED for the Policy Development Committee of North Devon Council to allow questions from members of the invited public present; and

b) That at the discretion of the Chair of the External Overview and Scrutiny Committee of Torridge District Council that Standing Orders be SUSPENDED Council to allow questions from members of the invited public present.

The Chair invited the members of the invited public present at the special meeting to ask questions of the panellists and received the following responses:

1. **Why isn't dentistry truly part of the NHS? Why are you not salaried employees? Why when the NHS was introduced in 1947 did they not included dentistry as part of the NHS?**

   - **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** If you go back to 1948 when Aneurin Bevan was the governments Health Minister; he was quoted as saying that he was able to deliver the NHS by "stuffing the Doctors' mouths with gold" which was a reference to the GPs who didn't want to work within the NHS in that he allowed some British Doctors to continue to continue to see private patients if they also accepted NHS patients.

     For the first 12-18 months NHS dentistry was free but within two years the government quickly realised that free dental care under the NHS was not financially sustainable and as a result, charges for treatment were introduced.

The government didn't buy out dental practices in the way that they did GP practices because it was not a feasible option for them; as the GP model was set up very differently. If this had happened potentially productivity together with performance levels for dentistry would have reduced significantly.

Community dental services existed to provide care for those with additional needs and this service was also massively underfunded and the impact of those contracts on already stretched resources made it even harder for dentists to achieve their UDA targets.

2. **The commissioned UDAs in Barnstaple were mainly held by a corporate body. Why does the company who were awarded the orthodontic contract in Barnstaple continue to apply for NHS contracts and then not deliver the service? This doesn't help the NHS patients, who were then offered a private service and stops other dentists using the NHS resources that they absorb?**

   - **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** This was a question that should be put to the NHS commissioners of South West England together with the Devon ICB as it was a cause of huge frustration. There was a £5m clawback for dentistry in Devon in 2023. However, that money was not being used to commission more dental services. Local dental practices were unable to fulfil their NHS contract provision due to a lack of employee resources.

3. **There were currently not enough dentists to provide care to local communities and emergency care was extremely difficult to access for both children and adults. Patients were advised to ring NHS 111 only to be told by NHS 111 to contact the emergency dentist at 8:00am. Many patients had waited up to an hour on the phone only to be told that there were no appointments available that day and that they had to try again the following day. There was again a financial impact upon patients if they are unable to drive or didn't have access to a vehicle and had to rely on public transport or travel further afield to seek emergency treatment. What would be your advice to these people?**

   - **Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School:** The commissioning of emergency care during working hours was the responsibility of NHS England, the South West Local area team and the Devon ICB. Through this process they had identified a huge problem.

     For example patients who were presenting for emergency care with an abscess or broken tooth were being treated through urgent dental care sessions from specific practices. The problem with this arrangement was

that the patient could not then access an NHS dentist for any follow up treatment or ongoing care.

So, the patient would continue with their daily lives until the problem occurred again when they would once again present to an emergency dentist. This recurring cycle of emergency treatment would be completely avoidable if the patient had access to regular dental treatment and a suitable care plan in place. NHS England were now commissioning stabilisation sessions so that the individual who had presented with pain would be directed to a practice where they would be given a course of treatment to render them dentally fit.

There would be more availability for emergency treatment as a result of these interventions. However, the knock on effect would mean that there was less availability for routine patient's ongoing care as the existing workforce did not have sufficient personnel to accommodate everything.

However, if the patient had a regular dentist and the profession was staffed appropriately the problem would never have occurred in the first place. Commissioners were in effect trying resolve a problem that shouldn't have been created in the first place.

Lobbying was key to bring about rapid change to the existing system and to raise the profile of the issue with NHS England together with the ICB and the Local MPs as they were the people who would ultimately make the decision regarding the commissioning of services.

The Chair of the Policy Development Committee of North Devon Council thanked the panel for their attendance at the meeting together with their high quality informative input. Both Chairs agreed that it was important for the Councils to work collaboratively and to lobby the government jointly.

The Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School advised that he was happy to offer guidance and support to the lobbying process.

In response to a question regarding dentists working part time hours and whether more would be achieved if dentists worked longer or full time hours, the Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School advised that he worked full time hours. However, his time was divided between working at his dental practice teaching at the Peninsula Dental School.

The Specialist Orthodontist, (Bude) advised that whilst his contract was part time he actually worked 42 hours a week and added that when he first qualified as a dentist and worked in Barnstaple he was working up to 120 hours a week. He acknowledged that it was important to promote living in the South West to attract those who enjoyed an outdoor lifestyle and to encourage more people to move to the

area by introducing more training places and a bigger skills mix to cover different aspects of dentistry.

The governance of dentistry had increased dramatically there were clerical and governance issues within the profession and it was really important to try and increase the number of training places and not to expect people to work more hours than they did currently.

Councillor Jones, North Devon Council advised that the Council had recently attended graduate events to promote the Council and the employment opportunities that it could provide. He questioned whether the same approach could be taken for dentistry by holding a workshop for local industries to get involved and produce marketing materials to promote the profession?

The Partner at Torrington Dental Practice/Associate Professor of Primary Care Dentistry, Peninsula Dental School advised that he had been involved with a South West work force task and finish group marketing. He advised that marketing was vital to promote dentistry as a profession and that developing and growing the workforce would take a number of years. So, it was a good idea to start now and there were a lot of exhibitions and conferences that were attended by the Penisula Dentist School to promote dentistry could be promoted and depending on the resources that the Councils had the dental profession could provide support through manpower. As Chair of the Devon LCB who were reasonable financially secure together with a great amount of enthusiasm and ideas to bring more dental professionals to the area.

29. ACTIONS/NEXT STEPS

The Vice Chair advised that he had made a summary of the key points from the discussions held and the Committee would consider these alongside the formal minutes at the next meeting of the Committee.

The Chair of the External Overview and Scrutiny Committee, Torridge District Council thanked the panellists for their attendance at the meeting and their openness in the discussions of the issues and spoke of her desire to work together to see improvements going forward.

The Chair of the Policy Development Committee, North Devon Council thanked the officers involved in attendance at the meeting. She also thanked the Corporate and Community Services officer for her support during the meeting and the Clerk to the Committee for her hard work behind the scenes to facilitate the arrangements in the run up to the meeting.

Chair

The meeting ended at 8.29 pm

NOTE: These minutes will be confirmed as a correct record at the next meeting of the Committee.